Committee to Ensure Safe Patient Care
Response to ENA Position on Question 1

Supporters of Question 1, The Patient Safety Act, and the Massachusetts Nurses Association, which represents more than 1,800 emergency department nurses working in 65 percent of the state's acute care hospitals, are taking this opportunity to respond to the recently announced stance by the executive leadership of the Emergency Nurses Association (ENA) to oppose Question 1. We are disappointed by the decision given that, as outlined below, the opposition to the question is not supported by a factual analysis of Question 1, the overwhelming scientific evidence, or the 14 years of experience with the law by ED nurses in California.

The table below tracks the chart provided by ENA that details their interpretation of how aspects of Question 1 match the current ENA Position Statements on staffing. For each ENA rationale, we have provided facts and evidence to provide ED nurses with an accurate appraisal of Question 1 so that ED nurses can make a truly informed decision about this vitally important patient safety initiative.

ENA Position on Staffing	House Bill 3114 – Question 1	The Truth About Question 1
Registered nurses are essential to the delivery of quality, cost-efficient emergency care.	Yes – the bill/Q1 supports this	Agreed
Patient care delivered by nurses educationally-prepared with a BSN or higher degree in nursing can lead to improved patient outcomes and nurse satisfaction.	No – The bill does not have provisions about educational levels. The addition of 5,000 nurses in the state may lower the percent of BSN prepared nurses at the bedside.	There is no evidence to support this ENA position. First, nothing in this bill prevents hospitals from hiring BSNs. More importantly, Massachusetts is one of two states in the nation deemed to have NO shortage of nurses, with a surplus of nurses, including BSNs, projected through 2030. In fact, according to the Mass. Action Coalition, the number of BSN grads in Massachusetts increased by 62 percent between 2010 -2015, and RN to BSN graduates increased by 187 percent. And an analysis of Board of Registration in Nursing statistics project an additional 6,500 BSN graduates over the next three years.
Regardless of ED census and acuity, a minimum of two registered nurses responsible for providing care in the ED at all times facilitates safe emergency care.	No – the bill does not require at least 2 nurses at an emergency department.	Again, nothing in this law prevents hospitals from meeting this requirement. What Question 1 does do is ensure that more nurses are available and patient assignments are adjusted when census and acuity requires more care to meet the needs of patients. **Right now, there is no requirement for executives to ensure safe staffing based on acuity and census.**
Ongoing systemic evaluation of staffing and productivity is essential to the delivery of quality emergency care.	Partial – The bill requires that hospitals have review programs, however there is no mechanism to adjust the limits once the bill is passed without further legislation.	The limits for EDs in the law are maximum limits that were developed specifically based on ENA's ESI guidelines and in consultation with ED nurses across the state working in a variety of hospitals, including teaching, trauma centers and community hospitals. The bill calls for every hospital ED to work with staff to develop an acuity system and a process to monitor and adjust patient assignments based on the needs of patients and a variety of factors. Recent surveys of nurses find that the vast majority report patient acuity to be on the rise and the idea that an increase in nurses' patient assignments may be justified seems ludicrous. Visit www.safepatientlimits.org to read the full text of the law.

Emergency nurses support the use of evidenced-based methods to calculate staffing and productivity.	Partial – There is no evidenced based research that connects nurse to finite patient limits with improved outcomes. There is evidence about average ratios, however this bill does not use average assignments.	There are literally dozens of studies that link patient limits to a number of patient outcomes, including studies that do measure outcomes to specific patient assignments. This includes five such peer reviewed studies specific to Massachusetts hospitals, including Massachusetts EDs. A 2017 study in the journal *Emergency Nursing* of Massachusetts hospitals found the number of patients assigned to Emergency Department (ED) nurses has a direct impact on ED wait times, at a time when our state ranks 48th out of 50 for patients waiting for needed care. A 2010 study in the journal for the *Society for Academic Emergency Medicine* funded by the ENA to evaluate the impact of the limits law in California, found that following the implementation of the law, "ED wait time and ED care time were shorter" with limits in place, and concluded that efforts to staff EDs with mandated limits "do have a beneficial effect on patient flow." It is important to note that ED wait times in Massachusetts are now 47% longer than those for California patients. And a 2018 study in the ***Western Journal of Emergency Medicine*** found that excessive patient assignments and lower staffing levels in hospital emergency departments harm patient care, resulting in longer ED wait times, and the likelihood that patients will leave without being seen.
Evaluation of staffing and productivity is based on patient census and acuity, direct and indirect time for care delivery experience and skill mix of the ED staff, and include the impact on patient emergency nurse safety and satisfaction, and the recruitment and retention of qualified nurses.	Partial – The bill does take into account triage acuity, however indirect care time such as follow up, quality assurance, triage and training are not covered	As stated above, the ballot language calls for management and staff nurses to work together to develop a hospital specific acuity system to ensure your staffing approach meets the needs of your patient population, It includes all the requirements identified to be accounted for by both the ANA and the ENA. Here is that language: Patient Acuity Tool. The patient acuity tool shall serve as an adjunct to the assessment of the registered nurse and shall be designed to promote and support the provision of safe nursing care for the patient(s); however, such tools are not to be utilized as a substitute for the assessment and clinical judgment of the registered nurse assigned to the patients. Each facility shall develop a patient acuity tool for each unit designated in Section 231C. The patient assessment and use of the patient acuity tool shall be performed by the nurse who has accepted the assignment for that patient(s). The patient acuity tool for each unit in a facility shall be developed by a committee, the majority of which is comprised of staff nurses assigned to the particular unit. The patient acuity tool shall be developed to determine if the maximum number of patients that may be assigned to a registered nurse(s) should be lower than the patient assignment limits specified in Section 231C, in which case that lower number will govern for those patients. The patient acuity tool shall be written so as to be readily used and understood by registered nurses, shall measure the acuity of patients not less frequently than each shift, upon admission of a patient, and upon significant change(s) in a patient's condition and shall consider criteria including but not limited to: (1) the need for specialized equipment and technology; (2) the

		intensity of nursing interventions required and the complexity of clinical nursing judgment needed to design, implement and evaluate each patient's nursing care plans consistent with professional standards of care; (3) the skill mix of members of the health care workforce necessary for the delivery of quality care for each patient; and (4) the proximity of patients to one another who are assigned to the same nurse, the proximity and availability of other healthcare resources, and facility design. A facility's patient acuity tool shall, prior to implementation, be certified by the Massachusetts Health Policy Commission as meeting the above criteria, and the Commission may issue regulations governing such tools, including their content and implementation.
Emergency nurses support further research regarding staffing models and their impact on patients, nurses and organizations.	No – the bill does not have a review period where best practice or evidence based care could be included in the future.	The hospital industry is free to do further research if they so choose whenever they wish. What the bill prevents is the creation of a staffing model that leads to patient assignments exceeding what is provided by Question 1 as these limits are evidence based and proven by the literature and 14 years of experience with the law in California to result in better patient outcomes, better ED patient flow and significantly shorter ED wait times.

In addition to the issues above, the ENA also cited the following statement as a rationale for their opposition:

> "Emergency medicine is a specialty that relies on the abilities of a team to accomplish the best outcomes for our patients. This legislation places a priority on improving the number of nurses working in a unit at the possible expense of our multidisciplinary team we work with each day."

We take strong exception to this blatantly false claim, as Question 1 includes a specific provision that explicitly prohibits the reduction of any non RN members of the health care workforce to meet the requirements of this law. This language is so strong, that the hospital industry appealed to the State Supreme Court to strike down the law because of this provision. The court ruled in support of Question 1 and this provision to protect all members of the health care team.

For more information about the law, please visit the web site for Question 1 at www.safepatientlimits.org, or contact ENA member Mary Sue Howlett at mhowlett@mnarn.org.