BRIGHAM AND WOMEN'S
Faulkner Hospital

1153 Centre Street
Boston, Massachusetts 02130
T: 617-983-7000

April 1, 2015

David M. Seltz
Executive Director, Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Mr. Seltz:

I am writing to express my concern regarding the possible interpretation of 958 CMR 8.00, Registered Nurse to Patient Ratios in Intensive Care Units.

My role as Chief Nurse holds me accountable for the Nursing care and outcomes of all patients here at Brigham and Women's Faulkner Hospital. In that capacity I have worked with the care team in our ICU for the past ten years.

We are a community hospital with one ICU and as such depend on this staff to care for our patients who are most at risk. We utilize the Quadramed Acuity tool to measure nursing workload. The staff have validated the tool and after three years of investment are able to recognize the value in terms of input to patient care assignments. The ability to identify a patient with 1:1 needs versus 1:2 is based on the tools we have available and the judgment of staff and their leadership.

We also participate in quality outcomes benchmarking. NDNQI a national data base specific to nursing sensitive outcomes. Patient Care Link specific to Massachusetts Hospitals and University Hospitals Consortium a national hospital data base. In all of these compare groups our ICU is a top performer. The staff is extremely proud they have not had a hospital acquired pressure ulcer since 2012, no ventilator associated pneumonias for the past two years and the same could be said for many more of the metrics we follow.

I am most concerned about the discussion regarding the "at all times" interpretation that is occurring. Should this interpretation be applied the outcome for our hospital would be to add a Nurse seven days a week twenty four hours a day to cover breaks and other patient care needs that may necessitate a Nurse in a two patient assignment to temporarily be able to care for one. Examples being a patient traveling off the unit for an exam or a patient having a bedside procedure. These situations occur every day. The addition of this nurse would cost us just over 600,000 dollars. This addition would not improve the care of our patients and at a time we are trying to manage health care dollars would have the opposite effect. Given the size of our hospital and the small margins we can generate this expense will significantly hinder our ability to invest in items that would be able to offer our patients access to technologies and equipment that would enhance patient care. My greatest concern however is the very real possibility that patient access

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may be unnecessarily restricted due to the potential at all times language. Patient care and staffing is a dynamic process. To restrict our ability to provide quality care to all patients seeking that care with no data to support such mandates is not in our patient's interest. Please feel free to contact me with any questions you may have regarding the impact of this law's interpretation or the care of patient's at Brigham and Women's Faulkner Hospital.

Sincerely,

Judy Hayes MSN, RN

Judy Hayes, MSN, RN
Vice President, Patient Care Services and Chief Nursing Officer
Brigham and Women's Faulkner Hospital