

# Important Information About Draft Regulations on the New ICU Staffing Law And How Nurses Can Shape These Regulations to Protect Patients

*Please Read and Join Us at Public Hearings on March 25 and April 2*

In January, the state's Health Policy Commission (HPC) released draft regulations that will establish a process for hospitals to develop an acuity tool to be used by nurses determining if and when an ICU nurse can take a second patient. These draft regulations are now out for public comment and the HPC has scheduled public hearings on them. *The MNA has a number of concerns about the draft regulations and is currently working with ICU nurses and other nurses across the state to prepare for these hearings. We encourage all interested nurses to attend these hearings on March 25 (in Boston) and April 2 (in Worcester).*

This publication includes the full text of the **draft** regulations and, throughout, you will find “red flag” boxes where the MNA shares specific concerns about key aspects of the draft regulations that we believe need to be revised. We're hoping that after reviewing the regulations and our concerns, you will be interested in testifying at the hearing, or in submitting written testimony. The MNA is ready and willing to provide whatever assistance you need in drafting your testimony. Whether it is written or oral, please note that it is important that your testimony speaks to the draft regulations and how they need to be changed in order to ensure the safety of your patients. If you have questions about the law and would like to speak at the hearing or submit written testimony, contact Megan Collins in the MNA/NNU Division of Legislation and Governmental Affairs via email at [mcollins@mnarn.org](mailto:mcollins@mnarn.org). Even if you do not want to testify, we are hoping you will attend the hearing to show your support for the MNA's efforts on this issue.



*Readers: Please Note that in addition to the comments made by MNA staff throughout this document, there are a number of minor changes we have noted for the HPC that we have not addressed here, such as changing the word “ratio” to “limits” in all instances.*

## PROPOSED REGULATION

Approved by HPC Quality Improvement and Patient Protection Committee • 1-6-15

958 CMR 8.00: REGISTERED NURSE-TO-PATIENT RATIO IN INTENSIVE CARE UNITS IN ACUTE HOSPITALS

Section

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## 8.01: General Provisions

Scope and Purpose: 958 CMR 8.00 governs the implementation of M.G.L. c. 111, §231, which establishes a Registered Nurse-to-patient ratio of one-to-one or one-to-two in Intensive Care Units in Acute Hospitals licensed by the Massachusetts Department of Public Health and in hospitals operated by the Commonwealth of Massachusetts.



*The major concern we have here is that the language specific to nurse-patient assignments differs from the law. The law says an ICU nurse's patient assignment "shall be 1:1 or 1:2 depending on the stability of the patient." Yet, according to these draft regulations, the ratio could be one-to-one OR one-to-two; no consideration of patient's stability is referenced. Any attempt to differ from the law violates the clear intent of what we negotiated with the legislature.*

## 8.02: Definitions

As used in 958 CMR 8.00 the following words mean:

**Acute Hospital** - The teaching hospital of the University of Massachusetts Medical School, any hospital licensed by the Department of Public Health pursuant to M.G.L. c. 111, § 51 or hospital operated by the Commonwealth, and which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department.

**Acuity Tool** - A decision support tool using a method for assessing patient stability for the ICU Patient according to a defined set of indicators, and used in the determination of a Patient Assignment.

**Commission** - The Health Policy Commission established in M.G.L. c. 6D.

**Department** - The Massachusetts Department of Public Health established in M.G.L. c. 111.

**Intensive Care Unit ("ICU")** - A unit physically and identifiably separate from general routine and other patient care areas, in which are concentrated special equipment and skilled personnel for the care of critically ill inpatients requiring the immediate and concentrated continuous care and observation, and which meets the Medicare requirements in 42 CFR 413.53(d) for intensive care type inpatient hospital units, and licensed by the Department, including coronary care unit, burn unit, pediatric intensive care unit and neonatal intensive care unit, as defined in 105 CMR 130.020, however named by the Acute Hospital; and an ICU service or beds in a hospital operated by the Commonwealth.

**ICU Patient** - A patient occupying a bed in an ICU.

**Nurse Manager** - A nurse with management responsibility for nursing services for the ICU.

**Patient Assignment** - The assignment of a Staff Nurse to care for one or two specified ICU Patient(s) for a Shift, consistent with the education, experience and demonstrated competence of the Staff Nurse, the needs of the ICU Patient, and the requirements of 958 CMR 8.00.

**Registered Nurse** - A nurse who meets the criteria for licensure under M.G.L. c. 112, § 74 and 244 CMR 8.00, and who holds a valid license from the Massachusetts Board of Registration in Nursing to engage in the practice of nursing in Massachusetts as a Registered Nurse.

**Staff Nurse** - A Registered Nurse providing patient care in an ICU who is not a Nurse Manager.

**Shift** - A designated period of work time within the ICU.

## 8.03: Applicability

958 CMR 8.00 applies to Acute Hospitals licensed by the Department to provide ICU service(s) or with licensed ICU beds, and to hospitals operated by the Commonwealth and authorized to provide ICU service(s) or with ICU beds.

## 8.04: Staff Nurse Patient Assignment in Intensive Care Units

(1) In all ICUs, the Patient Assignment for each Staff Nurse shall be one or two ICU Patients at all times during a Shift.

- (2) The maximum Patient Assignment for each Staff Nurse may not exceed two ICU Patients at any time during a Shift.
- (3) Nothing in 958 CMR 8.00 prohibits a Patient Assignment of more than one Staff Nurse for an ICU Patient.



*Our concern under this section, 8.04 (1) above is the definition of a patient assignment as “one or two ICU Patients.” As stated earlier, we believe these regulations must comply with the legislative intent of the law, which is that the default patient assignment is one nurse to one patient, with the option of taking a second patient depending on the stability of the patient as assessed by the staff nurses on the unit who will be using the acuity tool.*

*On a positive note, this section of the regulations does include a clear statement that the patient assignment can never exceed two patients, and that this standard is in effect at ALL TIMES. The Massachusetts Hospital Association (MHA) contends, and nurses are reporting their administrators are saying, that nurses can take a third patient or change a one-to-one assignment to a two-to-one assignment when nurses are on break or leave the unit with another patient. The HPC’s clear statement that the regulation is applicable at all times is appropriate given that the negotiated language of the law purposefully excluded any exceptions to the limits.*

#### **8.05: Assessment of Patient Stability and Determination of Patient Assignment**

- (1) For purposes of determining a Patient Assignment, the Staff Nurse assigned to care for the ICU Patient shall assess the stability of the ICU Patient utilizing:
  - (a) The Acuity Tool developed or selected by the Acute Hospital and certified by the Department, pursuant to 958 CMR 8.00; and
  - (b) The exercise of sound nursing assessment and judgment within the parameters of the Staff Nurse’s continuing education and experience.



*Again, our concern with this section is that it fails to recognize the intent of the law, which is that the staff nurses on the unit make the assessment of their patients and collectively determine the appropriate patient assignments based on that assessment, utilizing the acuity tool as just that: a tool to support their assessment if needed. This true intent of the law was clearly stated by Senator Rosenberg, the author of the law, on the floor of the Senate.*

- (2) If the Staff Nurse assigned to care for the ICU Patient determines within the exercise and scope of sound nursing assessment and judgment within the parameters of the Staff Nurse’s continuing education and experience that the ICU Patient’s stability requires a different Registered Nurse-to-patient ratio than that indicated by the Acuity Tool, the Nurse Manager or the Nurse Manager’s designee shall resolve the disagreement between the Acuity Tool and the Staff Nurse’s assessment, in consultation as appropriate with the other Staff Nurses on the unit and taking into account critical environmental factors such as nursing skill mix and patient census on the unit, and shall determine the appropriate Patient Assignment.



*This section is also problematic in that it places the emphasis on the acuity tool as the determining factor in the assignment of patients, as opposed to the assessment by staff nurses on the unit. This section also fails to acknowledge the law’s intent that the nurse manager or supervisor has no role in assigning patients to a nurse, so long as the nurses on the unit can agree on the appropriate assignments. It is only when there is a dispute among the nurses on the unit as to the proper assignment of patients to nurses that management can be called in to resolve the dispute.*

*On a positive note, the regulations here and elsewhere acknowledge that critical environmental factors and the skill mix on the unit (availability of a secretary, etc) must be accounted for in the nurses’ determination as to what is a safe patient assignment.*

- (3) The Staff Nurse assigned to care for the ICU Patient shall assess the stability of the ICU Patient using the Acuity Tool at a minimum:

- (a) Upon the ICU Patient's admission or transfer to the ICU;
- (b) Once during a Shift; and
- (c) At other intervals or circumstances as specified in the Acute Hospital's policies and procedures established pursuant to 958 CMR 8.07(6).



*Under 8.05 (3) above, we believe the regulations should require nurses to assess the stability of the patient every four hours, and at any time there is a substantive event or change in a patient's condition. We also believe the regulations should stipulate that the staff nurses' assessment and resulting patient assignment should be documented by the staff nurse in the patient's record.*

#### **8.06: Development or Selection and Implementation of the Acuity Tool**

- (1) Each Acute Hospital shall develop or select an Acuity Tool for each ICU that meets the requirements of 958 CMR 8.00, in order to:
  - (a) Support the determination of whether each ICU Patient requires care by one or more Registered Nurses, or by a Registered Nurse assigned to care for no more than two ICU Patients; and



*Again, the language in the draft regulations fails to make clear that the default patient assignment is one nurse to one patient, and that the acuity tool is to be used in addition to the nurses' assessment in determining those instances when a patient is stable enough to be included in a two-patient assignment.*

- (b) Address the unique care needs and circumstances of the patient population in and physical environment of each ICU at the Acute Hospital.
- (2) Each Acute Hospital shall develop, implement and document the process for development or selection and implementation of the Acuity Tool to be deployed in each ICU, which shall include but not be limited to the following required elements:
  - (a) Formation of an advisory committee to make recommendations to the Acute Hospital on the development or selection and implementation of the Acuity Tool, which committee shall be composed of at least 50 percent Registered Nurses who are not Nurse Managers, a majority of whom are Staff Nurses, and other members selected by the hospital including but not limited to representatives of nursing management, and other appropriate ancillary and medical staff;



*The MNA has serious concerns about the language in the draft regulations calling for the creation of an "advisory" committee at each hospital to develop the acuity tools specific to that hospital. First, as an advisory committee, the draft regulations make clear that the final selection of the acuity tool will be made by hospital administration, not the committee. THIS MUST BE CHANGED. The regulations must provide the Acuity Tool Committee with the power and final say over the creation and adoption of acuity tools for that hospital's ICUs. Second, as to the makeup of the committee, stronger language is needed in order to ensure that front-line nurses are in control of this process, not administration. To assure the committee's work reflects the clinical expertise and experience of the nurses who will ultimately be responsible for the outcome of these patients, each Acuity Tool Committee must be composed of at least 50 percent registered nurses who are direct care ICU staff nurses; with the addition of other representatives of nursing management and other appropriate ancillary and medical staff.*

*In cases where members of the Acuity Tool Committee are represented by a certified collective bargaining agent (such as the MNA), the regulations should clearly state that the locally elected bargaining unit for that hospital will select the members to the committee.*

- (b) A process for the advisory committee to address and make recommendations on the elements of the Acuity Tool and other considerations for its implementation including but not limited to the following:
  - 1. The defined set of indicators to be assessed by the Acuity Tool, including clinical indicators of patient stability and other indicators of Staff Nurse workload as set forth in 8.07(4);
  - 2. Scores to be assigned to each indicator;

3. How scores are tabulated and used in the determination of whether each ICU Patient requires care by one or more Staff Nurses, or by a Staff Nurse assigned to care for no more than two ICU Patients; and
4. Critical environmental factors relevant to the particular ICU and that may affect the ability of Staff Nurses to care for one or two ICU Patients that should be addressed in the selection or development of the Acuity Tool, such as:
  - (i) Physical environment of the unit, including visibility of patient/monitoring equipment;
  - (ii) Nursing skill mix, competency and familiarity with the ICU;
  - (iii) Availability of patient care equipment and technology; and
  - (iv) Availability of ancillary and support staff in the ICU (e.g., pharmacist, IV team/respiratory therapist, nurse practitioner, clinical nurse specialist, physician assistant, unit secretary, sitters, aides/technicians, staff to operate patient care equipment and technology, patient transport services, travel team/coverage);
- (c) A process for Staff Nurses and Nurse Managers to test, validate and recommend any revision to the Acuity Tool prior to implementation;
- (d) A process for the Acute Hospital to address and respond to recommendations of the advisory committee regarding the selection, development or revision of the Acuity Tool pursuant to 958 CMR 8.06;



*As stated previously, we believe the Acuity Tool Committee must have the power and authority to develop an acuity tool to submit to the Department of Public Health (DPH) for certification, and that senior administration must abide by the work of the committee.*

- (e) Development and implementation of policies and procedures for assessment of patient stability and determination of the appropriate Patient Assignment in any ICU in the Acute Hospital, consistent with the requirements of 958 CMR 8.00; and
- (f) A process for periodic review and evaluation of the implementation of the Acuity Tool.
- (3) Nothing in 958 CMR 8.06 shall restrict or limit any additional obligation of an Acute Hospital to bargain with a labor organization under applicable law, regulation or collective bargaining agreement.

### **8.07: Required Elements of the Acuity Tool**

Each Acute Hospital shall develop or select an Acuity Tool that meets the following minimum requirements:

- (1) The Acuity Tool shall be in writing either in electronic or hardcopy format;
- (2) The Acuity Tool shall be tailored to the unique care needs and circumstances of the patient population in any ICU in which the Acuity Tool is deployed;
- (3) The Acuity Tool shall include a method for scoring defined clinical indicators of patient stability and other indicators of Staff Nurse workload as required in 8.07 (4)(a) and (b); and
- (4) The Acuity Tool shall include a defined set of indicators incorporating:
  - (a) Clinical Indicators of Patient Stability related to physiological status and clinical complexity and related scheduled procedures, medications and therapeutic supports appropriate to the ICU Patient population in the ICU in which the Acuity Tool will be deployed in clinical domains such as:
    1. Respiratory;
    2. Cardiac;
    3. Surgical;
    4. Neurological;
    5. Gastrointestinal;
    6. Skin;
    7. Orthopedic;
    8. Reproductive;

9. Hematologic;
  10. Renal;
  11. Metabolic/endocrine;
  12. Immune; and
- (b) Other indicators of Staff Nurse workload associated with caring for the ICU Patient appropriate to the ICU Patient population in the ICU in which the Acuity Tool will be deployed such as:
1. Patient age, including gestational age as applicable, and cognitive/functional ability;
  2. Patient and family communication skills and cultural/linguistic characteristics;
  3. Need for patient and family education;
  4. Family and other support for the patient;
  5. Need for care coordination; and
  6. Transitional care and discharge planning required for the patient.



***Behavior health and substance abuse issues should be included in the indicators addressed by the acuity tool as should the critical environmental factors listed in 958 CMR 8.06(2)(b)(4)(iv).***

- (5) The Acute Hospital shall develop written policies and procedures specifying how the resulting Acuity Tool score will be used to support the determination that the ICU Patient requires care by one or more Staff Nurses, or by a Staff Nurse assigned to care for no more than two ICU Patients; and
- (6) Other requirements as may be specified in guidance of the Commission.

#### **8.08: Records of Compliance**

- (1) Development or Selection of Acuity Tool(s). Each Acute Hospital shall document, retain for a minimum period of ten (10) years and provide to the Department and the Commission upon request, the process it followed for development or selection of the Acuity Tool required by 958 CMR 8.06(2), including but not limited to:
  - (a) Membership of the advisory committee including name and title;
  - (b) The rationale for selection or development of an Acuity Tool including how the Acute Hospital addressed recommendations of the advisory committee and the decision to include or exclude certain clinical indicators of ICU Patient stability and other related indicators of Staff Nurse workload, and how critical environmental factors in 958 CMR 8.06 (2)(b)4 were taken into account in the selection and the method for scoring of the indicators;
  - (c) Written policies and procedures regarding the implementation of the Acuity Tool required in 958 CMR 8.07(5); and
  - (d) The process for validating and periodically evaluating the use of the Acuity Tool in each ICU in the Acute Hospital.
- (2) Records of Staffing Compliance. Each Acute Hospital shall document and retain for a minimum period of ten (10) years records indicating the results of the assessment of ICU Patient stability and determination of Patient Assignment for each ICU Patient.

#### **8.09: Acuity Tool Certification, Enforcement by the Department of Public Health**

- (1) Each Acute Hospital shall submit the Acuity Tool for each ICU to the Department for certification prior to implementation and periodically as determined by the Department;
- (2) The Department shall determine whether the Acuity Tool(s) was developed or selected by the Acute Hospital in accordance with the procedures and requirements of 958 CMR 8.00; and
- (3) Acute Hospitals shall comply with the procedures for certification and enforcement as established by the Department.



***In the creation and certification of the acuity tool for a specific hospital, the regulations should make clear that creation of the acuity tool is to assist in the assessment process, not to act as a managerial substitute for the professional judgment of the registered nurses. There will be variations in patients and the nurses caring for those patients and in the facilities in which the patients have been admitted. But in the final analysis a fresh post op AAA***

*(ascending aortic aneurysm) patient should be 1:1 no matter what nurse, what hospital. If the regulations for the formulation of an acuity tool allow a hospital to pursue such a patient as a 1:2, which we believe the regulations as proposed would do, then we will have failed the patients and the ICU law that seeks to ensure a consistent standard for patients in spite of the health care chaos around them.*

#### **8.10: Public Reporting on Nurse Staffing Compliance**

- (1) Each Acute Hospital shall report to the Department, at least quarterly and in the form and manner specified by the Department:
  - (a) Reports of Staff Nurse-to-patient ratios by ICU; and
  - (b) Any instance and the reason in which the minimum Staff Nurse-to-patient ratio of one to two was not maintained by the Acute Hospital.



*As to reporting, we believe hospitals must document and report to DPH those instances where there is a disagreement over the assignment of patients. We also believe the regulations should call for posting of the law on all units and the family waiting area for each ICU, with instructions on how the family member can question the determination of acuity and patient assignment.*

- (2) Each Acute Hospital shall issue reports quarterly to the public on Staff Nurse-to-patient ratios by ICU on the Acute Hospital's website, and as may be specified in guidance of the Commission.

#### **8.11: Collection and Reporting of Quality Measures**

Each Acute Hospital shall:

- (1) Report ICU-related quality measures to the Department, as specified in guidance of the Commission;
- (2) Report the specified quality measures to the Department, at least annually, and in the form and manner specified by the Department; and
- (3) Issue reports to the public on the specified quality measures for each ICU, at least annually, on the Acute Hospital's website, and as may be specified in guidance of the Commission.

#### **8.12: Development of ICU Staffing Plan**

Each Acute Hospital shall develop and implement a Registered Nurse staffing plan for the ICU in which the Acuity Tool is deployed that incorporates data gathered from implementation of the Acuity Tool.

#### **8.13: Implementation Timeline**

Each Acute Hospital shall submit an Acuity Tool for each ICU to the Department for certification no later than October 1, 2015.

#### **8.14: Severability**

If any section or portion of 958 CMR 8.00 or the applicability thereof is held invalid or unconstitutional by any court of competent jurisdiction, the remainder of 958 CMR 8.00 or applicability thereof to other persons, entities, or circumstances shall not thereby be affected.

REGULATORY AUTHORITY • 958 CMR 8.00: MGL c. 111, § 231.

## **Attend the Public Hearings on the ICU Staffing Law**

**Wednesday, March 25, 2015**

12 Noon  
One Ashburton Place • 21st Floor  
Boston, MA 02108



**Thursday, April 2, 2015**

10 a.m.  
Worcester State University • Blue Lounge  
486 Chandler St  
Worcester, MA 01602

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