NNOC/ NNU Pocket Notes

Navigating through an Anti-Union Campaign

National Nurses Organizing Committee

National Nurses United

Contents

Introduction

Join NNOC/NNU's national RN movement — a strong voice for our profession and our patients

On behalf of the elected RN members of our Board of Directors, welcome to the National Nurses Organizing Committee/National Nurses United (NNOC/NNU). NNOC, together with California Nurses Association (CNA), has more than 130,000 RN members in hospitals throughout California, Florida, Illinois, Maine, Missouri, Nevada, Ohio, Texas, and West Virginia, and is proud to be an affiliate of NNU, the nation's largest and fastest-growing union of direct-care RNs, founded in 2009, representing 170,000 members from all 50 states.

NNOC/NNU is a national union and professional organization for RNs who are pursuing a more powerful agenda of patient advocacy, which promotes the interests of patients, direct-care nurses, and RN professional practice. We exist to give a voice to the working, bedside nurse and to give a vision for our nation's health care system.

From coast to coast, we have won the best contracts in the nation for RNs. Nearly 50 years ago, RNs were among the lowest-paid professionals, had no retirement, and worked every weekend.

Today, through the collective action of our members, nurses at NNOC/NNU facilities have safer staffing conditions, a more secure retirement, and salaries commensurate with experience. Our agreements are also noted for enhancing the collective voice of RNs in patient care decisions.

We believe that a strong, professional RN union empowers us to take our patient advocacy from the bedside to the statehouse and beyond. We have repeatedly stepped outside the walls of our facilities, from our fight to win and defend California's safe staffing ratios, to forming the Registered Nurse Response Network (RNRN), a national network of more than 20,000 volunteer direct-care RNs, ready to be deployed to disaster-stricken areas — such as Puerto Rico after Hurricane Maria and the Philippines after Typhoon Haiyan — where and when they are needed.

Join Us!

For more information, visit our website at www.nationalnursesunited.org.

Why do hospitals hire anti-union consultants (aka union busters)?

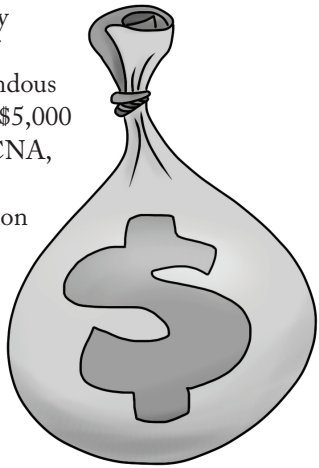
In every NNOC/NNU election campaign, nurses ask the question: "Why is our administration so opposed to RNs organizing?" No employer, including yours, wants to be required to sit across a bargaining table from an elected committee of RNs to negotiate a legally-binding contract.

They don't want to lose the power they now have to change policies and benefits at a moment's notice. They are threatened by the idea of nurses gaining an independent voice. It's as simple as that.

Most hospitals hire professional "union busters" to try to stop RNs from organizing. Administrations claim that they hire them because managers need assistance in abiding by the law. This assertion is contradicted by anti-union consultants' long history of unlawful conduct.

How much are they paid?

Under federal labor law, hospitals must disclose how much they are paying anti-union consultants by filing an LM-20 form with the Department of Labor. Hospital administrators devote a tremendous amount of time and money — from $3,000 to $5,000 per RN. According to an invoice obtained by CNA, Antelope Valley Hospital, located in southern California, spent $55,000 per week on anti-union consultants. Another example is an anti-union firm Reliant Labor Consultants was paid $3000 per consultant plus travel allowance. That's a lot of money that could be better spent on hiring additional nursing staff and on patient care.



What they do: pressuring supervisors to pressure you

Under the direction of these anti-union consultants, administration will order supervisors to take the lead in the campaign against NNOC/NNU. Even supervisors who support RNs organizing will be required to conduct one-on-one, anti-union meetings with each RN on their unit. Supervisors do not have the protections of federal labor laws during an organizing drive.

Your right to organize

Your right to organize with NNOC/NNU is protected by federal labor law, the National Labor Relations Act (NLRA).

Under the NLRA, you have the right to:

- Sign an NNOC/NNU card and attend meetings to discuss NNOC/NNU.
- Talk to other RNs about NNOC/NNU during non-work time in non-work areas.
- Hand out written materials on non-work time, such as breaks, and in non-work areas, such as the cafeteria, locker rooms, and nurses' lounges.
- It is illegal for your employer to require you to discuss your feelings about NNOC/NNU or to discipline you in any way for exercising your rights to join or support NNOC/NNU.

So-called "right-to-work" laws that exist primarily in southern and western states such as Arizona, Nevada, Texas, and Florida do not affect your rights to organize with NNOC/NNU and participate in union activities.

How to navigate and win

Read this booklet. Explained here are 17 myths that form the core messages of the union busters' campaign. Talk about it with your colleagues. Keep track of the number of anti-union messages you hear.
There's a scorecard in the back.

Informed responses to counter the negative messages of management and their anti-union consultants are only one part of the RN's arsenal. To truly win the hearts and minds of the RN majority in your hospital, nurses must understand the positive vision NNOC/NNU offers. Today, through the collective action of RNs at NNOC/NNU facilities, nurses enjoy safer staffing conditions, a more secure retirement, and salaries commensurate with experience. Our agreements are noted for enhancing the collective voice of RNs in patient care decisions.

A well-respected, representative, and engaged NNOC/NNU RN leadership committee at your facility is essential to ensuring all RNs understand the truth behind the myths.

The leadership of the nurses in your hospital must work with CNA/NNU organizing staff to develop this vision and, in that context, unfold the truths to counter the myths spread by management.

If you are prepared and informed, you will be successful in winning your election, gaining a voice, and securing a good first contract with enhancements in salaries, benefits, and patient-care protections.

Keep in mind

1. NNOC/NNU has won 90 PERCENT of elections over the last 20 years.
2. From 2000 to 2020, National Nurses United (NNU), has organized more than 52,000 nurses from 144 hospitals across the country.
3. NNOC/NNU has successfully settled first contracts in more than 95 percent of these hospitals, all resulting in improved wages and benefits, stronger patient care protections, and an independent voice for RNs to better advocate for their patients and their profession.

Myth #1

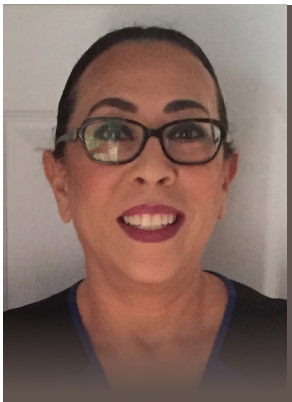
"With NNOC/NNU, you will lose your flexibility in scheduling."

Truth »

NNOC/NNU RNs can self-schedule, have a master schedule, or devise a new system. The difference is that with a collective bargaining agreement, it is the nurses in each department who determine what they want.

"We are still able to self-schedule on my unit. We can also trade shifts with one another. We are even able to trade on-call time. We can sign up for on-call days. If something comes up where we need a day off, we can just trade the day with someone else. We enjoy more flexibility with our contract than we did before we had one."

Audrey Michael, RN
Providence Hospital, OR
— Washington, D.C.



Lucia Adams, RN
Las Palmas Medical Center, NICU and Neonatal Transport
— El Paso, TX

"Nurses at my hospital love the flexibility and guarantees we have in the union contract when it comes to scheduling. We negotiated language into our contract that codified some practices we had at the time we organized, and proposed new concepts that the company ultimately agreed to. Bottom line? We self-schedule. The manager balances the days in an equitable fashion, and once the schedule is posted two weeks before it starts, by contract management can't make changes unless the nurse agrees. So we can trade days with other nurses, or even pick up extra shifts, if both we and the hospital want. Another great flexibility is that we have an extra-shift bonus that is offered during times of a critical staffing shortage. So if we voluntarily pick up an extra shift after the schedule has been posted, during a time of critical staffing needs, we get a bonus on top of our pay and differentials."

Myth #2

"With NNOC/NNU, you won't be able to talk directly to your manager or supervisor."

Truth »

The relationship between RNs and frontline managers generally improves with a NNOC/NNU contract. That's because arbitrary and confusing policies are replaced by a contract that clarifies issues including scheduling, call off, floating, promotion, vacation, clinical ladder, etc. In fact, RNs are always encouraged to first approach their managers directly on all issues that may arise.

If you are unable to reach a satisfactory resolution on your own, you have the option of contacting a NNOC/NNU nurse representative (one of your RN colleagues, elected by your unit, and trained by NNOC/NNU) or your NNOC/NNU labor representative.

"We never have a problem resolving issues with our managers. But if we do, we have an NNOC/NNU contract and have even more opportunities to communicate with our managers about our needs...and we get results."

June Phillips, RN
Fawcett Memorial Hospital, Ortho-Spine — Port Charlotte, FL

Myth #3

"Managers and unit coordinators can't help us with patient care in an NNOC/NNU facility."

Truth »

In every NNOC/NNU hospital, frontline managers and charge nurses help out all the time. We welcome managers who want to continue to provide direct, patient care rather than sit behind desks. We do not allow frontline managers to be counted in the staffing matrix. For example, if the census calls for five RNs, then there should be five full-time, direct-care nurses, not four RNs plus a manager taking patient assignments.

NNOC/NNU advocates for strict enforcement of the safe staffing ratio law, now in place in California and pending before legislatures in many other states. **The law does not** allow charge nurses to be counted as part of the staffing ratio. This does not mean that while waiting for a registry nurse or an on-call nurse to come in that a charge nurse or manager cannot help.

NNOC/NNU also advocates for full-time break RNs rather than making frontline managers and charge nurses do break relief on a routine basis. An RN manager may ONLY accept an assignment to relieve a nurse for an absence from the unit for tests, transferring monitored patients, or for a break, and the manager can only do so if that manager has current validated competency for that specific unit.

NNOC/NNU's position is derived from California's Title 22: Section 70217, which states:

"Nurse Administrators, Nurse Supervisors, Nurse Managers, Charge Nurses, and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the ratio.

Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses who have demonstrated current competency to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit."

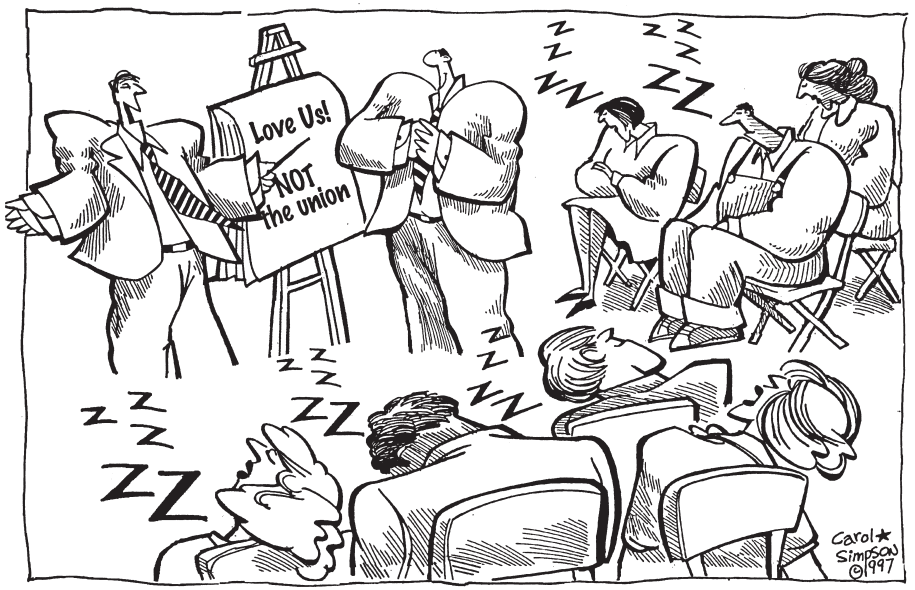
Myth #4

"The hospital won't be able to discipline or terminate incompetent RNs with an NNOC/NNU contract in place."

Truth »

NNOC/NNU protects RNs from arbitrary and unjust actions by management. However, disciplinary action can and does take place against nurses in NNOC/NNU-represented facilities.

The difference is that the hospital must follow progressive discipline such as oral counseling, written warning, suspension, and termination. They must show just cause for their actions at each step and allow a sufficient amount of time for a nurse to improve. If an RN still cannot adequately perform their job, the hospital has the right to take disciplinary action against the nurse.



"Our anti-union message must be getting through. Nobody booed."

Myth #5

"NNOC/NNU can't do anything about staffing and patient care."

There are many ways NNOC/NNU addresses staffing and other practice-related problems.

Truth »

An independent voice for patient care and nursing practice: the Professional Practice Committee (PPC)

The PPC is a staff RN-controlled committee, negotiated into every NNOC/NNU contract, with the authority to document unsafe practices and the power to make real changes. Direct-care RNs elect representatives from every major nursing unit in your facility to serve on the committee, which meets in the hospital on paid time. The PPC tracks unsafe conditions through an independent documentation system called Assignment Despite Objection (ADO).

Language in your collective bargaining agreement requires administration to respond to the PPC. The PPC can also go to regulatory agencies, or the public, with its concerns. This option puts pressure on administration to resolve issues internally and quickly.

NNOC/NNU RNs negotiate patient care and staffing-related language into their contracts. A few examples:

- Restrictions on floating and addition of new, float-nurse positions.
- Prohibition of the use of mandatory overtime except in the case of a declared emergency.
- Unresolved staffing issues that arise between RNs and management can be submitted to a neutral, third-party arbitrator for a binding decision.
- Safe lifting policies.

NNOC/NNU RNs have patient advocacy protection

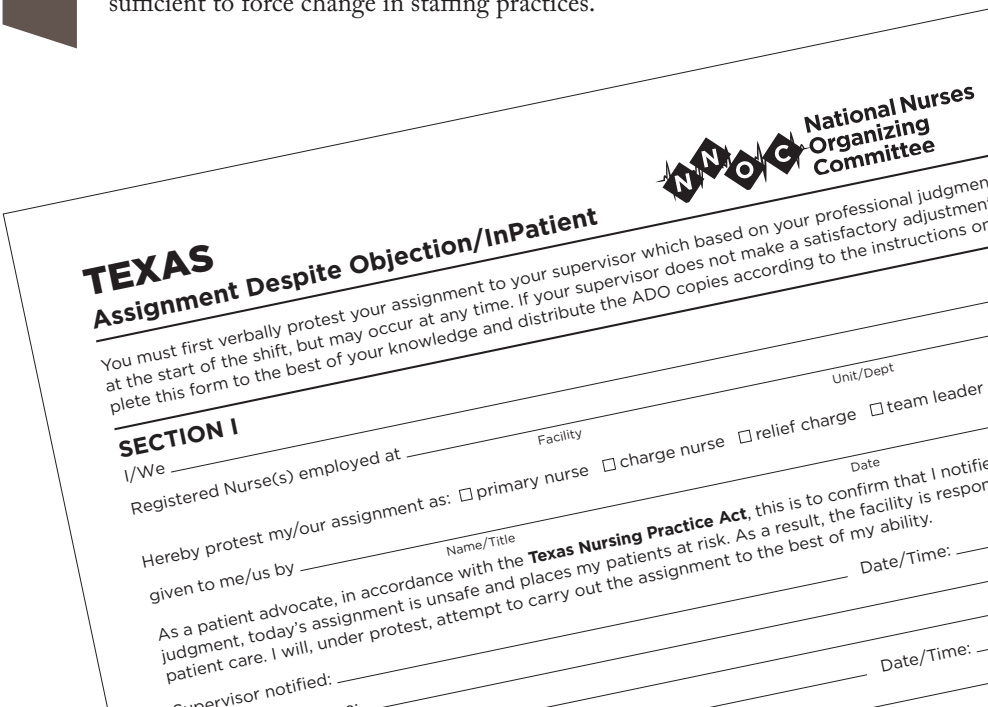
With NNOC/NNU representation, RNs are no longer "at-will" employees. They can only be disciplined for just cause and cannot be retaliated against for insisting on adequate staffing and safe floating practices.

Independent documentation system: Assignment Despite Objection (ADO)

One of the first steps in the advocacy process is documentation. The ADO is a tool that allows the RN to document unsafe conditions that may put patients and, as a result, your license at risk. A few examples of reasons to fill out an ADO include: unsafe floating, insufficient skill mix, or patients placed inappropriately on the unit who require a higher level of care.

Filling out an ADO at the time you believe the assignment is unsafe is a formal notification to management and protects your licensure in the case of a bad outcome in the course of the assignment.

ADOs are admissible in court and are protected under federal labor law. You cannot be disciplined or retaliated against for filling out an ADO. Often, filling out an ADO, or even threatening to fill one out, is sufficient to force change in staffing practices.



TEXAS
Assignment Despite Objection/InPatient

National Nurses Organizing Committee

You must first verbally protest your assignment to your supervisor which based on your professional judgmen at the start of the shift, but may occur at any time. If your supervisor does not make a satisfactory adjustmen plete this form to the best of your knowledge and distribute the ADO copies according to the instructions on

SECTION I

I/We _____

Registered Nurse(s) employed at _____ (Facility) _____ (Unit/Dept)

Hereby protest my/our assignment as: ☐ primary nurse ☐ charge nurse ☐ relief charge ☐ team leader

given to me/us by _____ (Name/Title)

As a patient advocate, in accordance with the **Texas Nursing Practice Act**, this is to confirm that I notifie judgment, today's assignment is unsafe and places my patients at risk. As a result, the facility is respon patient care. I will, under protest, attempt to carry out the assignment to the best of my ability.

Supervisor notified: _____ Date/Time: _____

Date/Time: _____

Legislation and education

NNOC/NNU's nursing practice program conducts continuing education classes to educate RNs in patient advocacy and the law. The government relations/legislative advocacy program is involved in all regulatory and legislative areas affecting the RN profession and patient care.

In January 2004, California enacted the first-in-the-nation ratio law, sponsored by NNOC/NNU, mandating minimum RN-to-patient ratios for all hospital units. NNOC/NNU has authored similar patient protection acts, modeled after the California law, that have been introduced in state legislatures across the nation.

NNOC/NNU has won other major legislation, including workplace violence protection regulations, whistle-blower protection for health care employees who expose unsafe hospital conditions, a ban on phone advice by unlicensed persons, and a law requiring that caregivers disclose their credentials while providing patient care.

Patient Care Success Stories from CNA/NNU Facilities

Objection to unsafe assignment leads to new training program:

"An RN from PACU was told she would have to take care of a pediatric patient (infant) on a ventilator. Since the only requirement at the time was for the PACU RNs to be PALS certified, she was the first to point out that they weren't competent to care for ventilated pediatric patients. She refused to take the assignment and notified the nurse rep that she faced the potential for disciplinary action. Instead of being disciplined, her knowledge of the law and the unity of the PACU RNs led to an annual skills day with specific patient population competency validation for the unit."

Cathy Kennedy, RN
CNA/NNOC President, NNU Vice President
Kaiser Permanente
— Sacramento, CA

UCLA-OR nurses educate, agitate, and eliminate rotating shift proposal:

"Our unit director tried to implement a night shift rotation assignment for day shift RNs. Nurses with more than 22 years of UC service had never been assigned a rotating shift. Working with their nurse reps, the OR nurses researched the physiological impact rotating shifts have on the circadian rhythms of the nurses. Altering RN shifts have been well documented to increased patient care errors. A delegation of nurses met with the medical director of the department and implementation of rotating shifts was cancelled."

Fong Chuu, RN
UCLA Medical Center, OR
— Los Angeles, CA

Myth #6

"California's ratios are failing. There is a nursing shortage so it doesn't matter if you get a union; we don't have enough RNs. There is no proof that ratios improve care."

Truth »

In fact, after ratios were introduced, California increased the number of all actively licensed RNs by more than 120,000 RNs — tripling the average annual increase prior to its enactment. According to the California Board of Registered Nursing, the total number of actively licensed RNs in California as of August 2020 was 450,055 compared with 246,068 in 1999. This increase in numbers was seven times more than the total number state health officials said would be needed to fulfill the ratios for general medical/surgical units.

- In 1999, the year ratios passed, there were 106,264 RNs working in hospitals (65,955 full-time and 40,309 part-time).
- In 2004, the year ratios were implemented, there were 121,923 RNs working in hospitals (76,315 full-time and 45,608 part-time).
- In 2009, five years after ratios were implemented, there were 147,261 RNs working in hospitals (98,905 full-time and 48,356 part-time).
- In 2014, 10 years after ratios were implemented, there were 164,235 RNs working in hospitals (108,875 full-time and 55,360 part-time).
- Since the passage of ratios, the number of RNs working in hospitals has increased almost 58,000 (57,971) or an increase of 54.6%.

Source: American Hospital Association's AHA Hospital Statistics, appropriate years

Myth #7

"There are no guarantees with collective bargaining. Management has to bargain but doesn't have to agree to anything."

Truth »

When you negotiate a first contract, you start with the pay and benefits you have now and build on them. After you win your election, the law prohibits administration from unilateral takeaways.

You will decide what to ask for in your contract and vote on it.

RNs have tremendous bargaining power, especially with the current nursing shortage, and enjoy overwhelming community support. It is in the hospital's best interest to keep its nurses and the public satisfied.

Since 2001, NNOC/NNU organized 128 new acute-care facilities and has successfully settled contracts in over 95 percent of them — every one of them with improved wages, benefits, and patient care protections. RNs have gained an independent voice to better advocate for their patients and their profession.

The strength of your contract will depend on the strength and participation of you and your colleagues.

Stanford ValleyCare victory

Kaiser LAMC victory

Myth #8

"Nurses won't have any power in the negotiating process. NNOC/NNU staff will be at the bargaining table, not the RNs."

Truth »

"Your first NNOC/NNU contract will provide you an opportunity to work with your RN colleagues to improve conditions for nurses and enhance protections for patients. With an NNOC/NNU contract, your employer cannot unilaterally change your working conditions or reduce salaries and benefits. Any changes in the workplace must be negotiated between management and RNs. You will elect your nurse colleagues who will represent you at the bargaining table, and you will, of course, vote on your contract."

Janice Webb, RN
UC San Diego Medical Center — San Diego, CA

Step #1

Facility Bargaining Council and RN negotiating team established

After the election, the RNs in the NNOC/NNU bargaining unit at your hospital will elect a Facility Bargaining Council (FBC). There is no limit to the number of RNs on the council. Ideally, there should be at least one RN per department and per shift. The FBC is the crucial link between your nurse negotiating team and all RNs in the bargaining unit. A well-balanced FBC assures maximum input from all RNs in the contract process.

The FBC selects the nurse negotiating team. The negotiating team should be made up of representatives from different units to have the broadest possible knowledge of the facility. The size of the team depends on the number of RNs in the bargaining unit at your hospital.

Step #2

The RNs at your facility decide what is important: the bargaining survey and development of proposals

The bargaining survey is distributed to every RN in the bargaining unit to fill out. The FBC then tabulates the surveys to determine the unit-specific proposals (e.g. call policy for OR), current policies and practices that RNs want to maintain, and the overall priorities for bargaining. The results of these surveys help to determine bargaining priorities.

Step #3

RNs are directly involved in negotiations

The RN negotiating team and an NNOC/NNU labor representative sit across the table from the management team. NNOC/NNU provides bargaining training. The RN bargaining team keeps the RNs informed through the publication of bargaining updates and a hotline. General meetings occur at critical junctures throughout the negotiating process.

Step #4

RNs vote on the contract

When the team reaches a tentative agreement, it is brought back to the general RN membership at your facility for discussion and a vote. Before a contract goes into effect, it must be approved by a majority of the RNs who vote at the facility in a secret ballot election.

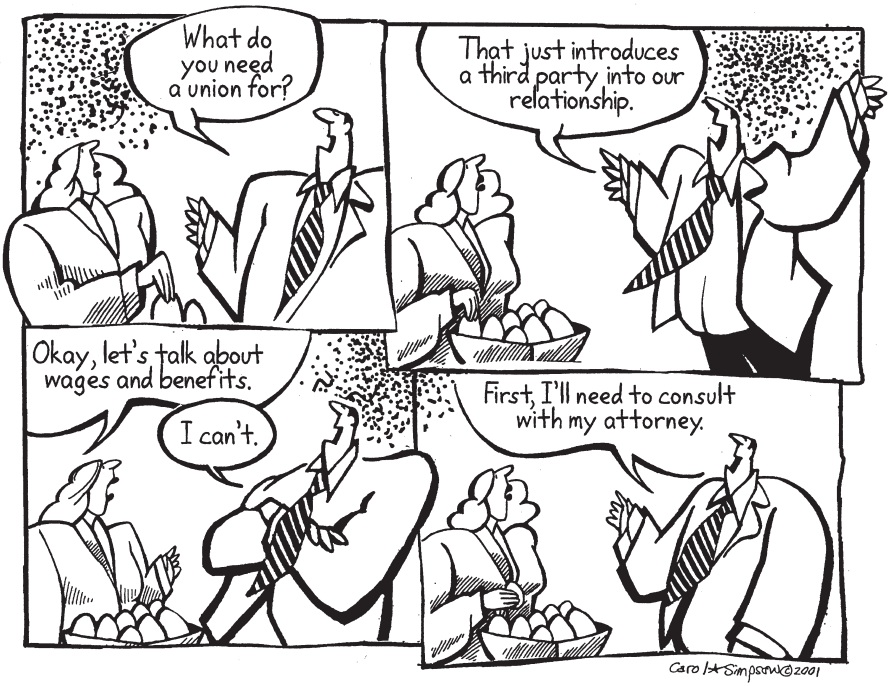
Myth #9

"NNOC/NNU is a third-party outsider."

Truth »

NNOC/NNU is a democratic organization run by direct-care RNs at every level.

- It will be you, the RNs at your facility, who decide what to propose in your contract and who then vote to accept or reject the resulting contract.
- You decide which RN colleagues will serve on your PPC to address staffing and other practice issues at your facility.
- You elect your coworkers to serve as in-house NNOC/NNU nurse representatives/shop stewards.
- You elect an RN from your region to sit on the 32-member, all-RN, direct-care board of directors.
- You vote for delegates to represent you at the triennial convention where policy is set for the organization.



Myth #10

"Dues are expensive."

Administration will tell you that dues are expensive. They often cite an incorrect higher dues amount. They say that the union is a business and needs revenue, and the only reason NNOC organizes is to get more revenue (i.e. dues).

Truth »

NNOC/NNU is a nonprofit organization that exists to improve the RN profession and patient care standards, and to end the health care crisis by fighting for health care reform that will guarantee every patient a single standard of care. We are NOT a "business."

Dues constitute about one hour of your base pay per pay period for nurses who have elections, then gain a contract. Dues are necessary to have an effective professional RN organization, and rates are democratically established. RN delegates are elected by their peers in each facility based on proportional representation. The current dues formula was democratically approved by majority of our members.

Our members pay lower dues than RNs represented by other unions. NNOC/NNU does not have an initiation fee to join.

No RN pays dues until you have negotiated a contract that a majority of RNs at your hospital vote to approve. Dues are minimal when put in the context of regular annual wage increases, better benefits, and improved working conditions.

RNs almost always overwhelmingly vote to accept their collective bargaining agreement because just the gains in the base rate are worth much more than the dues.

Myth #11

"NNOC/NNU will make you go on strike."

The administration will claim that NNOC/NNU will force you to go out on strike and can call one at any time. They will say that during a strike you will lose work. They will ask how you will support your family if you are "forced" out on strike. They will say that you are abandoning patients and compromising care.

Truth »

It's your decision.

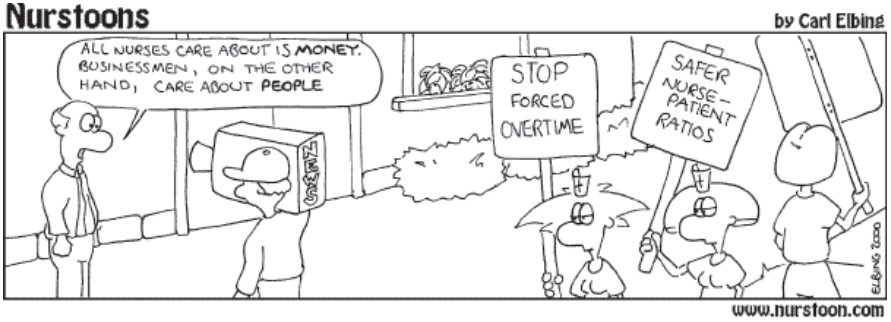
In NNOC/NNU, you cannot be forced out on strike. Only RNs at your hospital can decide to strike through a secret-ballot vote that has to be approved by overwhelming majority. No other NNOC/NNU officer, representative, or member from another hospital can make you strike.

The 2012 Sutter Health strike was approved by a more than 95 percent vote of the RNs.

A strike is the most drastic weapon, and it is used with caution, careful preparation, and only as a last resort.

Where strikes are necessary, RNs vote for typically one or two days.

NNOC/NNU RNs usually vote to strike from one to two days, though sometimes the hospital keeps the nurses out for a few more days after the strike. NNOC/NNU assists RNs who need to work elsewhere during a strike through job fairs and registries.



NNOC/NNU RNs protect patients in the event of a strike.

When NNOC/NNU RNs strike, there are mechanisms that ensure the well-being of their patients and community. They are as follows:

- **Ten-Day Notice**
  The law requires a 10-day advance written notice of intent to strike. This is to give the hospital time to stop admitting new patients and to begin the process of transferring patients who can be safely moved.
- **Patient Protection Task Force**
  RNs form a task force to make the process of patient transfers and hospital phase down go as smoothly as possible. A few days before a strike is to begin, the task force issues a written advisory to the hospital summarizing nursing recommendations on which patients may be safely transferred that day.
- **RN-Controlled Emergency Care**
  During the strike, the task force makes a nursing assessment of each situation where emergency care is requested and will assign an RN to stabilize a patient.
- **Patient and Family Education and Counseling**
  RNs are made available to provide patients and families with information and counseling on the transport process.

Myth #12

"You can be disciplined and/or fined by NNOC/NNU according to its constitution and bylaws."

Truth «

Unlike management, NNOC/NNU does not use disciplinary measures (or fines) to control its membership.

CNA/NNOC and NNU are the fastest-growing and most powerful direct-care RN professional organizations in the nation. CNA is more than 100 years old and has a constitution and bylaws like all well-established organizations.

Myth #13

The "Vote No" committee.

Truth »

An essential item found in every anti-union consultant's bag of tricks is the "Vote No" committee. In most NNOC/NNU elections, a "Vote No" committee made up of a handful of RNs from your hospital mysteriously appears to distribute anti-union literature. They go under such names as "I Stand with (hospital name)," "Guardians of (hospital name)," or "Our Vote, Our Voice."

This "Vote No" committee usually uses a homemade style for leaflets so it won't look like the hospital is producing the material. In this day and age of the internet, a website often springs up.

Its primary purpose is to create the impression that RNs are deeply divided on the issue of organizing, when in fact they are usually a very small handful of RNs brought together and encouraged by management and the union busters.

The "Vote No" committee may be recruited from among RNs who once had a bad experience with another union or are philosophically opposed to all unions for religious or ideological reasons.

The "Vote No" committee is given free rein to distribute materials and campaign against NNOC/NNU throughout the hospital, in contrast to a policy of harassment applied to pro-union nurses.

The creation of a well-respected pro-NNOC/NNU committee of RN leaders representing every unit in your hospital is the essential element for success in winning your election.

Myth #14

"Give us another chance — you can always organize again later."

Truth »

Every time RNs decide to organize, administration asks for "one more chance." They claim they had no idea how strongly RNs felt, even though nurses had already given them many opportunities to respond to their concerns.

Frequently, hospitals will bring in a new CEO, a new VP of Nursing, or change unpopular department managers to put a "new face" on administration.

Without a union, the hospital still has the last word. New procedures for hearing complaints may sound good at first, but without a union, administration can simply ignore your ideas.

RNs know how much of their personal time it takes to launch a strong, positive effort to gain a professional voice. This effort could not be duplicated on a whim.

Real lasting change will only come by forming a union and sitting down at the bargaining table as equals with the hospital administration and negotiating a legally-binding agreement that cannot be changed without a vote of the nurses.

Myth #15

"Voting for NNOC/NNU will adversely affect the ancillary staff."

Truth »

The working relationship between the RNs and the ancillary staff can be preserved and enhanced through provisions in a legally-binding contract. When RNs gain a collective voice and the right to negotiate, they can bargain improvements in patient care issues that can positively affect both the RNs and ancillary staff. NNOC/NNU RNs have a history of advocating for more staff assistance when necessary for the well-being of all patients.

"We know how important the support staff are in providing high-quality patient care. Even though our union does not represent them, we have time and again gone out of our way to defend support staff against layoffs or any other form of a reduction in staffing and cuts in hours. Adequate staffing based on appropriate skill mix is the way to ensure high quality of care. We are committed to standing up for our colleagues to make sure they have our backing when it comes to proper staffing."

Falguni Dave, RN
John H. Stroger, Jr. Hospital of Cook County, Med-Surg
— Chicago, IL

Myth #16

"Signing a union card will give away your rights, and you are automatically a dues-paying member."

Truth »

Signing a union card does not create a legal obligation.

You are not bound to any legal obligation by signing a card.

After RNs vote "Yes" to win union representation, you sign a second card, the union membership card, to become a dues-paying member.

Dues-paying members are able to hold positions in the union, vote in internal union elections, and have a say in the direction of the union. No RN pays any dues until a contract is reached and approved by the members of the union.

Dues are necessary to have an effective organization.

They are democratically set by the elected CNA/NNOC board and NNU Executive Council, made up of direct-care RNs. Dues help to finance new organizing, collective bargaining, educational, and legislative efforts to protect and improve RN practice and patient care.

Myth #17

"NNOC/NNU is against MAGNET."

Truth »

CNA/NNU RNs are focused on having a collective voice and power to make positive changes for their patients. Out of the 30 magnet hospitals in California, 14 are union facilities, and nine of them are CNA/NNOC and NNU. The best way to improve conditions in the hospital is not through magnet, but through a strong union contract.

Notes

Was NNOC/NNU Right? Did You Hear These Myths?

You Keep Score »

- ❏ You lose your flexibility in scheduling.
- ❏ You won't be able to deal directly with your manager.
- ❏ Managers and unit coordinators can't help us with patient care in an NNOC/NNU facility.
- ❏ The hospital won't be able to discipline or terminate incompetent RNs with a NNOC/NNU contract in place.
- ❏ NNOC/NNU can't do anything about staffing and patient care.
- ❏ California's ratios are failing. There is no proof that ratios improve care.
- ❏ There are no guarantees with collective bargaining.
- ❏ Nurses won't have any power in the negotiating process. Only NNOC/NNU staff will be at the bargaining table, not the RNs.
- ❏ NNOC/NNU is a third-party outsider.
- ❏ Dues are expensive.
- ❏ NNOC/NNU will make you go on strike.

- ❏ You can be disciplined and/or fined by NNOC/NNU.
- ❏ The “Vote No” committee.
- ❏ Give us another chance — you can always organize later.
- ❏ Voting for NNOC/NNU will adversely affect the ancillary staff.
- ❏ Signing a union card will give away your rights, and you are automatically a dues-paying member.
- ❏ NNOC/NNU is against MAGNET.