Massachusetts Nurses Association MNA National Nurses United

TO: The Health Policy Commission's Quality Improvement and Patient Protection Committee

FROM: Karen Higgins, RN- Medical Intensive Care Unit at Boston Medical Center and Co- President, National Nurses United

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RE: Intensive Care Unit Staffing Acuity Tool

I am a practicing medical intensive care unit nurse at Boston Medical Center. My testimony will provide an overview of the MNA's comprehensive recommendations for appropriate acuity criteria that we believe should be included in any acuity tool eventually adopted by individual hospitals for use by their ICU nurses.

To prepare this material, we met with and interviewed several hundred ICU nurses who work in all manner of ICUs, in hospitals of all sizes from the largest tertiary care facilities to the smallest community hospitals in every area of the state. We asked them to tell us, for their units and their patients, what clinical factors or levels of patient status would dictate a one-to-one patient assignment. We also asked them to share what other environmental factors on their unit and in their hospital impacted their ability to accept a second patient. Once we had this criteria collected, we went back and reviewed this criteria with nurses working in intensive care units of all sizes and types to make sure these made sense.

There are three sets of recommended criteria that we have developed for different types of ICUs:

- There is one set of guidelines for critical care units including Medical Intensive Care Units (MICUs), Surgical Intensive Care Units (SICUs), Coronary Care Units (CCUs) and Burn Trauma Units (BTUs);
- There is another set of guidelines targeted at Pediatric Intensive Care Units (PICUs);
- And finally, there is a third set of guidelines for Neonatal Intensive Care Units(NICUs).

All three sets of recommendations are included with this testimony. The various clinical criteria is further categorized under specific headings, such as issues related to patients with respiratory issues, cardiac issues, surgical, neurological, and so on.

In this first set of criteria for the MICUs, SICUs, CCUs and BTUs, we have identified 43 specific clinical situations for patients that would dictate a one-to-one patient assignment. For example, this includes patients who are:

- Status post cardiac or respiratory arrest;
- Ventilator dependent or intubated patients requiring frequent intervention for respiratory compliance, suctioning, trach care, sedation protocols, etc.;

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- Patients in septic shock requiring continuous monitoring and multiple intravenous vasopressors with hemodynamic instability;
- Patients in acute organ failure (liver, kidney, brain, etc.) requiring constant monitoring and intervention.

Again, these are just some of the 43 different conditions we have listed for adult patients. We have similar lists for pediatric and neonatal patients. And all of those listed in our recommendations would demand a one-to-one patient assignment, without exception.

Further, our recommendation is that any regulations developed by the Health Policy Commission should call for an assessment of acuity upon ICU admission with verification every four hours. However, it is important for the nurse assigned to the patient to have the authority to signal a change in acuity at any time, with staffing on the unit to be adjusted as determined by the nurse, using the acuity tool. The intent of this law is to base patient assignments on the needs and acuity of the patient and this provision would ensure that occurs.

If these clinical factors are not in place for the patients assigned to the nurse, then it may be possible to assign a nurse a second patient.

While this list is not exhaustive, we believe all of this criteria, and potentially more, should be included in the final acuity system, to avoid any ambiguity in the system that could open the door to confusion and opportunities to circumvent the standard of care. That being said, the law is clear that if there is an issue not listed in the acuity criteria, the power still lies with the staff nurses on the unit to use his or her assessment as the final arbiter as to what constitutes a safe assignment for his or her patients. The acuity tool is just that, a tool, to aid the nurses in making their assessment of the patient's needs.

In addition to the clinical factors delineated in these documents, we have provided a detailed listing of all the environmental factors we believe are essential and must be included as criteria in the acuity system. The listing of environmental factors includes basic workplace factors that impact every nurse's ability to provide appropriate, safe care. For example, patient assignments must also account for the skill and competency of the nurses on the unit. A clinical assignment for a regularly scheduled nurse on a particular ICU may be significantly different for a unit that is staffed with a temporary float, per diem or travel nurse. The availability and nature of support staff also impacts the nurse's ability to assume a specific patient assignment, for example, is there a hospitalist on the unit, a physician's assistant, unit secretary, or appropriate numbers of aides to assist in the care of the patient.

The physical layout of the unit must be considered. Are the patients in one room or in rooms where a single nurse can keep eyes on both patients efficiently? How visible are the monitors for nurses to check? These factors, along with availability of patient care equipment, i.e., lifting devices and the types of beds in the unit, all impact the ability of nurses to provide appropriate care.

The type of documentation system and medication administration systems also must be factored into the ability of nurses to respond to the acuity of the patient and the patients' needs for care.

There should also be a means of calculating the time required to adequately admit and discharge a patient, as well as to account for times when staff are called off the floor to transport a patient or respond to a code (if they are part of the rapid response team) .

We believe the acuity system must include both clinical and environmental factors, with weights given to each factor that can be calculated easily by the user to ensure patients receive the appropriate attention based on their needs for care.

While not called for under the law, we think the committee needs to explore the issue of when patients can be safely discharged from an ICU to a step down or other floor. We have already heard from nurses about efforts to dump patients from the ICUs, patients who still need ICU level care, to step down or medical surgical units to make room for other patients needing ICU care. We would argue that a patient that still meets the acuity criteria stipulated by this tool and the nurses' assessment should not be allowed to be discharged from the unit unless they are receiving the same level of care.

We have a similar concern about patients who have yet to make it into the ICU, but are being held for extended periods of time in the emergency department, patients who are clearly ICU patients, but who may be sharing their nurse with several other patients.

If we cannot prevent this from occurring outright under this law, perhaps we can create a way to track and report these instances for our use in developing other remedies in the future.

Thank you for your time and attention to this important component of the ICU staffing law. The MNA is ready to work with this committee in any way to aide in the development of an effective acuity tool that serves the needs of our patients.