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HARVARD MEDICAL SCHOOL
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Patient Care Services
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Testimony in Opposition to Senate Bill 557
An Act Relative to Patient Safety

Testimony in Opposition to House Bill 1008
An Act Relative to Patient Safety

Testimony in Opposition to House Bill 3843
An Act Relative to Patient Safety

Testimony in Opposition to House Bill 3844
An Act to Limit Excessive Hospital Operating Margins and CEO Compensation Through Greater Financial Transparency

Submitted to the Joint Committee on Health Care Financing by:
Cassandra Mombrun MS, RN, Staff Nurse Level II
Boston Children's Hospital
March 24, 2014

Chairman Welch, Vice-Chair Benson and distinguished members of the Health Care Financing Committee, my name is Cassandra Mombrun MS, RN and I have been a registered nurse in Massachusetts for eight years. I have worked on the solid organ transplant and surgical post-op floors at Boston Children's Hospital for the past six years and as a representative of nursing and patient care services, I wish to be recorded in opposition **to Senate Bill 557; House Bill 1008; House Bill 3843 and House Bill 3844.**

The solid organ transplant and surgical post-op unit at Boston Children's Hospital (BCH) is a busy 24 bed unit. The majority of the patient's on this unit have received a kidney, liver, lung, intestine or multi-organ transplant and are recovering from that surgery, adjusting to their new anti-rejection medication regimen, and learning about their adjustment back into life at home. The nursing intensity of these patients depends on when they had their transplant, how medically stable they are, their age, and the level of participation of their families. We care for babies through young adults and work to address the medical and developmental needs of each patient through our model of family centered care. Based on my experience, I know that the acuity of pediatric patients can change in an instant, and a large component of providing high quality nursing care is ensuring staffing is available to meet the needs of our patients. During my testimony I hope to show you, through the eyes of the charge nurse, why staffing decisions are best left at the point of care, where an educated and experienced nurse can continually reassess the needs of the patients and families, and the staff available to meet these needs.

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My day as the charge nurse begins before 7am, and one thing I know for certain is that today will be entirely different than yesterday. The shift starts off with charge nurse report where I get my first preview of what is happening on the unit. I immediately begin to understand what the day is going to look like for our patients, and make assessments about which patients are going to very busy during the course of the day. This is the fist step in my continual process or reassessing the workload of nurses on my unit.

At 10am I participate in a huddle with the coordinator of patient care placement and other charge nurses and it is during this huddle that I get an understanding of possible admissions for the day. Patients can be admitted to our unit several ways, they can be direct admissions through the transplant medical team, they can come through the emergency department or they can come to our unit from the post anesthesia care unit (PACU), or from the intensive care unit (ICU). We discuss the plan for discharging patients, and get an idea of where admissions are likely to go throughout the hospital. During this huddle, we also discuss nurse staffing on all units, with charge nurses asking for help if their unit is very busy or if they had some last-minute sick calls. During this time the charge nurses work collaboratively to critically think and make the necessary adjustments, float nurses, redistribute patients amongst nursing assignments and come to a mutual agreement. All of this impacts the care of the patient, and all of us work together to ensure appropriate resources are available to meet the needs of our patients.

Daily transplant rounds begin at 2pm. During this time, members of the multi-disciplinary transplant team, including physicians, dieticians, pharmacists, nurses, and medical residents review the plan of care for each patient on the unit. From these rounds, I am able to learn about the patients coming to our floor from the ICU, which patients will need frequent blood work drawn to assess their medications, and which patients need to be transported off the floor to ultra sounds or nuclear medicine for an hour or more. I want to take a minute to discuss scenario because it is just one example of how a charge nurse, such as myself, rebalances staffing during the course of a day.

Following the transplantation of a new organ, our patients often go to nuclear medicine to assess the function of their new organ(s). During this time, they remain connected to many intravenous lines that must be monitored and maintained by the nurse caring for them. As the charge nurse, it is my responsibility to redistribute other patients from the nurse's assignment, so that the nurse can accompany the patient off the unit for the test. In most situations like this, I expect the nurse will be away from the unit with their patient for about one hour. In most cases the remaining patients in her assignment can be divided and covered by other nurses on the floor, based on my assessment of what is happening on the floor. Other such examples requiring a flexible approach to staffing includes supporting a nurse who has to emergently prepare a patient to return to the operating room, or be transferred to the ICU, additionally there are often educational in-services provided during the course of the day, and I work hard to rotate the nurses into such education, all the while asking other nurses to cover their patients. I do such things with a firm understanding of the needs of our patients and the staff nurses on the shift. Nurses on a unit like mine work together as a team, and expect to be able to cross-cover patients in such situations.

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This process of continuing to assess patient acuity and nursing workload continues throughout the day. I carry a phone, where any nurse or member of the care team can reach me to help troubleshoot a situation, or to ask for a helping hand. Because patient acuity can change at any given time, it is important to have ongoing communication with the nurses, and if there is a situation in which I am unable to resolve, I call on my chain-of-command for additional support.

In the early afternoon, I begin the process of making the assignment for staff coming in at 3pm and 7pm. I use the same approach of balancing patient acuity and knowledge of the oncoming nursing staff to make an assignment that will best serve our patients. This is the time of day that sick calls start coming in, and I have to make decisions about contacting a nurse on call, or asking the registry if they have anyone who could help us. There is an afternoon huddle at 4:45pm, again with the coordinator of patient care placement and the charge nurses from the other units in the hospital. At this huddle we get an idea of how busy the Emergency Department is, how the Operating Room is running, and what patients might still be coming out of the ICU. We identify patients who are still likely to be discharged, and we again cover staffing for the evening and night shifts. This collaborative effort helps to ensure that needs are met across the hospital. Limiting the flexibility of our staffing model, that is based around patient needs and the individual skills of the nurses, would interfere with the collaboration that goes into providing high quality, high value patient care.

At Boston Children's Hospital our goal is to provide exceptional care until every child is well. Having mandated staffing ratios will impact the quality care we give to our patients each day because it removes the critical element of nursing judgment from the practice of providing patient and family centered care. Regulating staffing to specify a number of patients assigned to a nurse is oversimplified and flawed, in my opinion. Decisions about staffing are clinical decisions that require critical thinking and nursing judgment.

The practice of nursing is both an art and science, and the evolution of nursing leadership is an upward climb. More than ever the value of a well-educated and well-experienced nursing workforce is being understood through the demonstration of patient outcomes. Nurses have the clinical knowledge of pathophysiology and disease trajectories as well as understanding of their hospital and unit workflows; this knowledge informs sound decisions regarding safe staffing assignments. Patient acuity mixed with nursing education and experience is always the top priority for me as a charge nurse. I believe that staffing decisions have to be made at the unit level, under the discretion of direct care providers because there is no such thing as a "regular patient" or a "regular nurse". Changes occur from hour to hour on inpatient units, both on the patient side and on the nursing side of staffing. Charge nurses like myself are educated professionals who understand how to assess the care required on the unit and make the necessary changes to meet our patient's needs.

It was important for me to come and provide testimony today as part of my own leadership journey, but also because I think this is an issue central to the way we practice nursing. My education and training has well prepared me to make decisions to support safe patient care. In closing, I would like to thank you for the opportunity to testify as a charge nurse and aspiring nurse leader, in opposition this legislation.

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I thank the committee for receiving my testimony today and respectfully request that you oppose Senate Bill 557; House Bill 1008; House Bill 3843 and House Bill 3844.

Sincerely,

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