LWVN Topic Meeting
October 18th, 2018

Question 1 Discussion:

Kevin Whitney, Coalition to Protect Patient Safety: Registered nurse and former paramedic, 30 years experience in health care, why opposed to ballot initiative:

- 100% committed to appropriate nurse staffing, NWH has adjusted staffing ratios—got good feedback from staff
- Quality: only state in country that passed similar legislation—California; MA already exceeding in quality—better times for different care; better pain management; better CMS measures; outperform CA—their ratio is 1:5, which ours is proposing 1:4; MA is 4th safest state in country, CA is 25th
- Way too rigid—not practical option; many decisions go into staffing—layout of dept, acuity of patient, etc. Staff right now 1-4 patients per nurse, but things change. What if got an influx of urgent patients all at once; way law is written, any time a nurse is out of range, 25K fine per incident per day; don't know where money will go; while not what is meant, not what is written
- Will happen in 6 weeks—will need to hire a large number of nurses all at once;
- Professional groups that set ideal standards can't agree on numbers (i.e. with maternity patients)
- Access—patients will be delayed—will be accepted and triaged, but will wait longer in waiting rooms to be seen, not just for Emergency but because people having to wait to move into hospital
- Costs: wide range of predications—seem to be closer to 900m dollars

Denise Garlick, Safe Patient Limits: State Representative and former nurse; Why did this issue come up?

- In 1990s, was deregulated and have been asking for legislation on safe patient limits for years;
- copious literature about safe staffing; no limit in MA on # of patients assigned;
- agree need flexibility—but if don't have enough nurses, end up taking them away from patients who need them;
- nurses say that errors etc. are related to number of patients;
- cost issue--$46m to $900m—real amount is somewhere in middle;
- concern about community hospitals—won't let them fail, state will leverage resources; big hospitals won't be affected;
- issue of quality—if limit, will be impacted; house has voted twice for limits, then recession; now have agreement for ICUs. Seen violations in law.
- Nurses who are asking for help are not the nurse managers—they can't do the job; need help from the legislature; health care lobby is the most powerful in the state, so turn to voters for help; this is a negotiation on behalf of the bedside nurses—people need to say that there are some limits; believe we have good quality care—but have a lot of room to move forward;
- idea of access—if there are more nurses, should move through the system much more quickly; if they are not supported, look forward to time when unlicensed person is giving care

Questions from audience:

About night nursing:

DG: usually isn't a whole lot going on; but acuity is so very high in the hospital now—admitted when so ill or just out of surgery-need nurse 24 hours per day;

KW: is 24/7; but also need that now; already hiring to accommodate change in acuity; Critical Care org. recommended 1 – 2 patient per nurse range. Always been in place. When passed as a compromise—found no change in ICU staffing or mortality; actively committed to appropriate staffing and making changes

Nursing shortage:

DG: no nursing shortage—shortage of those who will hire new grads (and are offering voluntary retirement), and of experienced nurses who will work in unsafe conditions; right now they get burned out and leave profession

KW: are hiring new graduate nurses, but there is a shortage; 50% of NWH nurses are at the top level, will retire in the next few years; have to plan for that accordingly; state produces about 3000 new grads each year—challenge is that retiring nurses is 4000 per year. So is supply-demand issue; have to balance experience; have a nurse educator to support new nurses and have a charge nurse as an additional resource

Flexibility:

DG: still to be negotiated—say a nurse needs to go to the bathroom—still to be worked out. Will be a common sense solution for that—all to be negotiated.

Costs—is cost really the bottom line? Where do travel nurses fit in? Travel nurse—hired by agency, placed at hospitals who need extra staffing for 13-week periods:

KW: NWH currently use agency staff, but at a premium cost—when can't fill vacancies. Create own agency—150 new graduate nurses to give them the experience, then hired some; not all nurses support this law—feel that having explicit numbers devalues the profession—about a 50-50 split; at times have the best plan, but people go out on unexpected leave—there are time when it won't be 100% exact.

DG: intimidation is overwhelming; come to the decision with our own biases as patients; its always about the money—put money in the nurse at your bedside or somewhere else? Around here, hospitals are well-funded, but not in Holyoke or Berkshires or Martha's Vineyard; travel nurses—just-in-time nursing staff; sometimes work at 3 different hospitals part-time because hospitals won't hire and don't want to give benefits. Healthcare industry is biggest in MA, most powerful.

How will nurses lose their autonomy:

KW: flexibility—some hospitals have Emergency Department (ED) boarding, try to keep to staffing guidelines, will get worse; always have a certain number of vacancies—takes time to hire more people; if this passes, becomes so rigid makes it difficult to get patients out of ED to reg hospital beds, won't have staff to match exactly

DG: if more nurses on floor, better able to accept patients; Need government in healthcare—is already there for VA, Medicate, etc. More decisions made on Beacon Hill about healthcare; how we control quality—MA government is involved in healthcare; biggest mistake was to deregulate

Wrap-up:

DG: asking for yes vote for direct care nurses; legislature won't take it up; have come with negotiating position—start high, end in middle—can't do it any longer, it is dangerous

KW: hospitals are already doing the right thing, focused on appropriate staffing, need flexibility—is written way too rigid; 86% of nurses in ad? Based on small survey, not an accurate number