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**November 19, 2014 Listening Session on Nurse Staffing Law**

**Questions on Acuity Tools**

1. How is patient stability or acuity assessed currently in ICUs in Massachusetts hospitals? What types of acuity or patient assessment tools are used for staffing and staff planning purposes?

**At this time, based on surveys of ICU nurses statewide, we are not aware of any hospital that utilizes a tool to assess acuity and adjust staffing based on the patient stability. Any tools currently in use are for the purposes of budgeting of all staff.**

**It is important to note that while there were acuity tools used by hospitals under the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in the 1990s, their effectiveness was eroded over time as the acuity criteria were adjusted to meet budgets and existing staffing plans. We cannot allow this to happen again. The most important aspect of this law is that it gives staff nurses the primary role in assessing the acuity level of the patient based on the tool and their own nursing judgment, so this new tool will be unlike any that have existed in our state.**

1. What specific clinical indicators and/or nursing workload indicators are assessed by such acuity tools? How are such indicators selected and validated? What additional factors are appropriate to consider in assessing individual patient stability or need?

**As stated previously, the tools currently used in Massachusetts hospitals are not acuity tools for patient assessment for the purpose of nurse staffing according to patient stability in real time. They are budgetary tools. Direct care nurses are not included in the development or adoption of these existing tools and have no real authority or ability to utilize these factors to adjust their patient assignment based on the needs of the patients under their care.**

**The Massachusetts Nurses Association (MNA) 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 to create a comprehensive list of the clinical factors and levels of patient status that would require a 1:1 nurse to patient assignment.**

**The clinical criteria varied among the different ICU specialties (NICU, PICU, MICU, SICU, etc). If any clinical factor on the tools submitted is present, then the nurse caring for that patient should be caring for only that patient. A list of environmental factors to consider was also included in the tool submitted by the MNA. This tool was presented at the October 29th Listening Session and another copy has been provided with this testimony.**

1. In making patient assignments for nurses in ICU units, what environmental (or non-patient-specific) factors are appropriate to consider (such as, for example, patient census and mix in the unit, level of nursing experience, availability of ancillary and support staff, and physical layout of the unit)?

**All the environmental factors listed in Question 3 are important to consider in determining the appropriate nurse-to-patient assignment. As state previously, the MNA included recommendations for environmental factors to consider in its October 29th testimony. Each of these is crucial in determining the amount of time nurses will have available to care for their patients and they must be accounted for in the acuity criteria.**

**There is one additional factor the MNA recommends including. After hearing testimony from ICU nurses at the October 29th Listening Session, the MNA strongly supports including a language and cultural component among the environmental factors. The patient population presenting at our hospitals has grown more diverse. There are dozens of languages and dialects spoken in Massachusetts and when these individuals are patients, communicating with the individual or his/her family often requires taking the time to locate a translator and additional time spent with the patient and family. There are also cultural factors to be considered when it comes to medical care and treatment. All of this requires a nurse’s time and attention and could affect his or her ability to take on a second ICU patient.**

1. When during a shift is it appropriate to assess patient stability with an acuity tool in the ICU (i.e., upon admission, beginning of shift, etc.)?

**Assessment of patient acuity should take place upon ICU admission with verification every 4 hours. However the nurse assigned to the patient must be able to signal a change in acuity, with staffing to be adjusted as determined by the nurse, using the acuity tool. In addition, patient assignment changes, including the need for a nurse to travel with a patient being transferred or having extensive testing or procedures outside of the ICU would call for a reassessment of patient assignments.**

1. What are appropriate considerations for the process of hospital development or selection and implementation of an acuity tool for use in nurse staffing?

**After the Health Policy Commission promulgates regulations governing the formulation of the acuity tool, each hospital must include the staff nurses in the development and adoption of the acuity tool, as stipulated in Chapter 155 of the Acts of 2014. For nurses at unionized hospitals, the development and adoption of the acuity tool will be a mandatory subject of bargaining.**

**Each hospital should then adjust the acuity tool based on which specialty ICUs are present in the facility. While ICU specialty-specific clinical criteria should be the same across all hospitals, environmental factors should be weighted based on the ICU specialty and each individual hospital’s physical layout and staff experience. For example, a Cardiac ICU typically gets the bulk of its admissions within a specific timeframe. That should be an environmental consideration based on the ICU specialty. One hospital’s ICU may include multiple single rooms while another hospital’s ICU may have patients in one large room. In each case, those specific environmental factors must be considered and incorporated into the acuity tool.**

**Finally, ease of use and compatibility with existing tools and systems should be considered.**

1. Where are the results of a patient’s acuity measure recorded?

**As stated previously, hospitals are not currently employing patient acuity tools in ICUs to adjust staffing based on the needs of patients. Any information that is collected is not recorded in any place or manner that is accessible to ICU staff nurses.**

**Any information recorded in an acuity tool developed in accordance with the ICU staffing law should be considered an extension of the staff nurse’s documentation and part of the patient’s record. This will ensure that any information recorded by the staff nurse as part of the patient assessment is not able to be altered by anyone else. Any disagreement between the nurses on the unit and the nurse manager about the nurse to patient assignment that results in a change from the staff nurse recommended nurse-to-patient assignment should also be recorded as part of the patient’s record.**

1. What training is required for hospital implementation and use of an acuity tool for staffing purposes?

**Hospitals should follow the same procedures currently in place for training staff on maintaining their Nurse Competencies, and this should apply not only to all ICU nurses, but any and all nurses who may possibly work on these units, including, floats, per diems and travelers. This education and training should be competency tested annually.**