

TO: Health Policy Commission

FROM: Donna Kelly Williams, RN and Julie Pinkham, RN

RE: Proposed regulations 958 CMR 8.00 Registered Nurse–to–Patient Ratio in Intensive Care Units in Acute Hospitals

DATE: January 14, 2015

The attached document contains the changes to the proposed regulations which MNA believes reflect the intent of the law and agreement reached with the MNA to withdraw two Ballot questions in exchange both for the explicit language as well as the passage of the law.

Beyond some simple housekeeping edit/suggestions, these changes fall into several general categories

- 1) A 1:1 patient limit standard. The clear intent that the assignment of an ICU patient is one to one except in limited circumstances where the patients' condition is stable enough for the nurse to be responsible for a second ICU patient.**

The foundation of the compromise law, the intent of the Legislature and the MNA's decision to withdraw the two ballot questions was grounded in a 1:1 patient limit as the standard. During the negotiations that created this law in exchange for the withdrawal of the ballot questions, several variations were offered – and rejected. Those variations included the concept of no more than two with a tool to staff up. In the end the law was fashioned after the ballot question - the assignment shall be one to one or one to two if the patient is stable enough. The reverse situation was deemed acceptable to assure a second patient would only be assigned when the patient assessed is stable enough to do so. Any regulations promulgated to reverse this agreement directly undermine the intent of the language negotiated and agreed upon.

This 1:1 patient limit standard was clearly legislative intent as noted by the attached transcript of the floor debate.

The assessment of such patient condition brings us to the second area of changes;

- 2) The assessment by the staff nurses (plural) in the ICU.** That discussion was purposeful. During the negotiations we discussed that the nurses function as a team and the assignments accepted by the nurses reflect that team effort. That assessment of the patients by the staff nurses in the ICU, the experts, was to be further supported by an acuity tool.

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Only where a disagreement existed by the staff nurses (plural) and/or the tool was a manager or designee to be involved. It was readily acknowledged that managers are not present due to their work hours as well as their work often has them off the unit.

This brings us to the third area of concern;

- 3) **Involvement of the nurse manager and non-nurses in the determination of an assignment which under the nurse practice act is ultimately a decision of the individual nurse whether he or she accepts or rejects an assignment.** This is why the language expressly excludes language indicating it is the manager's discretion in making the final determination. They are involved when there is a dispute to help resolve it but in the final analysis, the individual licensed nurse must make the final determination whether he or she accepts an assignment. What the consequences of the nurse's decision are as an employee is a different matter than his/her right and obligations under the nurse practice act whether he or she will accept the patient assignment.
- 4) **Creation of the Acuity Tool.** Similarly the creation of the acuity tool is to assist the assessment process, not to act as a managerial substitute for the professional judgment of the registered nurses. In order to assure this, the makeup of the Committee must have direct care ICU staff nurses working with management to formulate the tool. – The direct care ICU staff nurses cannot be just a minority representative to a management process that historically has resulted in staffing tools masked as acuity tools whose ultimate function is to retrofit data to achieve budget limitations or goals.

Indeed there will be variations in patients and the nurses caring for those patients and of the facilities in which the patients have been admitted, but in the final analysis a fresh post op AAA (ascending aortic aneurysm) patient should be 1:1 no matter what nurse, what hospital. If the regulations for the formulation of an acuity tool allow a hospital to pursue such a patient as a 1:2, which we believe the regulations as proposed would do, then we will have failed the patients and the ICU law that seeks to assure a standard for patients in spite of the health care chaos around them.

We deeply appreciate the work of the HPC. During bargaining for the law and on the ballot (possibly to the chagrin of HPC) the organization was specifically written in and when it was proposed to be removed – this too was rejected. We are well aware of the challenge of getting this “right.” MNA, as the primary organization moving this law forward to protect patients shares your desire and commitment for that outcome and we will continue to work with you to achieve the right regulations understanding that any one of us and our families will likely be directly impacted by the law and the regulations implementing the law.