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### Presentation of MNA/NNU Recommendations for Acuity Criteria

Good morning, I am Kimberly Adam and I am a practicing Intensive Care Nurse at Cape Cod Hospital. I am here this morning to provide a perspective from a community hospital with 11 ICU and 12 CVICU beds. While the patient care is the same as the bigger teaching hospitals, our staffing levels have declined and we are being expected to do more with less. An appropriate acuity tool that could be used to determine a safe level of staffing for the number of patients and the acuity of them would provide all nurses with the ability to provide a standard of care state wide. While many hospitals have criteria for Intensive Care admission, it would benefit the people of Massachusetts to have a standardized criteria adopted by individual hospitals for use by their ICU nurses while caring for our communities sickest patients.

To prepare for this hearing I asked many of my co-workers what they saw as the most important issues facing us on a daily basis. The overall feeling was that we the Nurses did not have a say in how our patient assignments are made. It is solely based on how many patients and how many nurses. At Cape Cod Hospital we have had to ask Doctors to make their patients a 1:1 when the level of care has warranted one Nurse for one patient based on the nurses assessment of patient needs. Management will only comply with 1:1 recommendations in the ICU when a Doctor writes an order.

Some of the criteria that were consistently brought up in the discussion about formulating an acuity tool for 1:1 nursing care are:

- Status post cardiac or respiratory arrest
- Ventilator dependent or intubated patients requiring frequent intervention for respiratory compliance, suctioning, trach care, weaning and extubation protocols.
- Patients requiring continuous monitoring with multiple intravenous vasopressors and/or hemodynamic instability. Those may include but are not limited to Septic Shock, multitrauma, organ donation.
- Patients with acute organ failure (liver, kidney, brain, etc.) requiring constant monitoring and intervention.
- Patients that require travel to other departments for testing must have an RN with them

and many hospitals do not have Critical Care Transport teams.

- Bedside procedures such as line placement, EGD, endoscopy, EVD placement.
- Pronation for ARDS requires many staff and a Respiratory Therapist as well, some hospitals have pronation beds but we at CCH do not.
- Fresh post op patients that are not recovered in PACU.
- Violent patients/ Suicide patients (if no Nurses aid is available), some post op patients that are confused, those patients that are at risk for harming themselves or others.
- Training of a novice RN to Critical Care

The current staffing matrix at Cape Cod Hospital for Critical Care is to pool the staff from both ICU and CVICU and hope you have enough to cover a shift. The current ratio in critical care at Cape Cod Hospital is 2:1. The only patients that routinely are singled are fresh open heart, balloon pump, and arctic sun or induced hypothermia. There have even been a few times that nurses have been required to take 3 patients for a limited time. This is absolutely not in the best interest of an acutely ill patient expecting to have the highest level of care given to them. Recently the manager has also allowed non-Critical Care Nurses to float in and take a 1 patient assignment with minimal acuity but still requiring Critical Care. It is my belief that when a patient is admitted into an ICU they and their family have an expectation of a higher skilled level of care. The enforcement and utilization of the acuity tool with this law will assure all families and patients have what they need. At Cape Cod Hospital we are still being mandated to cover an increase in acuity if a patient does need to be singled. In the past few months we have seen an increase in our patient load as well as acuity increasing with most shifts being at full capacity. The problem arises when there are only 4 or 5 RNs scheduled for each unit for a shift but the patient census is 11 patients in one unit and 11 in the other. That does not allow for any 1:1 assignments even if a patients' acuity is such that it is warranted. The recommendation of those of us in Critical Care is that you develop an assessment tool of acuity for ICU admission and with reassessment every four hours based on the clinical needs of a patient. Staffing a unit could then be based on the clinical needs of the patient rather than daily census. Nurse's at the bedside are the ones that should have the authority to indicate if a change in acuity level is needed at any time, with staffing on the unit to be adjusted using the acuity tool. The intent of this law is to base patient assignments on the needs and clinical acuity of the patient. If a patients acuity drops then it may be possible for the RN to take another patient with the same level of acuity.

The physical layout of a unit must also be considered. Are the patients close enough to be visible by

the nurse if she has two patients? How visible are the monitors for nurses to check? Not having a unit secretary to answer the phone or open the door impedes a nurses ability to care for patients. Leaving the bedside is not always an option with a critical patient. Nurses rely on the other staff to assist them in providing patient care for repositioning, feeding, ambulation. Without a nurses aid or tech then we must wait until another RN is available. This is a delay that is not necessary with appropriate staffing levels.

Documentation and medication administration also must be factored into the ability of nurses to respond to the acuity of the patient and the patients' needs for care.

I believe that this committee can provide us with an appropriate tool for measuring the acuity of patients as they are admitted into critical care areas and maintain the highest standards of care that each and everyone of us in this room expect to give to our patients and receive when we become the patient.

I wish to thank you for hearing my testimony today. I want you to know that I'm proud of the career I've chosen and will continue to advocate for my patients, family and friends that receive their care here in Massachusetts.