

# Primer on the New Law For Safe Patient Limits in ICUs

## Landmark Law to Set Safe Patient Limits for Nurses in All Massachusetts Hospital Intensive Care Units Goes Into Effect on October 1, 2014

### *This is a historic step in our ongoing campaign for safe limits in all units.*

On October 1, 2014 a new law will go into effect that will dramatically improve the care for the state's most critically ill patients. The new law will require hospitals to adhere to safe patient limits for registered nurses who work in all the state's hospital intensive care units, ensuring that no nurse can be assigned more than one patient or in certain circumstances, no more than two patients based on the assessment of the staff nurses on that unit.

The baseline standard of one patient per nurse in hospital ICUs is the strictest regulation for ICU care of its kind in the nation, which was the result of concerted negotiations between the Massachusetts Nurses Association/ National Nurses United and Senate Majority Leader Stanley Rosenberg and was passed by a unanimous vote of the entire Massachusetts Legislature. The full text of the law can be found at the end of this flyer.

Below are some key highlights about the new law, with answers to commonly asked questions about the law:

- The new law applies to all acute care hospitals in the state both public and private and to all manner of ICUs as defined by the Department of Public Health, including NICUs, PICUs, CCUs, SICUs, MICUs, etc.
- The law sets a limit of **one patient per nurse**. A nurse can only take a second patient based on the assessment of the staff nurses in the unit and a soon to be developed acuity tool. The acuity tool will have standardized criteria to determine the stability of the patient, and all hospitals will be using the same criteria. **Further, in no instance and under no circumstances can an ICU nurse be assigned a third patient.**
- A powerful aspect of the law is the fact that it is the staff nurses on the unit who assess the acuity/stability of the patient, and it is the staff nurses on the unit who determine if and when a second patient can be assigned to a nurse. A nurse manager has a say on whether or not a second patient is assigned *only* in those cases where the staff nurses or acuity tool is in disagreement.
- **Who is charged with developing the acuity tool?** The state's Health Policy Commission will regulate the implementation of the proposed law, including the formulation of the acuity tool, the method of public reporting of staffing compliance in hospital ICUs, and the identification of three to five patient safety quality indicators. ICU nurses will have a chance to influence the development of the acuity tool criteria at a public forum to be held on October 29.

The Health Policy Commission, an independent body established by the legislature to oversee a number of aspects of health care law, is a group we have worked with in the past to establish strong language on what constitutes an emergency situation under our recently passed mandatory overtime law. The HPC will be charged with holding meetings and hearings with stakeholders, including the MNA, to develop the acuity tool criteria that will objectively measure when the patient is stable enough to allow the assignment of a second patient to a nurse's assignment. Once that acuity tool criteria is established, each hospital will then need to work with the staff nurses to incorporate *those criteria* into their own hospital-specific acuity tool, and that tool must be certified by the department of public health.

In MNA/NNU bargaining units, the creation of the hospital-specific acuity tool is a subject that must be negotiated with our union nurses.

- **What is the timeline for the Health Policy Commission to develop the acuity tool?**

The Health Policy Commission has already held a preliminary meeting with MNA leaders to discuss the process for the development of the acuity tool criteria, and it has set a date of October 29 to conduct a public “Listening Session” on the implementation of the new law. The October 29 meeting will be focused on helping the Commission formulate the “acuity tool,” the method of public reporting of staffing compliance, and identifying three to five patient safety quality indicators to be measured and reported by hospitals.

**Wednesday, October 29, 11:30 a.m. – 1:00 p.m.**  
**Daley Conference Room, Fifth Floor (China Trade Building)**  
**Two Boylston Street, Boston, Massachusetts**

We expect there may be other meetings scheduled. HPC has indicated it will take a few months to develop the final tool and expects it will complete its work by the end of December or January. Hospitals will then need to develop, in conjunction with the staff nurses, their facility based acuity tool and the DPH will need to certify the tool for use in ICUs.

- **While the acuity tool is being developed, how and who will determine when a nurse can take a second patient?**

As stated in the law, the decision as to if and when a nurse can be assigned a second patient will depend on “the stability of the patient as assessed by the acuity tool **and by the staff nurses in the unit.**” Under the law, it is the staff nurses on the unit who will make the assessment of the stability of the patient. Absent the availability of a certified acuity tool, it will be up to the staff nurses themselves to use their professional judgment as to when the assignment of a second patient is appropriate. In addition, managers and supervisors will have no role in making that assessment, unless the staff nurses themselves cannot agree. At that point, and only at that point, can management be involved in the process to resolve a disagreement.

- **What happens when nurses are on breaks, on a code team or have to leave the unit for supplies, etc.?**

The law is very clear that the standard of care is one nurse to one patient or at the most one nurse to two patients based on the acuity of the patients, with no exceptions. It says nothing about lowering the standard of care for patients based on operational decisions made by the hospital. These staffing levels **must** be in place at all times and it will be up to the hospital to staff these units to accommodate the legal and contractual rights of nurses to take their meal breaks or to be off the unit for other duties.

- **What is the MNA doing to assist in the development of the law in general and the acuity tool specifically?**

To educate the public, the MNA is launching an ad campaign to notify the public about the existence of the law, what it means for them, and the fact that they should expect and demand this level of care for their loved ones. We are also going to continue our campaign to educate the public and the legislature to extend these limits to all areas of the hospital to ensure all patients are safe.

To educate nurses we will be conducting forums in our bargaining units, MNA regions, and at other venues where nurses can learn about the law, ask questions, and find out how to work with the MNA to ensure that the law is followed by the industry.

To guide the development of an effective acuity tool, the MNA Division of Nursing has been holding meetings with ICU nurses and other members across the state, as well as working with nursing researchers and other experts to develop our position to be presented to the Health Policy Commission.

If you have questions about the new law and this process, we invite you to email or call the MNA/NUU Division of Nursing at [dmccabe@mnarn.org](mailto:dmccabe@mnarn.org); 781-830-5714.

- **What factors does the MNA see as being included in an effective acuity tool?**

The MNA believes that the decision to assign a second patient to a nurse must be considered in light of factors specific to: 1) the clinical status and acuity of the patient; and 2) specific operational and environmental factors on the unit.



Examples of clinical factors requiring a one-to-one patient assignment for a patient could include:

- o Status post code patients requiring frequent monitoring and multiple intravenous vaso pressors with hemodynamic instability.
- o Severe septic shock patients requiring frequent monitoring and multiple intravenous vaso pressors with hemodynamic instability
- o Unstable cardiac arrhythmias requiring frequent interventions such as defibrillation, transcutaneous pacing, and those requiring multiple anti-arrhythmia agents
- o Unstable hyperglycemic/ketoacidotic patients on insulin drip requiring frequent titrations and blood sugar determination
- o NIH stroke patients for 24 hours
- o Op day open heart surgery patients – during the first 12 hours postoperatively unless patient remains hemodynamically unstable.

***These are just some examples pulled from an acuity tool already in use to dictate one-to-one patient assignments at Steward St. Elizabeth's Medical Center. We are currently working on developing a more comprehensive list of factors specific to all types of ICUs covered under the law, and will be working with our members in those units to refine those lists for submission to the health policy commission.***

Examples of Operational/ environmental factors requiring a one-to-one patient assignment for the patient could include:

- o The skill mix and experience of nurses on the unit, including the use of recent grads, new orientees, floats, per diems or travelers, etc.
- o The geography of the unit
- o Availability of resources and support staff (MD, secretary, respiratory, pharmacy, ancillary staff, security, etc.)
- o Access to technology and equipment (monitors, charting systems, medications, etc.)

- **What do we do when the hospital violates the law?**

We expect some hospitals may not be in compliance with the new law and may challenge nurses' assessment of what constitutes a safe assignment to allow a nurse a two-patient assignment. One of the aspects of the law that will be developed by the Health Policy Commission is a process to monitor the law. Until that is in place, the MNA/NNU will be working with our negotiating committees in local bargaining units to monitor implementation of the law and to challenge management through the labor management process to adhere to the law. We are also creating special reporting forms for ICU nurses to fill out that can be shared with your MNA committee and representatives, and will also have a special form on our web site that nurses can fill out on line to report violations. We can then use that information as we work with the Health Policy Commission, other public officials and even the media to hold the industry accountable for adhering to a law they helped create.

Please keep in mind it is the obligation of licensed nurses to uphold the law that has been created to protect the patients.

- **In addition to this law, what is the MNA doing to ensure all nurses on all units will have safe patient limits?**

To be clear, in accepting the compromise that led to the creation of this law, our intent has always been to use this law as only a first step towards the ultimate objective, which is to extend safe patient limits to all other areas of the hospital for all nurses and all hospitals in the state. To that end we have been meeting with members and staff to plan the next phase in our campaign to make safe staffing for all units a reality. This will include the refiling and promotion of legislation to achieve this goal, as well as the consideration of a ballot initiative in 2016 to make this happen should the legislature fail to act on our bill.

We encourage all members and nurses in Massachusetts to stay involved with the MNA and to become active in this ongoing campaign. You can visit the MNA web site at [www.massnurses.org](http://www.massnurses.org), or our campaign web site, [www.patientsafetyact.com](http://www.patientsafetyact.com) or follow us on Facebook to keep abreast of ongoing activities. You can also email Eileen Norton in our Division of Organizing at [enorton@mnarn.org](mailto:enorton@mnarn.org) to sign up for the campaign going forward.





**The Commonwealth of Massachusetts**

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**In the Year Two Thousand Fourteen**

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An Act relative to patient limits in all hospital intensive care units.

*Be it enacted by the Senate and House of Representatives in General Court assembled,  
and by the authority of the same, as follows:*

SECTION 1. Chapter 111 of the General Laws is hereby amended by inserting after section 229 the following 2 sections:-

Section 231. For the purposes of this section, the term “intensive care units” shall have the same meaning as defined in 105 CMR 130.020 and shall include intensive care units within a hospital operated by the commonwealth.

Notwithstanding any general or special law to the contrary, in all intensive care units the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager’s designee when needed to resolve a disagreement.

The acuity tool shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff and shall be certified by the department of public health. The health policy commission shall promulgate regulations governing the implementation and operation of this act including: the formulation of an acuity tool; the method of reporting to the public on staffing compliance in hospital intensive care units; and the identification of 3 to 5 related patient safety quality indicators, which shall be measured and reported by hospitals to the public.