My name is Claire O'Connell. I am a registered nurse in the Burn/Trauma Surgical Intensive Care Unit in a Boston Hospital, where I have worked for more than 27 years.

I have serious concerns about the regulations as they are currently drafted, specifically your definitions under the law. In Sections 8:01 and 8:02, you state that a nurses can be assigned one or two patients, without reflecting the intent of the law, which is a default patient assignment of one nurse to one patient with the option of moving to a second patient only when both patients are stable enough to do so based on the assessment of the nurses in the unit in conjunction with an acuity tool. In your definition, there is no mention of patient stability and this is very concerning. Any attempt to differ from that one nurse to one patient default assignment violates the clear intent of State Legislature.

At my hospital, it can often be a struggle to ensure we have enough staff on hand to meet the dictates of the law and to ensure that patients that should be singled can be singled when they need to be. We have almost daily discussions with our management over the appropriateness of assignments for our patients. Our management doesn't always follow our assessment and the dictates of the law. The definition written under 8:01 opens the door for our management to continue to violate the law and require that we take a second patient when the patient is not stable enough to do so. My hospital has said in the past, that this law is just a guideline! This is also very troubling.

On my unit, we have many new staff and other nurses that do not have to care for our burn population and charge nurses who have no burn experience. This has been a big issue with scheduling staff. There have been times when there is only one nurse to care for a burn patient which is very dangerous and only adds to the staffing and acuity issues. Not scheduling nurses in a way that allows for specialized one-to-one care when necessary- and as the law dictates- cannot be allowed to stand, particularly at my hospital where we take care of the sickest of the sick patients with extremely high acuity levels.

This brings brings me to my second point, which is the need for a highly specialized acuity tool for our hospital that ensures that our patients are placed in a safe assignment. Under section 8:05, it needs to be clear that it is the assessment of the nurses on the unit that is the primary factor in determining if and when a patient can be doubled. The law stipulates that it is the nurses on the unit, not management, who makes this assessment with an acuity tool to assist us in our assessment. Once we make that assessment, these regulations need to ensure that assessment is honored by management, and so, I believe that our assessment should be a part of the patient record. This would allow management, staff, or even the patient to look back to see this information. It would also prohibit anyone from changing the documented assessment.

Finally, I have a few concerns with the process you have developed for the creation of the acuity tool for each hospital. As currently written under section 8:06, the committee created at each hospital is only advisory in nature, granting ultimate power to management to determine what acuity tool is submitted to DPH for certification. This is not how an acuity tool should be chosen. Having worked with numerous committees at my hospital in an advisory capacity, I can tell you this will not work. First, the committee that is formed must have a majority of its members who are practicing ICU nurses, not nurse managers from the ICUs. You need to ensure through these regulations that the nurses have a strong voice on these committees and that the recommendations of the committees are not able to be overridden by hospital management. Do not allow the fox to guard the hen house. Also, the regulations should stipulate that if the nurses are represented by a union, as we are at mine, then the union and its workers should select the members to participate that process. And when that committee finally develops an

acuity tool or tools for the ICU in that hospital, those tools should be the ones submitted to the DPH and management should not be allowed to overrule or change the work of that committee.
Finally, nurses must also be directly involved in any changes that might be made to the acuity tool once it is certified.

This law is a victory for patients because it placed the emphasis on the needs of the patients and what is best for them, not the hospitals profit margin. As a nurse who cares for these patients, I am pleading with you to create final regulations that uphold and enforce the intent of this great law and that prohibit administrators, who for financial reasons, want to undercut the law and endanger our patients.

Thank you for your time.