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An Act for Patient Limits in All Hospital Intensive Care Units: Testimony
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Thank you for taking this testimony on the proposed regulations for ICU Nurse Staffing. I have testified previously that I have four decades of nursing experience, 38 years of them in critical care. I point out to my newer colleagues that when I began nursing, there was digoxin, lidocaine, and a defibrillator. People died of acute kidney injury. We didn't see any adults with secondary malignancy due to the therapy they had received for their childhood leukemia: most of them had died.

Today, we routinely dialyze the most fragile patients, pull them through their acute crisis, and send them back to the medical floor where many are discharged. We support young parents on extracorporeal membrane oxygenation until lungs become available for transplant. We save life and limb, and then, when we cannot, we sit for hours at a bedside and help our patients to a peaceful death. The stable patients are at home.

When my patient has survived her critical illness, and is ready to be transferred, I am able to take a second patient: it only makes sense: I work the night shift. There is a finite number of critical care nurses to be found at 2 a.m. - we make sure the patients who need the most intensive care receive it. But only the professional providing that care can make that determination.

I work at two hospitals: a big Boston teaching hospital and a for-profit community hospital. At the latter the other night, there was a patient who was intubated, on a ventilator, on vasoactive infusions, and receiving many medications as well as enteral feedings. She had many draining wounds requiring frequent position, dressing, and linen changes. This required two persons and since this community hospital provides no

ancillary personnel or secretary after 3 p.m., this means two nurses. The supervisor arrived in the ICU, did not assess the patient, go in and look at the patient, or assist with care of the patient. She announced that the patient was “not a 1:1”.

This is the very essence of our goal to protect our patients. Should this patient survive and thrive, the nurse providing direct care would be able to determine whether there was another patient on the ICU who could also receive excellent care if this nurse were to be responsible for both of them. The professional judgement of the nurse must be the determining factor: any acuity tool is just that: an instrument to support the nurse’s assessment as needed.

I use Quadramed at the teaching hospital. I dutifully check the boxes, but do not believe it captures the intensity or the reality of the critical care bedside. It’s similar to you reporting to a friend that you sat in Hearings all day. Gee, doesn’t sound too tough. Only you, here on this Committee, understand that you hold people’s lives in your hands.