

OPPOSITION TO DPH POLICY ALLOWING BOARDING AND CARE OF PATIENTS IN THE CORRIDORS OF INPATIENT UNITS

April 2005

Executive Summary

In the strongest possible terms, the Massachusetts Nurses Association expresses its opposition and outrage relative to the policy introduced by the Massachusetts Department of Public Health and promoted by the Massachusetts hospital industry to allow the boarding and care of patients in beds stationed in corridors and hallways outside hospital inpatient units.

All hospitals are licensed by the DPH to provide appropriate nursing and medical care to a specific number of patients, with the understanding that a hospital will only admit those patients it has the resources, staff, equipment and facilities needed to deliver said care.

This policy was established and promulgated in January as a means of dealing with the problem of emergency department overcrowding and ambulance diversion. The MNA believes this policy is not a solution; rather, it creates more problems and raises further issues relative to the safety of patient care. As such, it generates a larger crisis than the one it was designed to resolve.

This policy directs hospitals and nursing staff to engage in practices which are unmistakably dangerous, irresponsible and unethical, and in many ways, are in direct violation of state and federal laws, HIPAA and JCAHO requirements, and the Department's own regulations. The DPH has created a policy specifically allowing a practice the department used to cite hospitals for violating.

For patients, this policy would promote degraded and substandard care that no one would wish to receive nor should expect to receive in a state that prides itself on having the nation's oldest public health department and the premier system of hospital care.

Any hospital implementing this policy is committing willful abuse and neglect of its patient population. Any nurse who is forced to accept such an assignment is being placed in an environment ripe with violations of the Nurse Practice Act and/or their

standards of nursing practice, which ultimately could result in harm to their patients and the potential loss of their license to practice.

Family members whose loved ones receive care in such an environment are advised to seek immediate transfer of the patient to a facility better equipped to provide a safe standard of patient care. By definition of this DPH policy, any patient eligible for care in a corridor must be “stable” and non emergent, and therefore, would not be harmed by being transferred to another facility to receive appropriate care in a properly appointed and staffed patient room.

Nurses, both in the emergency department and inpatient units are already working to their full capacity and under the current unsafe staffing conditions in hospitals, caring for far too many patients to provide appropriate care. Now we are asking those nurses to be assigned additional patients who must be cared for in an environment (hallways) that is not conducive to the delivery of any standard of appropriate care. In so doing, they not only jeopardize the safety of the new patients in the hallways, but would now be forced to provide their existing patients with substandard care as well.

Unless **all surrounding hospitals** have **no** beds available to admit patients, it is clearly safer for patients to be transported to another facility than it is to place them in an environment that puts them and all other patients on that unit at such great risk.

While the MNA agrees that ED overcrowding and ambulance diversion presents a longstanding and serious public health crisis that must be addressed, this DPH policy demonstrates a lack of commitment by the DPH to use its regulatory power and oversight to properly protect the health of the residents of the Commonwealth. This problem has been growing for many years, yet DPH has failed to generate long-term solutions. While the DPH oversaw the closure of hospital beds throughout the state, it has failed to:

- mandate that hospitals take appropriate control of elective admissions or regulate suitable hospital discharge procedures;
- assess the need and plan for added bed capacity;
- require improvement in patient flows nor assist in the development of appropriate inpatient bed capacity;
- investigate the creation of mobile units for disaster use or develop state facilities for emergency or overflow use; and
- support the nurse staffing levels widely judged necessary to provide adequate safe daily staffing for DPH-licensed beds, let alone staffing for patients in corridors.

For its part, the hospital industry has driven the macro policy changes that caused this problem with its push for deregulation of the industry in the early 1990's and its lust for cut-throat, free market competition and massive consolidation. These actions resulted in the elimination of 30 percent of our available hospital beds. In essence, the industry has created the very bed it wishes to foist into the hallway to accept a patient.

In issuing this statement we call upon the Massachusetts Department of Public Health to immediately rescind this policy and, as the largest stakeholder, request an immediate meeting on this issue. We call upon the Massachusetts Hospital Association to refuse to embrace such substandard care and to advise its members to reject this policy. In lieu of these actions, we call upon the Massachusetts Legislature to use its oversight authority to hold emergency hearings on this public health safety threat and intervene as required to protect the public.

For our part, the MNA is advising all registered nurses against accepting any assignment of a patient to a hallway or a corridor on an inpatient unit; and for nurses in emergency departments to accept such an assignment only if necessary staff have been added to properly monitor those patients while they await a proper inpatient bed assignment. Further, we intend to educate both the nursing community at large and the patient population about the dangers of this policy and to seek nurse and patient support in advocating for its immediate rejection.

Finally, we encourage the Department of Public Health to begin development of both an immediate and long-term plan that genuinely addresses the issue of emergency department overcrowding – a plan that doesn't give the illusion of stopping diversions and one that doesn't place patients in greater danger.

Major Concerns regarding DPH's "Corridor Care" Protocols:

- **Patient care needs**

It is impossible to provide even minimally safe or effective patient care in corridor conditions. The range of patient care issues is vast and includes the following major problems:

One of the greatest dangers for patients admitted to hallway conditions is the absence of emergency call lights or buzzers required to summon help in an urgent situation.

The lack of privacy is an extreme deterrent to patients who are asked to provide confidential health information to their caregivers. Therefore care

will need to be provided with inadequate or incorrect information. Patients cannot be asked to disrobe without privacy. As a result, examination, physical assessments and procedures—enemas, catheterizations, certain routine bedside invasive procedures—will be refused or delayed, negatively impacting patient care and increasing the risk of patient morbidity and mortality.

Clinicians will have difficulty listening to heart sounds in noisy hallways. They will likely be forced to use the deltoid (shoulder) muscle for intra-muscular injections instead of the gluteal muscle in the buttocks, preferred chiefly for female patients. In addition to the absence of emergency nurse call lights and buzzers, oxygen and suction equipment will not be available or set up for routine or emergency use as it is at bedside in patient rooms.

Patients needing oxygen will depend on the use of portable canisters, which have limited capacity and become quickly depleted of oxygen with no warning (i.e. no monitoring capability) to clinicians. In this situation patients may quickly find themselves in respiratory distress, with no call lights to request more oxygen. Moreover, oxygen canisters will be hung at the bedside, where they can be easily knocked off and explode (See Fire Safety issues below).

Space to seat family members, or bedside stands to hold water glasses, eyeglasses, dentures and other personal care items is highly unlikely in these surroundings. Lighting conditions are poor, ranging from inadequate illumination for proper patient observation to unacceptably bright light for evening and nighttime. Patients will have extreme difficulty resting or sleeping, which is problematic enough in room conditions. All of these factors present a multitude of patient care dangers and conditions conducive to medical error and increased patient morbidity and mortality.

Hallways lessen staff's ability to protect patients and staff from hostile and aggressive attacks from angry family members or other visitors. Also, the situation makes it harder to observe visitors who may interfere with medicine delivery machines, IVs, O2 settings, etc.

- **Patient dignity**

Patients will be bed-panned in their beds in hallways, or will need to vomit in public view, with no or minimal visual privacy and no auditory privacy. Patients may be in their last days or hours of life, placed in hallways with no privacy for themselves, their chaplains or their family members. Patients will

be asked to recite health care histories, concerns and symptoms (i.e. pregnancy, infertility, incontinence, impotence, abuse, AIDS, cancer fears, heart problems, fears of dying) with no consideration for others overhearing.

- **Ethical considerations**

One definition of “Ethics” is “The rules or standards governing the conduct of a person or the members of a profession, i.e., ‘medical ethics.’”

Using this definition, the DPH corridor care policy completely disregards standards and norms of healthcare practice and in doing so is ethically unsound for nurses as well as physicians.

In doing so, DPH violates numerous ethical standards contained in the National League for Nursing’s Patient Bill of Rights¹, the American Hospital Association’s Patient’s Bill of Rights², the American Civil Liberties Union’s Patient’s Bill of Rights³, the American Nurses’ Association’s Code for Nurses, the International Council of Nurses Code for Nurses⁴ and the American Nurses Association’s Standards of Nursing Practice.⁵

There are two principal areas of ethical concern: patient rights and caregiver rights.

1. Patient Rights

Patients have both rights and responsibilities when it comes to their health and the health care services they receive. On March 26, 1997, President Bill Clinton appointed the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which in March 1998 issued the final report, “Quality First: Better Health Care for All Americans.”

As part of its work, the Commission issued a “Consumer Bill of Rights and Responsibilities.” This document was intended to serve as a blueprint for improving systems and procedures that aim to protect consumers and ensure quality of care. Many health plans, including all those sponsored by the Federal government, have adopted these general principles. Among the specific rights and responsibilities that Federal health plans and others have adopted are the following, all which the DPH’s corridor care protocol completely violates:

a) **Confidentiality of Health Information:** “You have the right to talk in confidence with health care providers and to have your health care

information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.”

b) **Respect and Nondiscrimination:** “You have a right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives, and other health care providers.”

The DPH policy forecloses on patients’ health information confidentiality rights and also provides a discriminatory, substandard level of care to those patients placed in corridors.

2. Caregiver rights

Nurses have the ethical right and duty to practice according to commonly accepted standards of nursing practice and their professional Code of Ethics. The DPH corridor care policy forces nurses to violate accepted standards of nursing practice, as outlined above.

The new policy also places nurses in danger of losing their nursing license and the means of supporting themselves and their families. The Massachusetts Board of Registration in Nursing (BORN) can, and frequently does, look to the “Standards of Conduct for Nurses,” at CMR 244 9.00, when investigating a complaint against a nurse. Complaints may be lodged with the BORN against nurses by anyone—for example, by a co-worker, supervisor, employer, disgruntled patients or family members, and by the DPH. Complaints arising from the DPH tend to occur subsequent to a DPH investigation of a situation of patient harm due to error. In many if not most instances, errors are due to system problems, as would be the nature of errors caused by corridor care conditions. Since BORN will not explore system errors (BORN considers its charge to be the investigation and placement of individual, not institutional blame), the fallback regulation used by BORN for disciplinary purposes is the catch-all “Standards of Conduct” for nurses, below:

CMR 244 9.03 (10) Acts within Scope of Practice. “A nurse who holds a valid license and is engaged in the practice of nursing in Massachusetts shall only perform acts within the scope of nursing practice as defined in M.G.L. c. 112, § 80B and 244 CMR 3.00.”

From M.G.L. c. 112, § 80B:

“ Each individual licensed to practice nursing in the Commonwealth shall be directly accountable for safety of nursing care he delivers.”

From CMR 3.0: 3.02, Responsibilities and Functions - Registered Nurse:

“ A registered nurse shall bear full and ultimate responsibility for the quality of nursing care she/he provides to individuals and groups.”

The make-shift conditions under which nurses will be forced to practice corridor care—for example, by administering intramuscular (I.M.) injections into the shoulder muscle rather than the gluteal muscle—will give rise to actionable discipline against nurses by the BORN. This is neither an unlikely nor rare scenario. The BORN uses the nursing regulations as a strict standard against which to measure and punish nurses. Discipline for the specific infraction mentioned above was exacted against a nurse by the BORN in February 2005.

The DPH policy forces nurses to practice in substandard conditions, violates their nursing oaths and standards of practice, and places them in jeopardy of professional discipline, loss of their nursing license, and loss of the ability to support themselves and their families. This is ethically unacceptable and reprehensible.

Moreover, the Code of Ethics for Nurses of the American Nurses Association describes “Ethics as an integral part of the foundation of nursing.” It goes on to describe the industry’s “distinguished history of concern for the vulnerable and for social justice...and for the protection of health in the care of individuals...and communities.” It calls for nurses to “improve health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.”

The DPH policy flies in the face of these established professional ethical standards of conduct for nurses by advocating a substandard environment of care as a permanent solution to problems which can and should be resolved in a way to protect the public’s health and welfare.

• **HIPAA /Patient Confidentiality**

HIPAA (The National Health Insurance Portability and Accountability Act of 1996) privacy standards exist to “assure that individuals’ health information and privacy is protected and to allow the flow of health information needed

to provide and promote high quality health care and to protect the public's health and well being."⁶ There are strict requirements of providers, including individual caregivers, to refrain from sharing confidential health information. There are civil monetary penalties for individuals who violate HIPAA requirements of \$100 per failure to comply with a Privacy Rule requisite, up to \$25,000 per year for multiple violations. Compliance with this federal law is taken very seriously by institutions and individuals. Hospitals generally post signs in public view urging caregivers not to discuss patient care in elevators or hallways. Why is it a federal crime to discuss patients in hallways, but not to place the patients in hallways for their care? This is an inconsistency which presents two considerable dangers:

- (a) patients will not receive the privacy considerations ensured them by the federal government; and
- (b) strict legal liabilities: civil penalties and the potential loss of their nursing license—accrue to nurses, as well as legal liability for other caregivers and administrators.

- **Fire Safety**

Obstruction of hallways in hospitals and other medical facilities presents potential for direct violation of the Massachusetts State Building Code and Massachusetts Fire Prevention Regulations (527 CMR).

The primary Building Code concern is the Chapter 10 "Egress" requirements. A determination of compliance with egress requirements must be made on an individual facility basis. It is essential for patient and staff safety that corridors are free from obstruction in order to provide emergency egress. Moreover, patients located in patient care rooms are provided the added safety of a second fire-rated door, but hallway patients would only have corridor doors if they are present.

In addition, patients receiving oxygen in hallway beds will frequently find their oxygen canister hung on their bed, from necessity or for convenience. Oxygen containers hold highly pressurized gas which can be flammable and explosive if mishandled. It is possible that an oxygen canister knocked from its position resulting in a damaged top could become an explosive projectile—in effect, a bomb.

- **Infection Control Issues**

Hallway care presents extra challenges for infection control. The foundation of infection control is proper hand-washing, the most critical step in reducing the transmission of infections. Sinks for this purpose are generally provided inside every patient room. However for hallway patients, bedside sinks do not exist.

Hallway or corridor patients will either have to use the visitor bathroom or go into another patient's bathroom for toileting. This can present several infection control hazards. During the cold and flu seasons, corridor patients will be unduly exposed to a multitude of airborne bacteria and viruses.

To prevent infection stemming from indwelling catheters or drains, patients are typically required to disrobe and allow the nurse access to the device. This care might be avoided due to privacy issues.

Finally, exposure to infectious or contagious agents is increased for patients lying in hallway beds due to the amount of traffic and proximity to passerby-traffic.

- **Equipment**

Inadequate oxygen, suction, lighting, call lights, absence of bedside table and chairs, lack of space for personal possessions, wheelchairs, commodes, I.V. stands all present major problems for patients and staff. Moreover, patients stationed in hallways are obstacles for emergency access or egress and can create tripping hazards, etc. Patients in hallways who need to be resuscitated will fail to have the emergency equipment or space required, and there is the certainty of danger that code teams will be unable to locate patients quickly. Moving patients into hallways and the inevitable adjustments to their precise location increases the danger of patients being mis-identified by caregivers, dietary aids, and receiving the wrong medications, diets and treatments.

- **Patient, Staff and Visitor Safety**

Hospital hallways were not designed to accommodate admitted patients, caregivers and equipment on a semi-permanent basis. The danger of limited access and egress, inadequate space for wheelchairs and gurneys, electrical cords presenting tripping and fall hazards is unacceptable.

- **Staffing**

Clearly, hospital admissions and discharges fluctuate, although there is predictability over time as to which hospitals can apply staff appropriately.

Census levels typically employ a 30 percent variability range, considering time of day, day of week and seasonality. Approximately 50 percent of patients admitted to hospitals are “emergency department (ED) admissions”... patients arriving via the emergency room and later admitted. Another 30 to 35 percent of admissions are elective—primarily patients admitted for surgery planned in advance.

Hospitals track admission patterns closely. One hospital in Massachusetts gauges musical concerts held at a nearby amphitheater. It knows the type and number of concert attendee overdoses to expect in its emergency room based on the schedule of performing musicians. The level of sophistication and attention to detail by hospitals in this regard may vary, but the knowledge of how to predict staffing needs ranges from the colloquial to use of sophisticated software methodologies.

All hospitals staff below peak census expectations. Unlike fire departments, which are staffed, equipped and located to respond to the occasional fire call, hospitals are understaffed and under-equipped. The DPH is not applying the needed regulatory pressure to address this public health crisis.

Operations management and queuing theorists, along with local consultants/academicians who are expert in clinical operations management have census expectation information for the DPH, but this information is not applied in hospitals.

As pointed out in the amphitheater example above, random patient arrivals (largely, emergency patients) have some predictability. However, the opportunity for census control lies with the management of elective patient arrivals and surgeries, which are predictable and controllable and represent roughly one-third of hospital admissions. Since elective surgeries are a major source of revenue and profit for hospitals, they are treated as priority admissions. The urgent, emergent, trauma patients are those who arrive “unexpected” on the scene – as if no emergencies will occur that day. Since the DPH is “looking the other way” these newcomers can now expect to receive their care in hallways.

Steps can be taken to prevent these problems from occurring. Two major practical recommendations are to:

1. Require hospitals to track (identify, classify and measure) emergency admissions and staff according to expected ED arrivals; and

2. Schedule elective surgeries to coordinate with the above expected ED arrivals and staff according to predicted peaks.

Clearly, policies and procedures to manage patient census are available and can be employed and required by the DPH to address the systemic impact of unnecessary peak patient loads, an adverse consequence which leads to emergency department diversions, staff overloads, medical errors, system gridlock and ultimately faulty and futile quick fixes such as this one proposed by the DPH.

The potential benefits of clear-cut patient census policies and procedures are many: improved patient care and satisfaction; better utilization of resources; reduced ED diversions hours; and additional staffing resources.

Related Material:

- [MNA continues opposing placement of patients in halls](#)
- [The real solution to ED overcrowding](#)
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¹NLN: 'The patient has the right to considerate and respectful care.' 'The patient has the right to every consideration of privacy concerning his own medical program.' 'Case discussions, consultation, examination and treatment are confidential and should be conducted discreetly.' 'The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.'

²AHA: 'The patient has a legal right to privacy of both person and information with respect to: the hospital staff, other doctors, residents, interns and medical students, researchers, nurses, other hospital personnel, and other patients.'

³ACLU: 'The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.' 'The nurse participates in the profession's efforts to implement and improve standards of nursing.' 'The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high-quality nursing care.' 'The nurse participates in the profession's effort to protect the public...and to maintain the integrity of nursing.' 'The nurse collaborates with members of the health professions...in promoting community and national efforts to meet the health needs of the public.'

⁴ICN: 'The nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public.' 'The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or another person.' 'The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education.'

⁵ANA Standards Of Practice:

Standard IV: 'The Plan of Nursing Care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnoses.

Approaches are planned to provide for a therapeutic environment: Physical environmental factors are used to influence the therapeutic environment, e.g., control of noise, control of temperature, etc.'

Standard VI. 'Nursing actions assist the client /patient to maximize his health capabilities. Nursing actions are used to provide a safe and therapeutic environment.'

⁶"Summary of the HIPAA Privacy Rule," HIPAA Compliance Assistance, United States Department of Health & Human Services , 05/03 revision, Page 1.

For questions, contact the Director of Public Communications David Schildmeier at 781.830.5717 or dschildmeier@mnarn.org.