

Katherine Murphy, MSN, RN, CCRN, CNRN  
16 Powder Mill Road  
Framingham, MA 01701  
Staff Nurse, Medical Intensive Care Unit  
Brigham and Women's Hospital, Boston, MA

**An Act for Patient Limits in All Hospital Intensive Care Units: Testimony**  
**Health Policy Commission**

October 29, 2014

Good Morning, Chairman Altman and distinguished members of the Commission. My name is Katie Murphy. I have a Masters degree in Nursing Leadership as well as certifications in Critical Care and Neuroscience nursing and am entering my fourth decade in this terrific profession.

You will hear a lot of information and data on current acuity and the needs of our patients and families so I'd like to present a series of vignettes that reflect the people for whom it is our privilege to care. And that is the way we see them: that person in the bed attached to a ventilator, multiple beeping machines, and tangles of tubing is someone's mother or brother or child or beloved spouse.

As I enter my tertiary care Medical ICU in one of the nation's top teaching hospitals, my patient is a gentleman with malignancy, weakened kidneys, multiple skin lesions, respiratory compromise, and heart ischemia (a heart in need of help). He is on advanced oxygen and multiple intravenous medications to support his blood pressure. He requires almost hourly blood collections and then correction of what the blood samples reveal. He needs to have multiple invasive catheters placed in large veins and an artery to support these activities, all of which require hours of time to place and, by policy, a critical care nurse at the bedside throughout the entire procedure.

The medications are increased or decreased minute by minute, as is the oxygen. Later that night, continuous dialysis, initiated and managed by the Critical Care Nurse is begun. Family members are at the bedside, X-rays are taken, CT Scans are arranged, rounds are held, lab results are reported, teeth are brushed, linen is changed, intravenous fluids are updated, medications are administered. How would a nurse care for another patient? And this patient is not on a ventilator.

The patient next door is a young man who's lungs have failed and even mechanical ventilation can no longer provide his organs with the amount of oxygen required for life. His blood is being oxygenated by extracorporeal membrane oxygenation. He has a tracheostomy, a feeding tube, a catheter in his bladder, a catheter in the large vessels in his neck, and one in an artery. In addition to the large machine with pulsating tubes of blood snaking around it, there is a ventilator in the room and seven IV pumps. To turn this young man requires a minimum of two registered nurses and two respiratory therapists. To turn the patient. As you recall, CMS is no longer reimbursing for hospital-acquired pneumonias, of which frequent position change and lung exercise is a basic intervention.

In the scenarios presented, you see there is no lunch break, nor rest room opportunity. I know I represent many of my colleagues who gulp a cup of cold coffee once or twice a shift rather than place a patient at risk by leaving the bedside.

Also not mentioned are the myriad other tasks performed by the Critical Care Nurse as she or he cares for this most vulnerable of patients: calling Pharmacy for medications, calling equipment for pumps, compression boots, slings, etc. Taking lab results, discussing each aspect of care with the Care Team, explaining staffing needs to Administrators, answering phones that never seem to stop ringing, being on the Turn Team of the other patients on the Unit: If I need two or three nurses, then I turn their patients, as well. Some patients need to be turned hourly, with three, four, even five people for safety.

And this, Honored Commissioners, is the best case scenario. I also moonlight in a community hospital where the ICU patients are NEVER singled. Granted, the acuity is somewhat less, but, shock is shock. A ventilated patient on blood pressure medicine is the same everywhere. A gastric hemorrhage is a gastric hemorrhage: life-threatening.

With vital signs constantly fluctuating, the life of the person hangs in the balance. Who better to decide when that patient is stable enough for the provider to take on the care of another ICU patient than the nurse at the bedside?

One quick last illustration, this is in a community hospital: 5 patients: a 17-year-old with compartment syndrome (threatening to life or limb), a middle-aged heart patient awaiting a bed in Boston; a long-term ventilated patient with a resistant-organism pneumonia on contact precautions; a fresh post-operative patient; and another post - and pre-op patient who was in a pre-cardiac arrest situation. There were 3 nurses for these 5 patients: a new nurse, a float from a general floor, and a per diem: yours truly.

While we had the emergency cart at the bedside with one nurse at the bedside, and I was helping her as well as caring for two of the patients and supporting the float nurse: the Nurse Administrator arrived in the ICU to tell me she had an admission for me and in what bed did I want to put it?