

Education: Key to Ensuring High-Quality Cancer Care Before, During, and After a Nursing Strike

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In June 2006, the United Steelworkers Union, representing approximately 1,500 RNs at Robert Wood Johnson University Hospital (RWJUH) in New Brunswick, NJ, voted to reject the hospital's contract offer. The union and the hospital did, however, agree on a contract extension to allow for further negotiations. Subsequently, two contract offers were proposed by the hospital, but neither was accepted by the union. On August 15 of the same year, the union voted to strike and presented hospital administration with a 10-day notice. On August 24, 2006, the nursing strike at RWJUH began.

In the midst of contract negotiations, hospital administrators and nursing leadership began preparing for a potential strike, during which the hospital would be staffed with replacement workers. This article outlines the preparations for work stoppage and describes the oncology orientation and education components developed to ensure high-quality cancer care.

Hiring Replacement Staff

Like most hospitals, RWJUH used a contracted nursing agency to provide personnel during the work stoppage. The benefit of the

arrangement was that the management personnel from the outside agency are experts in providing replacement nurses during strikes. However, the outside agency did not perform all of the preparatory work. Quite the contrary: The oncology nursing staff provided by the agency was chosen based on a needs assessment that the RWJUH oncology nursing leadership team conducted in preparation for the strike. Prior to work stoppage, the leadership team, made up of nursing directors (managers of the units), the oncology educator, and the oncology clinical nurse specialist (CNS), met regularly to discuss concerns in the oncology service. The strike preparations were facilitated because an established team was in place.

The leadership team's first task was to critically examine the oncology service line and to determine specific skill sets for each of the five oncology units in the hospital. The five units were comprised of a 31-bed inpatient medical oncology unit, a 20-bed hematology/oncology unit, an 11-bed bone marrow transplantation (BMT) unit, a 31-bed surgical oncology unit that houses an 8-bed intermediate care unit, and an 8-chair same-day chemotherapy infusion unit. Of the 93

inpatient oncology beds, 46 are designated as telemetry capable.

Planning meetings were held daily during contract negotiations, often lasting several hours. Two primary tasks of the leadership team were to formulate oncology education requirements for replacement workers and to determine the frequency rate of skills needed to care for patients with cancer. The information would enable the team members to decide which skills to include in the "must have" criteria for nurse competencies for the replacement nurses. The undertaking was not as easy as it may have sounded. For example, if a skill was performed infrequently on a unit (e.g., arterial line monitoring) but was listed in the scope of service, provisions had to be made to ensure that the skill would be provided elsewhere in the hospital. This led to some challenges as the leadership team worked with other nursing leaders at the institution to determine the logistics of where nononcology-specific services and infrequently performed skills would be provided.

Although everyone functioned as a team, different members took responsibilities for specific areas of preparation. For example, the nursing directors were responsible for compiling the skill sets needed for each of their units, whereas the oncology educator and CNS evaluated all essential competencies. The group functioned by consensus, with all members reviewing work produced by each individual member.

While hospital administrators continued negotiations with the union, immediate

Leadership & Professional Development

This feature provides a platform for oncology nurses to illustrate the many ways that leadership may be realized and professional practice may transform cancer care. Possible submissions include but are not limited to overviews of projects, accounts of the application of leadership principles or theories to practice, and interviews with nurse leaders. Descriptions of activities, projects, or action plans that are ongoing or completed are

welcome. Manuscripts should clearly link the content to the impact on cancer care. Manuscripts should be six to eight double-spaced pages, exclusive of references and tables, and accompanied by a cover letter requesting consideration for this feature. For more information, contact Associate Editor Paula Klemm, PhD, RN, OCN®, at klemmpa@udel.edu or Associate Editor Judith K. Payne, PhD, RN, AOCN®, at payne031@mc.duke.edu

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