THE NURSING CRISIS IN MASSACHUSETTS

REPORT OF THE LEGISLATIVE

SPECIAL COMMISSION

ON

NURSING AND NURSING PRACTICE

MAY 2001

"The most recent trend I believe I am witnessing is that very competent practitioners are seeking job choices that move them away from direct patient care. I hear them say, 'I have loved my work It continues to challenge me but I need to step away ... take a break. I feel burnt out. I go home at the end of a shift wondering if I did all I was expected to do ... correctly.'."

Donna Mae Donahue, PhD, RN - 9/21/00 - Salem State College Hearing

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“In response to our new cost-based health care system, nurses have reengineered, redesigned, down-sized, cross-trained, mandated to 16 hour shifts, and replaced

with techs. Nurses have been devalued, disrespected and exploited to increase the bottom line."

Terri Arthur, RN, BSN,MSM 9/12/00 Cape Cod Community College Hearing

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“Over the past two decades, studies have shown that care provided registered nurses decreases the length of stay, decreases patient complications and increases patient satisfaction."

Dorothy Upson McCabe RN, MS, M.Ed. 10/24/00 Massasoit Community College Hearing

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THE GENERAL COURT OF MASSACUSETTS

STATE HOUSE, BOSTON 02133-1053

To The Honorable Members of the Great and General Court:

The Special Commission on Nursing & Nursing Practice is pleased to present to you their final report. The Commission members have worked diligently to compile the data collected at the six hearings held during the year 2000. We have arranged the report into distinct sections that develop the subject area presented by the participants. We have endeavored to be thorough but succinct. It is our desire to present you with a report that is readable in one sitting and understandable to all. The report we present to you has met those goals.

Throughout the hearing process, we listened to licensed nurses and other health care professionals who care deeply about their chosen profession and are truly

disheartened by the current environment within which they practice. They attended the hearings in large numbers. Some presented written testimony and others presented oral testimony. We have relied heavily upon these testimonials for the body of this report. It is our belief that the words of the participants are powerful and truly reflective of the crisis in nursing that we are now experiencing. We have referenced quotes with either the initials and title of the person testifying or both.

All the data collected is kept on file and available for inspection upon written request. All requests should be addressed to Representative Canavan, House Chairman of the Special Commission.

We would like the reader to note that throughout the Commission's work, we learned that the health care industry is seriously short of working licensed nurses, and the shortage has developed into a problem so negatively pervasive that current nurses are leaving the profession in numbers large enough to offset any gain in new graduate nurses. Retention and recruitment in the nursing profession are the two main themes that this report addresses.

Lastly, one thing became very clear to the Commission members. Licensed nurses and the patients are inextricably linked. If the working conditions of the licensed nurse improve, direct patient care improves. If the patients' concerns for quality care are met, the working conditions for the licensed nurses have been addressed. Their relationship is symbiotic.

In conclusion, the Commission members hope that this report enlightens all who take the time to read it and that our recommendations are supported.

Respectfully Submitted,

Christine E. Canavan
House Chairman

Robert S. Creedon, Jr.
Senate Chairman

The Special Commission on Nursing and Nursing Practice in the Commonwealth of Massauchusetts:

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Senator Richard Moore (Chair of Joint Committee on Health Care) (D-Uxbridge)
Senator Michael Morrisey (Chair of Joint Committee on Government Regulations) (D- Quincy)
Senator Therese Murray (Chair of Joint Committee on Human Services and Elderly Affairs) (D-Plymouth)
Senator Henri Rauschenbach (R-Brewster)

This committee, composed of five members of the House of Representatives and five members of the Senate, convened to address the issues of patient care with the health care workers of the Commonwealth. This report is the result of these hearings and the resultant recommendations (Section 338 (H284) of Chapter 127 of the Act of 1999).

State Representative Christine E. Canavan and State Senator Robert Creedon have been appointed to co-chair the Special Commission to investigate and report on matters affecting the practice of nursing and the delivery of health care services by nurses. "The committee will gather information from healthcare providers and licensed or unlicensed employees, on the impact of their job performance of any/all current regulations, promulgated by any and all state agencies." Journal of the House, March 2, 2000.

The hearings were held at the following sites:

College of the Elms, Chicopee MA, May 18, 2000
Montachusett Vocational Technical School, Fitchburg MA, June 15, 2000

Cape Cod Community College, West Barnstable MA, September 12, 2000
Salem State College, Salem MA, September 21, 2000
Bristol Community College, Fall River MA, October 12, 2000
Massasoit Community College, Brockton MA, October 24, 2000

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Publicity:

Nursing Spectrum Magazine

The Special Commission On Nursing And Nursing Practice gratefully acknowledges the assistance of Massasoit Community College in the printing of this report.

Statement of the Problem:

A CRISIS IN NURSING AND NURSING PRACTICE

The Special Legislative Commission on Nursing and Nursing Practice, appointed by Governor Argeo Paul Cellucci and the Massachusetts Legislature in March 2000 has been authorized by Chapter 127 of the Acts of 1999 to investigate and report on matters affecting the practice of nursing and the delivery of healthcare services by nurses. This report documents the findings and recommendations of the Commission, which were derived from the hearings on nursing care, which were held from May to October 2000.

In these hearings, it became apparent that the issues that affect the delivery of patient care are common to each of the regions of our Commonwealth. It is the unanimous consensus of licensed nurses, health care personnel and administrators that the shortage of nursing care in the Commonwealth is endangering the quality of care that our nurses can provide to the patient. Each nurse working in a dangerous situation is jeopardizing his or her license to practice. The Commission is called upon to encourage the Commonwealth to take a leadership role; to commit her expertise and resources in support of quality patient care, to increase retention of experienced licensed nurses, to recruit prospective nursing students and to ensure safety for our sick and elderly, our school children, and our nurses with safe practice guidelines for staffing and caregiving.

As many nurses and healthcare representatives testified, this crisis in nursing practice stems from several complex factors. The Balanced Budget Act of 1997 has had a major impact on the healthcare system of the Commonwealth and on nursing care for patients. Medicare cutbacks have been severe at the Federal level, in addition to inadequate funding of Medicaid by the State and decreases in

HMO payments that have affected the quality of healthcare for all citizens of the Commonwealth. As our population ages and requires more health services, the acuity of the nursing shortage becomes more severe.

The shortage of nurses is the critical element of these crises. "Unlike previous shortages, this one is not expected to improve in the near term. It is expected to reach full impact between 2008 and 2010 and to have an effect far greater than any of the cyclical shortages that the profession has experienced in the past."(Testimony submitted to the Commission by Mass Hospital Association, Nov.16, 2000)

Many factors affect the shortage of nurses and further complicate the problems that are affecting the profession. These pressures are not unique to nurses but do affect every segment of patient care. Nursing issues are at the center, because it is these realities that define our patient care. All healthcare revolves around nurses. In all aspects of healthcare a nurse is involved.

Nursing concerns that consistently dominated each hearing are as follows:

A) Staffing of licensed personnel and their ability to practice safely
B) Mandatory overtime and its effect on the nursing personnel and their ability to practice safely
C) Workplace violence as a result of inadequate staffing, licensed and non-licensed
D) Changing preferences for nursing as a profession, and the ability of nurse education programs to meet the needs for nurses and nursing students
E) Complaints (that are really systemic) are being filed at the Board of Registration in Nursing against the only licensed personnel, the nurse
F) Specialty nursing and how this field is affected by the nursing shortage
G) Home Health Nursing
H) Reimbursement
I) Licensing

Massachusetts lacks definitive data to conduct a comprehensive analysis of

nursing care for its citizens. The Commonwealth does not have an ongoing system that assesses the supply of nurses who are currently employed at health care organizations. The Commonwealth does know how many nurses a have license to practice nursing. There is neither mechanism nor an office in the state to assess where nurses are employed. It is also clear that the important statistic of nurse\patient ratio is unavailable in most healthcare facilities that provide patient care.

"The public should have the right to know how many other patients share the time, expertise and knowledge of the same registered nurse." (Karen Daley RN, MPH Oct.24, 2000 Massasoit Community College)

This Commission has used information that is compiled from public hearings, material data, and hospital information to present a picture of the shortage (crisis) in nursing care for our residents This Commission has revealed that we do need some vehicle to present a complete assessment of nursing care, in the Commonwealth.

Patients in our state have had their access to necessary professional nursing care limited by the following factors:

1) Hospital stays are limited, so that patients maybe discharged in unstable conditions.

2) Hospitals and hospital beds are closed.

3) Insurers have limited nursing home care visits.

4) Unlicensed assisting personnel have replaced nursing professionals.

5) Occupational related illness and injury have reduced nurses from the workforce.

(MHA Testimony, Nov. 16,2000, and M.O., RN Oct. 24,2000

A. STAFFING AND SAFETY:

"Poor staffing and poor systems equals poor care." (Dorothy Upson McCabe RN, MS,

M.Ed. Oct.24, 2000)

In the managed care environment, strategies are designed to support budgetary goals by cutting the cost of nursing labor. Nursing staffs are downsized, resulting in fewer nurses caring for more patients. Registered nurses are replaced with lower paid unlicensed personnel performing nursing tasks. This results in licensed nurses being responsible for what an unlicensed person does, not the hospital.

Witnesses throughout the hearings testified that the short staffing of nurses combined with faulty systems is a ticking time bomb. Patients in understaffed environments are at risk for inadequate assessment of their conditions, increased infection rates, skin breakdown, medication errors, inadequate pain management, falls, and inadequate preparation for discharge. There is a positive correlation between an increase in licensed nursing staffing levels and reduction in medical errors and complications. (Massachusetts Nursing Association Testimony, submitted Oct 24,2000)

Over the past two decades, studies have shown that care provided by registered nurses decreases length of stay, decreases patient complications, and increases patient satisfaction. It is a flawed policy that removes nurses from the bedside. Nurses need time to provide nursing care safely. "My heart aches because I know I make a difference in my patients' care and I am so close to being burnt out that I feel like I smolder."(Shirley Webber RN, CNOR, June 15, 2000)

Staffing must include factors such as the patient's acuity level. There are no staffing guidelines except for dialysis and Intensive Care Units. Instead of short staffing a unit and then spending all their time trying to catch nurses making mistakes, administrators must provide assistance to the nurses by providing the resources needed to deliver good patient care. "There must be a safe, non-punitive environment that is system oriented with staffing patterns, which are

commensurate with the patient care required." (Oral Testimony from an RN, Oct 24,2000)

Insufficient staffing is evident in the following:

- Frequent use of mandatory overtime
- Use of temporary care
- Unfilled nursing vacancies (MNA, Oct 24,2000)

An LPN in a long-term care facility on Cape Cod presented this data for the record:

11-7 Shift	Skilled Nursing Floor	
60 Patients	40 Patients	40 Patients
2 RN	1RN	l RN
4 Aides	2 Aides	2 Aides (RN, Sept 12, 2000)

“The essence of the nursing concerns is that staffing patterns have left nurses unable to practice nursing at the level of standards to which nurses consider themselves ethically, professional, and legally bound. Patient access to nursing care is directly correlated to the outcome of care." (K.D., RN, MPH May 18, 2000). It has been noted that in specialty nursing (e.g., critical care, operating room, and emergency room nurses) it is difficult to fill positions that require specialized training.

With an expected nursing job growth at 23% by 2006, faster than the average of all other

occupations, and with both an aging RN workforce and faculty, who will replace our

nurses who hold the system together today? "The competency of today's nurses is what keeping the current system afloat." (Donna Mae Donahue, Phi), RN, Sept 21, 2000) It is the competence of these professionals who have prevented the collapse of the system, as we know it today. Working under such poor conditions, nurses jeopardize their licenses every day. "With deteriorating workplace conditions, safety, health, and work place violence, we are in crisis." (Oral Testimony, RN, Oct. 24,2000)

B. MANDATORY OVERTIME:

One of the indicators of severe workplace staffing issues is mandatory overtime.

Mandatory overtime, which forces tired nurses to work extra hours beyond their scheduled shifts, is a negative working condition directly attributable to short staffing. Negative working conditions such as this contribute to the unattractiveness of the profession further exacerbating the nursing shortage. Because of nurses' concerns for patient safety, they have valid fears that understaffed and exhausting hours do contribute to increased medication errors, patient safety, infection, and other poor patient outcomes. "It is a dangerous practice that has to be stopped not only for the patients but also for the nurses themselves." (Jeanine Cunningham RN, Sept 21) The current trend of inadequate working conditions that contribute to exhausted, overworked nurses clearly compromises the health and safety of the patient and the license of the nurse providing care.(MNA, Oct. 24,2000)

"I have watched the nursing profession slowly bleed out nurses." (Teri Arthur RN, BSN, MSM, Sept.12, 2000)

A nurse in central Massachusetts testified that within the current acute care atmosphere there is a level of increased stress, inadequate staffing, increased levels of anxiety and unacceptable scheduling patterns. "Today a nurse can not go into work, knowing that she/he will go home at the end of his or her designated shift. Today a nurse cannot go into work knowing that she/he has delivered the best care that the patient deserves...."The focus of the patient's comfort needs has

been put aside for increased technology, increased responsibility and an overwhelming patient load. Nursing is not about bedside care anymore; nursing has become a catalyst for the patients' revolving door. Increased mandatory overtime, which is forcing nurses to work extra hours beyond their scheduled shifts, is purely a symptom of not having enough staffing." (MNA, Oct.24, 2000)

"This (mandatory OT) is a practice used to staff hospitals. We are driving our nurses out with this kind of abuse." (J.C., RN, Sept 21,2000)

C. WORKPLACE SAFETY:

Violence in the workplace was mentioned in each hearing. An emergency room nurse with 26 years of experience in an inner city hospital draws our attention to the violence the ER that has increased in the last five years:

There has been an influx of psychiatric patients; others are on drugs and alcohol. We need one-on-one supervision of these patients. We put them all together and have one staff member to watch all of them. It is hard to have them (the patients) moved to a floor because of insurance issues. They (administration) are now pushing three-minute triage to move patients. You push them in and push them out... What if the reason they are there is domestic violence? How are you going to truly access this and intervene to prevent future injury in three minutes? (RN, Sept.21, 2000)

Working conditions need to be healthy and safe in order to retain our nurses and recruit new nurses. According to the center for Disease Control and MOSH, nursing is one of the most dangerous professions. Often the critical safe guard that is missing is sufficient staffing. "The disability of psychiatric nurses is the highest, as recorded by the Commonwealth insurance carrier." (Oral Testimony, RN, Sept 12,2000) We must address a comprehensive workplace violence prevention program.

There are safety issues in the workplace that affect the retention of nurses. Safety issues include the health of nurses who lift patients and lack of adherence to

OSHA Standards (ergonomics), latex allergy, the quality of indoor air that is found in our institutions, and serious back injuries. The passing of the needle stick injury prevention legislation in Massachusetts was an important step. "This law, signed in August by the Governor would not have been possible without the tenacity and leadership of Representative Canavan." (K.D., RN, MPH Oct.24, 2000)

D. NURSING AS A CAREER CHOICE:

There are several forces that are causing the decline in the numbers of men and women who are choosing nursing as a career. The themes that were most often mentioned throughout the sessions included the social preference for choosing nursing that are related to working conditions and control of their environments, the media and negative associations related to patient care, and nursing errors. The last concern centers on the constant fear of losing one's license to practice due to errors caused by poor working conditions. Prospective nurses are aware that their entire career can be scrapped for a mistake made while deep into the fourteenth or fifteenth hour of their workday. These people often shun nursing for a more stable profession.

"Much effort and money has been spent on recruitment, but little is done for retention. I contend that if the same effort and money were put toward retention, recruitment would not be a problem. ""(T.A., RN, BSN, MSM Sept 12,2000)

The amount of required education combined with low nurse wages and predictable markets for nursing practice affect occupational choice. School nurses are the lowest paid nurses of all yet are required to have a Baccalaureate degree and be responsible for hundreds of potential patients. In all fields of nursing the sheer difficulty of working with so many patients, unexpected layoffs, chaotic workplaces, and lack of respect for the profession cannot be ignored. The numbers of programs for nursing education and the capacity of current programs to graduate enough nurses is limited. Because of retirement, retention, and death, we will not be able to replace our current level of nurse

What are the incentives for new students to select nursing? (Oral Testimony, RN,

Sept. 21, 2000)

Social preferences for nursing as a career (multiplicity of career choice for woman) and capacity of nursing education program affect the number of nurses in our state.

- Supply of faculty
- Cost of tuition loan
- Length of time to earn degrees
- Nurses wages in the labor market
- Number of deaths and retirement
- The fear that managed care has led to cost cutting
- The physical demand on nursing and enrollment caps (RN, Sept.12, 2000)

There are budget caps on nursing. There are decreases in the number of nursing students because of the 10:1, faculty/student ratio regulated by the Board of Registration in Nursing. Nursing education is expensive for colleges because of the number of faculty needed. (Oral Testimony, RN, Sept.12, 2000)

There are inadequate numbers of nurses to care for an increasing diverse patient population due to immigration and refugees. A significant disparity in access to healthcare exists between the majority and minority populations in Massachusetts. A witness from Cape Cod with 28 years in maternity at the college and at a Boston hospital stated, “the workforce in nursing does not reflect the changing demographics of our society. It is only as we demonstrate that we value diversity will recruitment of minorities into our schools be possible and our profession enriched by our differences." (Oral Testimony, Sept.21, 2000)

E. BOARD OF REGISTRATION IN NURSING:

"The Board of Registration's responsibility is to protect the public." (Amy Fein, Attorney for BORN, June 15, 2000)

A school nurse with a heavy workload and two schools to cover testified "I value my nursing license which I worked hard to earn and don't wish to end up loosing it because I was at the wrong school at the wrong time." (P.C. RN, BSN Oct. 24,2000)

Nurses expressed many fears. Their work setting or specialty area made no difference. All of them vocalized that today's working conditions place their licenses in jeopardy. Working conditions set by profit margin often result in unsafe nursing practice thus placing the nurse's license and safety of the patient at risk.

Complaints that reflect systemic problems are filed with the Board of Registration against the individual nurse, who is the only licensed personnel. Throughout several hearings nurses questioned the role of the Board of Registration in Nursing to effectively look at the complexity of system failure. We need to set op a system approach for all errors, and to establish a non-punitive environment for Registered Nurses in Massachusetts. (RN, Sept.21, 2000)

Unlicensed personnel are being supervised by nurses. Often there are 35 patients for each nurse. As the only licensed individual, the nurse is held responsible for the safety all patients. Why are nurses held liable for what a non-licensed person does? These persons are trained by the hospital or institution so why not hold the training facility liable?

The Board of Registration in Nursing has new regulations regarding standards of conduct for nurses, and acts on complaints filed against nurses. The Board receives a complaint against a nurse's license and investigates to determine if there is a violation of a relevant law. The Board then determines "whether or not the individual nurse has the essential knowledge, skills and ability to continue to hold a license." (Written Testimony, Board of Registration in Nursing, Oct.24, 2000)

“…nurses need protection to stand up against unsafe health care without the Board responding to the administrative and corporate bodies' issues through

disciplinary regulations." (C.C. RN, CS May 18, 2000)

The failure of the system in which the nurse practices is not questioned.

A nurse for 29 years on Cape Cod states the acuity of patients (gravity of the illness) seems to be escalating. "Ratio of nurses to patients is 1-8. There are cardio-catheterized patients who need monitoring every 15 minutes. Staffing is per diem and floating. I may be the only nurse with the skills to carry out the medications. We don't have enough nurses. Every shift that I work, I work outside my license. I put my license on the line, but if I did not do it my patients would suffer. If the Board of Registration in Nursing wants to protect the public, they need to provide a safety net for the nurse too. The Board of Registration cannot hold the nurse responsible for an unsafe environment."(RN, Sept.12, 2000)

"You are frequently working outside the standards of practice... it is crisis nursing at every turn." (M.P. RNC May 18, 2000)

A nurse at the Massasoit hearing testified, "To reduce the medication errors, it is mandatory that all Health Care Organizations adopt a voluntary non-punitive blame-free environment (with the exception of poor performance). A blame-free environment is essential to an error-free environment. Nurses in particular fear the regulatory system in Massachusetts. It is viewed by one and all as a punishment system When a system is faulty and an error made, the nurse is blamed and often punished. The results are the underreporting of errors. In Massachusetts nurses are afraid." (RN, May 18, 2000)

Nurses who refuse to work in an unsafe setting are threatened and harassed.

F. SPECIALTY NURSING

Since specialty nursing positions such as acute care, operating room, maternity, pediatrics, geriatrics, emergency room and critical care require additional training; the general shortage of nurses is intensified in these important settings.

An acute care nurse describes the situation of staffing at the hearing in Chicopee. "In any wings of the hospital, I would be responsible for 12 patients. In the last several weeks, we have been at 2 nurses for 38 patients. They told me to take 24 patients. They are acutely ill, with an overworked staff. Most people (nurses) don't stay on that ..... .I have a problem going into work and learning that I am not getting to that dressing today and it's not fair to them (patients.)." (RN, May 18, 2000)

The cross training in hospitals to offset the lack of skilled nurses may be deskilling the young nurse. They may not have the opportunity to develop as a highly skilled nurse with a solid knowledge base. These nurses are robbed of the opportunity to build confidence in their ability to perform these skills. There are currently no regulations to prevent this occurrence. It contributes to the loss of young nurses. (RN, June 15, 2000)

An Operating Room nurse testified, "As an OR nurse, we are expected to take call. We rush in to save a life and have just rolled out of bed. You have worked your 12-hourshift, gone home to a late evening dinner, gone to bed early and boom… the phone rings. You rush to reconnect that finger from the snow blower injury and are facing yet another8 hours of work, under a microscope, no less trying to load suture that is hardly visible to the naked eye and keep everything under control. Often you face the emergency craniotomy of that poor 17 year old hit by a drunk driven who also has open fractures of the legs and also needs a splenectomy. This is a job for young nurses, yet there are very few young OR nurses. OR nurses need special training, yet programs to train them are few and far between... Working in a level one tertiary care unit needs the best. Not the tired." (RN, June 15, 2000)

A nurse at the Elms College hearing illustrates this point. "I was recently floated to Hematology/Oncology unit and had 8 patients. Six patients were on research protocols, each with 6 to 10 medications that I had to deliver. I didn't know any of these drugs."

Many nurses do not even know their deficits. There is a direct relationship to the

skill of nurses and the number of nurses to patient outcomes. (RN, May 18, 2000) "Patient safety is the bottom line for staff nurses and many are forced to work outside their licenses to achieve this." (T.A., RN, BSN, MSM Sept. 12,2000)

At Bristol, a witness and a Registered Nurse for 25 years working at a Boston hospital states that because of the nursing shortage, new graduates are coming into acute care. They are not receiving the support they need. Education departments have been downsized to cut costs. "Therefore, the vicious cycle continues, shortage exists, no support given, nurse is overworked, nurse leaves nursing." (RN, Oct.12, 2000)

Shortages in staffing are also relieved by floating nurses who work through the hospital, often outside of their area of expertise. Mandatory overtime and floating affect the quality of care. When terms like productivity and efficiency are need, it does not mean that nurses are providing good care. The hiring of temporary nurses who are unfamiliar with the institution is a practice that has significant implications for the occurrence of medication errors. (RN, Oct 12, 2000)

An RN from Brockton noted that drastic cuts in nursing staff have devastated care.

"Staffing is now based on projection, not actual beds, so there are not enough nurses when patients go beyond projections. There are mandatory overtimes employed by hospitals to accommodate for these shortages of nurses." (RN, Oct. 24,2000)

Ratio must refer to direct patient care staffing only. We need to separate the financial charges for nurses from the hospital charges. There needs to be some link between the nurse and the revenue stream

A 31 -year-old RN at a long-term facility stated at the Chicopee hearing:

Subacute - 38 patients: I nurse/5-6 aides

Average medications per patient - 12

On high end 36 medications per patient.

Because of high fuel costs, her facility cannot hire another nurse. (RN, May 18, 2000).

The reimbursement for care is just too low and patient care suffers.

A Subacute Care RN for 4 years reports:

- 8 hour shifts are 12 hours due to mandatory overtime
- Patient ratios - I RN -21 patients, 2 RN -38 patients
- An RN was asked to push two medication carts which is unsafe (RN, May 18,2000)

We must recognize that nurses have a license to practice and that forcing them to work in an unsafe atmosphere jeopardizes their license, their livelihood. Nurses are responsible when an unsafe environment leads to errors. The nurse gets the entire blame.

Unfortunately, we are not ready to provide support to a nurse working in an unsafe environment, but only too ready to punish nurses (through BORN) for what may be system inadequacies. (RN, Oct.24, 2000)

Another example of problems in specialty nursing involves school nurses. The role of the school nurse has changed substantially due to the mainstreaming of sometimes very medically compromised children, as well as school administration of children's medications and increases in certain health problems, such as serious asthma. Staffing levels have fallen far behind these changes in the student population. (RN, Oct.24, 2000).

"School nursing as a profession is also a unique situation in that nurses must comply with regulations promulgated not only by the Board of Registration in Nursing but also by the Department of Education" (M.~ BSN, MS Oct. 24,2000)

School districts do not as a whole, recognize the worth of a licensed nurse. (education certification). Gone are the days of diploma only nurses. They are college educated.

Long Term Care

It is poor policy to extend the administration of medication to unlicensed persons.

Addressing the shortage of nurses in long-term care for our elders, it is poor public policy to have unlicensed individuals administer medications. The elderly, unlike healthy individuals, metabolize medications in different ways. The reactions of elders to medication, and the serious side effects and their subsequent hospitalization, is the single largest Medicare and Medicaid expense. The effects of administering drugs by unlicensed persons may cause preventable deaths. It is not a task to administer medication to elders, it is a skill requiring education. (K.D. RN, MPH Oct 24, 2000)

G. HOME HEALTH NURSING:

At a Visiting Nurse Association of Southeastern Massachusetts, nurses care for 6,000 clients. There are 154 nurses who made 86,000 visits. There are more than 5,000 nurses working in home health care today in Massachusetts. With the current shortage, it is not possible to find enough nurses to meet the needs of Visiting Nurse organizations. (Written Testimony submitted to the Commission by an administrator at the Visiting Nurse Association, Oct.24, 2000)

Home health care nurses are under appreciated and undervalued. Often this is evident in the governance of the state policies and practices and regulations. Examples given at the hearing by an administrator at the VNA are as follows:

Example One:

The state funded homecare program which last year was budgeted at $980 million and which in 1999 was supplemented with the new chronic care fund of $11.6

million has expressly prohibited the purchase of nursing services with those dollars - even in cases where the client required home health aide, and even though this delegated class of workers can care for patients only as an extension of a licensed nurse or therapist. After several years of advocating for a change by the home health industry, EOEA issued a Program Instruction, which would allow for the purchase of nursing care. In practice, so far little has changed.

Example Two:

There are inequities in the state budget itself. At present, the state spends more than 95% of its massive long-term care budget on institutional care, leaving less than 5% for home care. Increases in rates of Medicaid payments, which translate into increases in salaries and benefits to nurses and other workers, are routinely built into the state budget for hospitals, nursing homes, and other providers. While these groups may not get what they want, the fact is it is assumed that they must get some increase. That has not been the case in home health. There have been only two rate increases in seven years, each one hard fought and insufficient. When our nurses tell us they are leaving us to take jobs in hospitals that are paying more per hour, we can do little. It is often the very same nurses who have told me that they have found more personal and professional satisfaction in being a visiting nurse. (VNA, Oct. 24,2000)

In written testimony, the Visiting Nurse association made the Commission aware of the following concerns: (The following is actually testimony submitted Oct. 24, 2000)

• Private duty nurse rates - We understand that the state cannot just throw money at these problems, and we are sensitive to wage escalation battles. However, the state private duty-nursing program is abysmally underfunded, with just one increase since1996 of 5.6%. With unfilled cases reaching previously unheard of levels, agencies would like to be able to use LPNs or staff nurses on overtime. The state LPN rate is not much higher than that for a home health aide and the state has refused to allow agencies to bill at an overtime rate that exists in the regulation but is not recognized by DMA. Please help us to get nursing to these most fragile children and their families.

• Paperwork - Our nurses are drowning in paper, with no end in sight. We have just implemented the federal requirement that we collect some 86 outcome measurements on all our patients, regardless of payment source, every 60 days. We as agency leaders are doing all we can to streamline this process with

measures such as the use of computers in the field, and adding additional support staff to assist registered nurses with clerical aspects of their jobs. We have heard that the state plans to require yet another assessment tool for state funded cases, which is duplicative and places an added burden on our nurses that they just don't need.

Join us in convincing the state that the single federal home care outcomes assessment tool must be used.

• Continuing education- Home health agencies traditionally have not hired new graduates. Reimbursement, which does not cover normal operating costs, will not begin to cover the costs of the additional orientation, mentoring, and supervision that new graduates would require to work in this setting.

• Recognition of the evaluation, assessment and management skills of nurses when working with paraprofessionals - CNA's/HHA's. Increasingly, in the home health field, there are pressures to use the most inexpensive person to do the caring in the home. There are some tasks that can be successfully delegated, but the process requires skilled nursing oversight, which the system too often ignores." (VNA, Oct. 24, 2000)

H. REIMBURSEMENT:

Reimbursements to healthcare organizations do not cover the cost of proper, safe care.

“Nursing services should be billed differently. They have always been seen as part of the

'room and board'." (G.C. RN, MSN Oct. 24,2000)

Nurses testified to the following:

Nurses are willing to work hard, cover the off shift, holidays and weekends to care for their patients. When they cannot receive a decent wage because

reimbursements to healthcare organizations do not cover costs, they become disillusioned and discouraged and potentially leave an organization or nursing altogether. This adds to the nursing shortage...

The more we cut costs, and the more we ask nurses to be efficient, the less we are reimbursed and at the same time, more patients come to our doors seeking care…

The reimbursement system for health care is failing; we have a severely underfunded Medicaid

program in this state, and it needs to be fixed. We owe that to the citizens who rely on MassHealth for their access to care, and we owe that to the nurses who care for them...

We need immediate relief through licensed Medicaid payments to our hospitals and a fully funded free care pool. Our low income and elderly citizens deserve the highest quality of care. We cannot continue to provide care if it is underfunded. You can already see decisions being made to close services such as inpatient, psychiatry, and obstetrics by financially distressed hospitals.

Decreased staffing does translate into less time spent at the bedside by licensed nurses. Nurses testified at each hearing that reimbursement rates play a key role in this unhealthy phenomenon but not the only role. Nurses feel strongly that their employers do not staff facilities according to patients and their acuity levels. They often spoke about high patient/staff ratios that not only referred to numbers but to patient physical needs. **Nurses feel very strongly that their employers are not listening to them**. As T.A., RN stated on Sept.12, 2000, "The truth of at management had an acuity tool. It was the nurse they put in charge."

Some nurses told the Commission about incidences of violence that could have been prevented if staffing levels had been 'more realistic'. J.B., RN, BA on May 18,

2000, spoke quite powerfully about an assault upon her person while working on

an understaffed psychiatric unit. "I struggled and then my entire face was ground into the floor. Still blinded,

I then felt a blow to the back of my head and then my head was slammed into the floor, breaking in half a six-inch hair clip. I screamed as loudly as I could, but no one was around to help me...it was fortunate that one of the patients rescued me, because no staff was available in either of the two main hallways to intervene...I lost an entire month of work to recover from this assault..." J.B. further testified that, “Our CEO has written that our hospital is committed to providing a safe workplace. Paradoxically, one nurse after another suffers brutal attack after patient attack. The nurses who survive these assaults are sometimes completely alone in the hallway. These facts are well known to our administrators. Yet, those who decide about staffing levels have not remedied the situation, claiming there is no money to increase staffing. Ironically, I witness luxurious crystal chandeliers installed, fancy diagnostic equipment materializing, and brand new wings being built upon our hospital grounds."

The workplace is extremely stressful and unfulfilling for many seasoned nurses. Their personal safety and that of the patients they care for was the most often repeated refrain of the hearings. Retaining these experienced and dedicated nurses becomes more difficult every year. Too many are leaving. This exodus of licensed nurses also carries with it an irony addressed by the following nurse:

“They may have escaped, but the patient cannot." P.D., RNC, NHA, May 18, 2000.

“Nurses have always ‘worked hard’. By this I mean that the physical, emotional, and intellectual nature of nursing practice has always been and always will be laborious. That is not the essence of nurses concerns. What concerns nurses is that the staffing patterns leave them unable to practice nursing to meet the standard to which they are ethically, professionally and legally held." (Karen Daley RN, MPH, Oct.24, 2000)

Nursing cannot bear the brunt of a health care financing system that is broken."

(Barbara Weatherford RN, MS, Oct.12, 2000)

Managed care /HMO's have taken the 'science' out of nursing. It has become $$$$ for tasks done and nursing is being deskilled." (Michael D'Intinosanto RN, June 15, 2000)

I. LICENSING:

In order to practice nursing, a state license is required. Every nurse takes an intensive examination after graduation from an accredited school of nursing. Once earned, every licensed nurse must earn the required number of Continuing Education Units (CEU) to fulfill renewal requirements. which are every two years. A nurse works hard to earn a license and hard to re in good standing. If a nurse should have their license suspended or revoked, they cannot practice their profession. Loss of license is a real fear experienced by nurses practicing in today's health care environment. This was an overwhelming theme of everyone's testimony.

"Patient safety is the bottom line for staff nurses and many are forced to work outside their license to achieve this." (T.A., RN, BSN, MSM, Sept.12, 2000)

"….nurses are too stressed & are placed in situations that jeopardize their license." (M.K. RN June 15, 2000)

The nurses who testified admitted that the working conditions in their institutions often forced them to meet the needs of the patients without the requisite backup from administration. They spoke of feeling abused and unappreciated in today's workplace.

"…hospital nursing units have become the new sweatshops." (T.A., RN, BSN, MSM, Sept. 1, 2000).

The licensed nurses also repeatedly expressed concern about the Board of Registration in Nursing (BORN) and its approach to the practice of nursing in today's environment. Many nurses testified that they felt that they were being "…held totally responsible for system failures."(T.A., RN, BSN, MSM, Sept.12, 2000). They told us that they believed that BORN worked "on a culture of blame' and left them without a support system.

“The nurse should be able to rely upon the Board to perform exploratory verification of the complaints as 1) lying within its jurisdiction of decision making & to 2) discriminate between frivolities & legitimate allegations between nurse conduct and health system complaints.” (C.C., RN,CS, May 18, 2000)

While nurses have a negative perception of BORN, the perception is not shared by the members of the Board of Registration. At each hearing, BORN was represented and at times testified in response to feelings aired by the nurses. BORN's full testimony is attached to this report. The Commission recognizes the 'disconnect' between the professional nurses and their regulatory board. At a time when nurses feel that the regulatory structure is "...more about punishment & legalities than about improving the quality of care." (P.D., RNC, NHA, May 18, 2000). The board expressed feelings of being squarely in the middle of the debate and unable to respond in the manner that the nurses want. They are a 'regulatory agency' charged by the state to oversee licensing and protect the public. Nurses want the Board of Registration to support and protect both them and the public. 244CMR 9.00 defines the standards of conduct for all nurses licensed the Board of Registration in Nursing. (see attachment)

When J.G.,a school nurse refused to give a medication because the order was not properly filled out, she was disciplined by her school system and appealed to BORN. BORN took a year to respond. During this year, she told the Commission that she was continually hassled by her School Board. BORN found her to be correct in her actions and stated so in their written response but she indured much waiting for their response. "It was a very lonely road to stand the nursing profession & do what was right."(J.G. RN, May 18, 2000). According to the many nurses who testified, they all agree that "...we are at the mercy of our employers...".

“We need a health care system that makes it easy to do the right thing and harder to do it wrong.” (T.A.., RN, BSN,MSM, Sept.12, 2000)

“…seems that a nurse is 'guilty until proven innocent." (P.M., RN, June 15, 2000)

“…I ask that you hold those who create this environment responsible for the consequences." (T.A., RN, BSN, MSM, Sept.12, 2000)

Mandatory overtime is dangerous because nurses are often too tired.. "Recently an OR nurse

she carne to work at 7am to scrub in for cases. She left the hospital at lam. How would you like to have been her last patient on the table 18 hours later?" (J.C., RN, Sept.21, 2000)

“We are at the mercy of our employers because refusal of mandatory overtime could constitute abandonment of patients. This could be grounds for dismissal and loss of your nursing license (J.C., RN, Sept.21, 2000)

“I’d like to emphasize that patient abandonment is now a regulatory matter and is not relevant to any discussion of mandatory overtime, which is clearly an employment matter." "In almost no instance would the Board ever entertain refusal to work an extra shift as requested by an employer as grounds to find a nurse guilty of a regulatory violation." (Rachel Tierney, RN, BSN, MSN, PhD), Chairperson of the Board(BORN), Oct.24, 2000)

CONCLUSIONS

"More than any other factor, what is driving good nurses out of practice is intolerable working conditions and the frustration of not being able to deliver safe patient care."(M.O., RN Oct.24, 2000)

Nurses licensed to practice in Massachusetts are working in a health care system that is hurting from personnel shortages and financial cutbacks. This system forces them to work in an environment that is not conducive to excellent quality care. Their working conditions are stressful for all and intolerable for many. They feel that there is little to no support for them and therefore there is no help forthcoming. They are leaving the profession in numbers that are alarming. Nursing schools are hurting financially and seeing their enrollments decline. Licensed nurses are scared of what the future holds for them. They want better working conditions so that they can practice safely and

"It must become illegal to have one nurse caring for 60 patients in a nursing home...It must become illegal to have one nurse responsible for 8 acute care patients. This is not only dangerous but also unacceptable." (K.D., RN, MPH Oct.24, 2000)

The nursing shortage is caused by two main factors: inability to retain licensed

nurses & the inability to recruit new nursing students. Recruitment and retention, both are vitally important to correct the crisis. Of the two, retention is the first that should be addressed because it would have the quickest results. Recruitment strategies should be underway as soon as possible because it takes several years to achieve the desired result. It must be noted that improvement of working conditions must be addressed for both recruitment an retention. Nurses must stay and students must want to join them.

"The health care system has its roots in the military model where it is expected that the

foot soldiers would have everything to do and nothing to say. No one listened to staff nurses because they felt they did not have to. There was always an army of young nursettes ready & willing to throw their bodies into the trenches and do the work." (T.A. RN, BSN, MSM Sept.12, 2000)

Retention...1) improved working conditions
2) mentor/support for new nurses

Recruitment... 1) financial support for non traditional students while in school
2) loan forgiveness for students who achieve licensing and work in a Massachusetts health care facility/institution for a designated time period or who choose field of nursing that has severe shortages of personnel
3) improved working conditions to make the profession more attractive to new students

Finally, on the issue of improved working condition. The following must be truthfully addressed and discussed in earnest: mandatory overtime, patient/staff ratios, unlicensed personnel, career ladders, weekend/holiday shifts and support services.

RECOMMENDATIONS

1) Legislation to limit mandatory overtime to a level that would permit nurses to work in optimum physical and psychological condition.

2) Legislation to establish patient/staff guidelines that are based in reality and based on patient acuity levels.

3) Comprehensive legislation to improve the image of nursing as a profession and entice and retain women/men into the field.

4) A legislative study of the constraints that nursing schools are under whether regulatory or financial and recommendations for relief.

5) A legislative study of BORN's scope of power and whether it should be expanded to include licensing support services that take into account the system failures that can lead to errors.

6) Licensed nurses who are currently practicing must be included on all levels when studies are being done and legislation is being written. They are the best judge of acuity since they are the patient's first line of care.

"The answer is not to throw more nurses into a troubled setting." (T.A., RN, BSN, MSM, Sept.12, 2000)

"Recently (perhaps within the last six months), the world of opportunity for graduating seniors (sic from nursing schools) appears to have broadened. However, often the fragile systems of support for novice transition, although bolstered from a year ago, cannot meet the overwhelming demand for competence characteristic of current practice settings. As a consequence, I believe that I have seen beginning practitioners lose confidence in their ability to practice safely. Many choose to leave and go in search of more supportive environments." (D.M.D., RN, PhD), Sept.12, 2000)

"Without legislation that regulates the amount of time a nurse can safely work, without legislation that regulates the amount of patients that a nurse can safely administer to, eventually, there will no longer be a nurse at the bedside." (K.L., RN, June 15, 2000)

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THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin, Secretary of the Commonwealth

State Publications and Regulations

REGULATION FILING AND PUBLICATION

Regulation Chapter, Number & Heading: 244 CMR

Name ofAgency: BOARD OF REGISTRATION IN NURSING

This document is reprinted from the Code of Massachusetts Regulations and contains the following:

244CMR
1.00 RESERVED

2.00 RESERVED

3.00 REGISTERED NURSE & LICENSED PRACTICAL NURSE

4.00 MASSACHUSETTS REGULATIONS GOVERNING THE PRACTICE OF NURSING

5.00 CONTINUING EDUCATION

6.00 APPROVAL OF SCHOOLS ON NURSlNG & THE GENERAL CONDUCT THEREOF.

7.00 DISCIPLINARY PROCEEDINGS.

8.00 LICENSURE REQUIREMENTS

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Under the Provisions of Massachusetts General Laws, Chapter 30A, § 6, and Chapter 233, his document may be used as evidence of the original documents on file with the Secretary of the Commonwealth

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A true copy attest:

WILLIAM FRANCIS

Secretary of the Cornmonwealth

244 CMR: BOARD OF REGISTRATION IN NURSING

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Commonwealth of Massachusetts

DIVISION OF REGISTRATION

Testimony of the Board of Registration in Nursing
Presented to the State Special Nursing Commission
at Cape Cod Community College, West Barnstable, Massachusetts
on September 12,2000

Good afternoon, my name is Rachel Tierney. I am the Chairperson of the Board of Registration in Nursing. I have been a nurse for thirty-eight years, primarily as a psychiatric clinical nurse specialist. I have served as a member of the Board of Registration in Nursing since January 1995. I am very happy to be here today and will address with you issues that the Board feels are important for your consideration.

As you know, the Board, regulates nursing practice and nursing education in the Commonwealth. The Board's formal mission statement as a consumer protection agency within the Division of Professional Licensure of the Office of Consumer Affairs is attached to this testimony. The Board's constituents are the citizens of Massachusetts who are the recipients of nursing care the Board's job, simply

stated, is to protect the citizens from incompetent or unsafe nurses would like to stress that all of the Board's work is in the interest of public safety.

As a regulatory agency, the Board is responsible to administer and enforce the laws and regulations governing the education and practice of nursing in the Commonwealth. The Board is authorized, among other regulatory duties, to administer and enforce the Nurse Practice Act, and make, adopt, amend, repeal, and enforce rules and regulations necessary to protect the public health, safety and welfare. These are the means by which the Board fulfills its essential public protection obligation.

While the Board's fundamental statutory directive is public protection, its administration of law, regulatory rule making and enforcement activities also serve to protect and promote the integrity of the nursing profession. These Board activities provide the regulatory framework, authority and guidance essential to ascertain and preserve the scope, standards, competence, safety and effectiveness of nursing practice in Massachusetts. Further, case law clearly establishes and supports the protection of the integrity of the profession as an appropriate and expected role for regulatory agencies.

To summarize this important point, let me reiterate that while the Board's primary purpose is to assure public protection through its regulatory activities, the Board also serves to protect and promote the integrity of the profession, by engaging in these duties.

Having said that, I'd like to describe who we are and how we accomplish our work. By statute the Board is composed of 13 volunteer members --9 RNs, 3 LPNs and one public member. We currently have two vacancies for registered nurses on the Board. The Governor appoints members to serve on three-year terms. The law states that each member may serve two consecutive terms and that the nurses on the Board must represent practice in long term care, acute care, community health and nursing education. At the time of their appointment, nurse members must be licensed to practice in the Commonwealth, must have had at least eight years of nursing experience and must be employed in a position

directly related to the designated seat to which they are being appointed. As a result, the Board's current membership brings over 200 years of nursing expertise to the table.

The Board meets every two months as a full Board to address a variety of practice and education related policy issues, and to review and vote on formal disciplinary matters. As an agency of state government, the Board recognizes the importance of its public accountability. For example, all Board meetings are open to the public; the names of nurse licensees disciplined by the Board are public information, as required by statute, in an effort to assist consumers in obtaining information necessary to making decisions about care givers; and the approval status of all Board approved nursing education programs is also published.

Two standing Committees comprised of Board members, Nursing Education and Discipline, assist the full Board in conducting its business. Each of these Committees meets monthly. The Discipline Committee is responsible for the evaluation of practice complaints against individual licensees. The Board's purpose in evaluating and taking action on complaints is not to punish nurses but to protect patients. Currently, the Board licenses almost 119,000 nurses. Of this number, the Board receives about 400 complaints each year against less than one half of 1% of all licensees. The Board dismissed seventy (70) percent of the complaints, which were closed in the past two fiscal years.

Over the course of your hearings, the Board will share with you detailed information about its proposed revisions to the discipline regulations. The current regulations at 244 CMR 7.00 have been in effect since 1986 and mainly address procedural matters, with only a few lines relevant to nurses' conduct. Historically, conduct standards were considered to represent the ideal professional performance and behavior, but were not prescribed by law or rule of any official regulatory entity. As health care delivery has grown more complex, boards of nursing have gradually developed standards of conduct, which could be legally enforced. Today, 60 state nursing boards indicate they have the authority to establish practice standards by administrative rule. The Board's proposed revisions are designed to better inform nurses and consumers about the conduct the Board expects of its licensees and about the complaint resolution process.

Two new provisions have also been added: a duty to report requirement and summary suspension. Mandatory reporting has proven an effective social tool for

protecting children and elders from abuse by their caretakers. Many nursing boards require some form of mandatory reporting. The proposed provision would require the reporting of three specific instances of serious misconduct: patient abuse, practice while impaired by substance abuse, and diversion of controlled substances. Summary suspension authority would prevent known, dangerously unsafe nurses from practicing nursing while the complaint resolution process is pending. Eighty-five(85) percent of all other U.S. nursing boards, as well as the Massachusetts Boards of Registration in Medicine, Dentistry, and Pharmacy currently utilize summary suspension authority.

The Nursing Education Committee is responsible for the business related to the approval of all entry level nursing education programs in the Commonwealth. There are four types of basic RN nursing education programs designed to prepare graduates for practice as Registered Nurses: hospital-based diploma programs (Brockton Hospital School of Nursing is the only such program currently operating in the Commonwealth); two year, community college-based programs offering an Associate Degree in nursing; four year, collegiate level programs offering a Baccalaureate Degree; and entry level graduate degree programs meeting the needs of individuals who hold a non-nursing baccalaureate degree and who interested in a career in nursing. There are 37 Registered Nurse programs located in the Commonwealth and approved by the Board.

Applicants for licensure as a Practical Nurse must graduate from a Practical Nurse program, which is a minimum of 10 months in length. There are 19 Board-approved Practical Nurse programs located in the Commonwealth.

The Board recognizes that nursing students may have competencies gained in other health or health related fields as a result of previous education; and that the environment for health care delivery is changing, requiring a sufficient supply of highly skilled practitioners. Successful relationships have been established among the Commonwealth's nursing programs for the purpose of facilitating educational mobility. It is the Board's position that educational mobility enables an individual to move from one educational level to another with an acknowledgement of acquired competencies and minimal repetition of previous learning.

The Nursing Education Committee also monitors the NCLEX performance of graduates of the Commonwealth's nursing education programs. Commonly referred to as "state boards", the NCLEX is designed to test the knowledge and skills essential to the delivery of safe, effective nursing care. It is administered by computer, daily, year round, in each of the 50 United States, and its territories, facilitating licensure by endorsement from one state or territory to another. The NCLEX pass rate for graduates of the Commonwealth's nursing education programs is comparable to or slightly above the national NCLEX pass rate - 85% for RNs and 88% for LPNs in 1999. However, this represents a decline in performance both nationally, and here in Massachusetts, since the early 90's when our RN pass rate was in the low 90's, and the mid 90s for LPNs. Some of the factors being attributed to this decline is the growing difficulty of nursing programs to recruit the "best and the brightest" students, as well as the increased NCLEX passing standard deemed necessary to insure a safe entry level nursing care.

Before I conclude my remarks, I'd like to highlight for you two initiatives the Board has recently undertaken. The first initiative is designed to facilitate a coordinated state effort for nursing workforce planning.

The Board, along with representatives from several nursing organizations, including the Massachusetts Nurses Association, the Massachusetts Organization of Nurse Executives, and the Center for Health Professions at Worcester State, is an active participant in a revitalized consortium, the Colleagues in Caring Project, to address the lack of a coordinated statewide system for nurse workforce planning. Originally convened in the Fall, 1995, the consortium, under the direction of the Board's Executive Director, achieved early success in not only bringing together nursing leaders from throughout the Commonwealth, but also in garnering contributions of monies and services totaling $210,872. Today, the consortium is administered through Worcester State's Center for Health Professions.

Data collected by the Board indicates an overall decline in the total number of

nursing student admissions, enrollments and graduates from the Commonwealth's Registered Nurse and Practical Nurse programs in the last 25 years. In 1999 alone 12% decline in the number of graduates from RN programs was noted in 1999 from the previous year. Shortages of nurses are predicted, particularly in nursing specialty areas such as emergency room and critical care settings. Some of the factors contributing to the future adequacy of the nurse workforce include: an insufficient cohort of younger nurses to replace those who will be retiring in the near future; a shortage of nursing faculty; a decline in the number of programs preparing nursing faculty; and older nursing students who will have a shorter active nursing career.

A second major initiative of the Board involves multi-state licensure for nurses

The Board is in support of the mutual recognition model established by the National Council of State Boards of Nursing. This licensure model would allow a nurse to have one license in his or her state of residency and practice in other states. In order to achieve mutual recognition, each state must to enter into an interstate compact. Currently, 12 states have entered into this compact. The advantages to this licensure model include a reduction in the barriers to interstate practice, including "telenursing", which would improves access to nursing care; improved tracking for disciplinary purposes; cost effectiveness and simplicity for the licensee; and the creation of an unduplicated listing of licensed nurses in the United States. This is particularly important in Massachusetts where residents may practice nursing in any of the border states; Maine, New Hampshire, Vermont, New York, Connecticut and Rhode Island.

Established in 1910, the Board continues to work tirelessly to safeguard the consumers of nursing care through the fair and consistent enforcement of the statutes and regulations governing the nursing practice and education. The Board fully recognizes that reforms to control health care costs, pressure to increase access and improve the quality of basic care, new practice settings, and technology challenge it to assure that its processes effectively protect the welfare of nursing care consumers without unnecessarily restricting the ability of competent nurses to practice effectively and efficiently. On behalf of the Board

and its staff, I look forward to working with you, and hope you will view us as a valuable resource as you complete your work.

Respectfully submitted,
MASSACHUSETTS BOARD OF REGISTRATION IN NURSING
By its Assistant Board Counsel
Thaddeus Swank

additional testimony given by the Board of Registration in Nursing

Commonwealth of Massachusetts

Division of Registration

239 Causeway Street . Boston, Massachusetts 02114

Massachusetts Board of Registration

In Nursing

Mission Statement

The mission of the Board of Registration in Nursing is to protect the health, safety and welfare of the citizens of the Commonwealth through the fair and consistent enforcement of the statutes and regulations governing nursing practice and education.

Goals

The goals of the Board of Registration in Nursing are to

- ensure that persons licensed as nurses are qualified to provide the citizens of the Commonwealth with safe and effective nursing care
- lead in state government and the public arena in the promotion of safe and effective nursing practice

Activities

Massachusetts General Laws (GL) Chapter 13, sections 13, 14, 14A, 15 and 15D and Chapter 112, sections 74 through 81 C authorize the Board of Registration in Nursing to regulate nursing practice and education. Pursuant to these laws, the Board

- makes, adopts, amends, repeals, and enforces regulations it deems necessary for the protection of the public health, safety and welfare
- issues advisory rulings and opinions which guide nursing practice and education
- approves and monitors nursing education programs which lead to initial licensure
- issues nursing licenses to qualified individuals
- authorizes qualified nurses to practice in advanced roles
- verifies the licensure status of nurses
- collects fees established pursuant to the provisions of GL c. 7, s. 3B
- investigates and takes action on complaints concerning the performance and conduct of licensed nurses
- audits the continued competency of nurses
- administers the Substance Abuse Rehabilitation Program
- prepares and publishes materials it deems integral to the delivery of safe, effective nursing care, including an annual notification to all licensees of changes in laws and regulations regarding nursing education, licensure and practice
- participates as an active member in the National Council of State Boards of Nursing
- provides consultation and conducts conferences, forums, studies and research on nursing practice, nursing education and related matters

Adopted 5/26/93

Amended 5/09/94, 8/12/98

Testimony of the Massachusetts Organization of Nurse Executives to the Commission on Nursing

November 2000

Chairwoman Canavan, Chairman Creedon and members of the Commission on Nursing,

The Massachusetts Organization of Nurse Executives welcomes the opportunity to share our perspective on the nursing workforce and the critical issues affecting the delivery of nursing care to the citizens of the Commonwealth.

The chaos within the health care delivery system is being felt by all caregivers, particularly nurses. The issues around staffing, scheduling, use of mandatory overtime and unlicensed assistive personnel are all symptoms of larger issues, some societal and some direct results of the way healthcare is funded in this country. These untoward symptoms will likely worsen over the next decade as we experience a growing shortage of nurses in the United States. This shortage is expected to reach full impact around 2008 to 2010 and will be unprecedented and more far reaching than any of the cyclical shortages driven by supply and demand that the nursing professional has experienced in the past.

Experts predict the demand for RNs will increase driven by higher patient acuity, technological advances and an aging baby boom generation. Concurrent with this increased demand will be diminished supply driven by many factors including a decline in societal preference for nursing as a career, decreasing capacity of nursing education programs driven in part by the aging demographics of the nursing workforce itself. The large baby boom generation of RNs will reach retirement age between 2005 and 2015. In 1996 the average age of all RNs was 44.3 years. The average age of faculty in nursing education programs was 55 years. Less than 20% of all the RNs in the country are under the age of 30. The smaller numbers in the post baby boom generation coupled with increased career opportunities for women have led to declining enrollment in nursing education programs during the 1990's. The number of women enrolled in medical school increased significantly during this same period. The current nursing workforce is predominantly white and female while the demographics of the nation have changed. Simply put, there is a significantly smaller post baby boom generation with far more career options to choose from that will not be sufficient to replace the aging nursing workforce.

Hospitals across the country are experiencing the first wave of this shortage today as it becomes increasingly difficult to fill positions requiring specialized training: Operating room, Critical Care, Emergency Room, Obstetrics. These areas are traditionally filled by seasoned, more experienced nurses - the group that is aging and leaving the workforce. The stresses of the modem day health care system are felt acutely by all direct caregivers including nurses. Wages over time have not kept pace with other professions. Schedules requiring shift rotation, weekends and holidays are less attractive to young people entering the workforce and a detractor over time for experienced nurses. This coupled with a strong economy and a growing number of career opportunities for nurses in managed care, home care and other areas offers opportunities for experience nurses to move away from the bedside sooner than might have occurred in the past.

There is currently no statewide data that captures the demographics and future employment plans of the current nursing workforce. Statewide vacancy rates and turnover data does not exist. There is also a lack of demand data from organizations providing healthcare that captures the projected demand for nursing services. The Center for Health Professions at Worcester State College, as the lead agency for the Massachusetts Colleague in Caring Initiative, is in the early phase of collecting such data that will be critical for the future.

The healthcare community is undertaking many initiatives to address the impending shortage of nurses. Some of these efforts include image campaigns aimed at elementary and junior high school students designed to educate this group about the opportunities of a career in nursing. Emphasis on recruitment of a more diversified nursing workforce reflective of society is a priority. Educating legislators about the need for funding and support for nursing education including loan forgiveness programs is underway. Individual health care organizations are looking at their nurses, projecting their needs and evaluating potential sources of new nurses in their own communities. Collaboration between nurse educators and service is ongoing as we explore new ways to transition nurses entering the profession from the role of student to practitioner. Internships similar to those afforded medical students are highly desirable but costly putting them beyond the budgets of virtually all hospitals. However all these initiatives have a common element: they require significant dollars to implement, making a major overhaul of the reimbursement structure the first, most critical step. Higher wages for nurses, more staff to care for increasingly more acute patients, smoother transitions into the practice setting for new nurses are all dependant upon the issues of Managed Care Reform, reversing the cuts that resulted from the Balanced Budget Act and allocating new dollars from the state and federal budgets to institute the strategies outlined above.

While these strategies are being played out at the state and national level, our members are committed to delivering the best possible care to their patient's day in and day out. Hour by hour decisions are made concerning staffing levels, whether or not to close an emergency department to ambulances, canceling elective procedures and other situations based on the ongoing assessment of nurse leaders in the facility. The constantly changing, dynamic situation requires that level of flexibility. MONE is on record as opposing legislated staffing ratios and we do not believe passage of such a bill would be a remedy for the challenges we face every day in providing adequate nursing care. We believe the experience of the

long-term care industry highlights the negative impact mandated ratios ultimately bring to bear. Ratios intended to be the minimum quickly became the maximum staffing patterns with no room for nursing judgment or assessment of patient needs.

We urge legislators to look beyond the quick fix that legislated staffing ratios appear to offer. Peter Buerhaus, RN PhD, Associate Dean of Research at Vanderbilt University in Nashville, TN recently stated, "Many people are reacting to the emotion, the reality, and the stress involved in confronting the staffing issue. The answer is not to regulate nurse staffing when it's just going to set us back. We're not going to have enough nurses to do it anyway. Which might be the most important take- home message in this debate... more nurses are needed soon."

Our members appreciated the opportunity to present oral testimony at the hearings and thank you for the opportunity to share our perspective in writing on these critical nursing issues with you. We look forward to working with you in the coming year to positively impact the delivery of nursing care to the citizens of the Commonwealth.

Sincerely,

Lorna R. Prince

President

Cc:Nursing Commission Members:

Representative Cory Atkins

Representative Barbara Hyland

Representative Kay Khan

Representative Mary Jane Simmons

Senator Richard Moore

Senator Michael Morrissey

Senator Therese Murray

Senate President Thomas Birmingham

Speaker Thomas Finnerman

Representative/Health Care Committee Co-Chair, Harriette Chandler

Testimony before the Special Commission on Nursing and Nursing Practice

Karen A. Daley, RN, MPH

President, Massachusetts Nurses Association

October 24, 2000

Dear Chairwoman Canavan, Chairman Creedon and Members of the Commission:

Thank you for the opportunity to present critical information about nursing and nursing practice to you today. You are to be applauded for your statewide efforts to “listen to and consult with" nurses from every area of practice, in all corners of the state.

I am Karen Daley, the President of the Massachusetts Nurses Association. As you know, the MNA was delighted to assist the legislature in the passage of the legislation, which led to this Commission. Further, we are gratified that you have heard from so many members of MNA and other nursing organizations from throughout the state.

Since this is the last of the planned Commission hearings, and since you have heard some recurring themes throughout the state, I thought it most appropriate to prioritize for your consideration, the most significant recommendations that could emanate from the work of the Commission. For nursing shortage; work place health and safety; workplace violence; patient advocacy and vision for nursing into the 21st century.

Sufficient Nurse Staffing

Many times over, you have heard from nurses that staffing patterns leave them very frustrated in relation to their ability to practice safely, competently, compassionately and completely. Nurses have always "worked hard”. By this I mean that the physical, emotional and intellectual nature of nursing practice has always been and will always be laborious. That is not the essence of nurses' concerns. What concerns nurses is that the staffing patterns leave them unable to practice nursing to meet the standard to which they are ethically, professional and legally held. Nurse staffing is insufficient for many reasons. First, there are no guidelines in relation to how many patients a nurse can care for at any one point

in time, except in critical care units and neonatal ICU and thanks to Rep. Canavan, out patient dialysis. Simply put, in this era of downsizing and the subsequent decrease in the number of registered nurses at the bedside, this has been an equation for disaster. The most recent article in the Chicago Tribune noted the increased numbers of patient deaths and medication errors by nurses. After you got past the horrific headlines you read the real problem was not incompetent nurses, but not enough nurses at the bedside.

There must be the passage of Massachusetts legislation, which finally creates legal standards to guaranteed access to appropriate nurse staffing. It must become illegal to have one nurse caring for 60 patients in a nursing home. Unfortunately this is commonplace in our commonwealth every day. It must become illegal to have one nurse responsible for 8 acute care patients. This is not only dangerous, but also unacceptable.

The MNA has placed before you and will again file legislation to consider a solution to “sufficient staffing”. 105CMR already mandates that through hospital licensure, institutions must guarantee “sufficient nursing to meet the planned and unplanned needs of patients". Never before have we defined what "sufficiency" is. Well, this legislation does. It is not a ratio bill. It is an equation that takes into consideration the patient population, their acuity, the level of nursing need, their level of self care and the standard of nursing to which we are held accountable. These are the very guidelines to which we are held and our institutions should also be held accountable. We need legislators to support this legislation. More importantly, the legislature to pass such an important law in the next session.

Another current trend in staffing is the inappropriate use of "mandatory or forced overtime". Many nurses testified to its personal and professional effects. This is a serious problem and a concrete recommendation by the Commission to ban its practice is needed and respectfully encouraged.

Sufficient staffing also means that staff have appropriate training for the care of specific populations. A nurse, is not a nurse, is not a nurse. By this I mean that, like medicine, nursing also has specialties. I practiced for 25 years in emergency

nursing. I was very proficient in providing emergency nursing care. However, I did not have the skill set to practice dialysis nursing, as you do Rep. Canavan, or psychiatric nursing as you do Rep. Khan. Those are specialties. So when an institution utilizes nurses to fill staffing vacancies, often referred to as "floating" it is their responsibility to guarantee that the staff has the competencies to care for those patients. We must hold nurse managers accountable for guaranteeing access to appropriately trained nurses based on the needs of patient populations. Unfortunately, the new Board of Registration in Nursing (BORN) Regulations at 244CMR 2.00 totally eliminates any reference to the role and responsibilities of the nurse in the management role. This is grossly inappropriate and falls unacceptably short of their mandate to protect the public health and safety. Direct care nurses bear all the responsibility before the BORN and the nurse manager is not even referenced in these new regulations. These regulations should be changed and this Commission should mandate those changes by the BORN.

Publicly Available Nursing Data:

Just last week, Linda Ruthhardt, Commissioner of the Division of Insurance announced a project with the Group Insurance Commission. The GIC is mandating the use of outcome data in making decisions about which institutions the GIC will contract with for their beneficiaries (all state employees). This is ground breaking, needed and to be applauded. It is consistent with Chairman Moore's attempt to force the reduction of medical errors and to use best practice models. If however, the collection of outcome data excludes nursing data, then a hole will exist in the use of this data. The patient's access to nursing care is directly correlated to the outcome of care. This has been documented over and over again for more than a decade in the nursing literature. Unfortunately without state legislation, the data, which will be collected, will be based on "billable" outcome data. Whether the data is from the Division of Health Care Finance and Policy, the insurer or the hospital industry as it exists, it comes from "billable episodes". Nursing is part of the cost of room and board and isn't "billable". So the direct effect on patient care is captured in our own literature only, mainly through quality assurance studies, which are consider proprietary and not reportable. This must change. I have included for your review an annotated

bibliography of studies, which support nursing's critical role in improving patient care. This data should be available to the public. The public should have the right to know how many other patients share the time, expertise and knowledge of the same registered nurse. This directly affects their outcome. If I knew that my chances for a wound infection after my surgery are directly related to whether or not I have RN at my side or a nurses aide, you can be assured I would choose an institution that guarantees me direct care by an RN. The fact the GIC, as the largest purchaser in the state, is going down this path, is important. They too deserve and need this information on behalf of their beneficiaries. The Nursing Commission must support the passage of legislation which collects and reports nursing data. Its' time to take nurses "out of the cost of room and board" and place nursing information front and center, because that is where the patients are. If you want to know how the patients are doing, follow the nurse!

Nursing shortage:

As you have heard the nursing shortage is two fold: Not enough people entering the profession and not enough nurses in specialty areas. First, some demographics. There are a number of industry factors that have impacted the health care workforce in America and in Massachusetts:

- An aging U.S. population with specific pockets in Massachusetts (Cape and Western Mass)

- Increasing ethnic/cultural diversity of populations

- Managed care

- Cost containment emphasis - to the exclusion of quality

- Technology growth

- Inadequate rates of reimbursement - Medicare, Medicaid and the Insurers

In terms of our aging population:

- Today 1 in 7 Americans receive health care coverage through Medicare

- Health care needs grow more complex with age and require increased nursing skill and knowledge, not less

- ¼ elderly have fair or poor health

- 23% have cognitive impairments

- 1 in 5 have functional impairments leading to long term care needs

The impact of managed care on our nurse work force has included:

- Work speed ups

- Higher patient acuity

- Downsizing and deskilling to cut costs

- RN position cutbacks

- An undermined ability to provide safe quality care I at this time, when the care needs and demands have grown in all settings, we are being forced to spend even less time with our patients -

- Finally, we are seeing many experienced RNs - because of intolerable conditions and staffing levels - leaving acute, community and long-term care settings in search of less hostile conditions

Current Nurse Shortage:

- Unlike the 1980's shortage

- Not simply about numbers

- Both supply and demand issues exist

- International scope: US, UK, Denmark

-It's a public health crisis in the US and here in Massachusetts.

Nursing Demand Issues:

- Specialty skill/experience demands

- Ability to lead multidisciplinary teams

- Patient/staff educators

- High skill level/intensive care/ OR

- Expect 23% nursing job growth by 2006 - faster than the average of all other occupations

- Growing technologic demands

Nursing Supply Issues:

- Aging RN workforce and faculty

- Decreased BSN enrollment

- Average age of new grad: 31 years

- Specialty and geographic maldistribution

- Inadequate number of minority and male RNs

- Deteriorating workplace conditions including: safety and health, and workplace violence

- Expanded job opportunities exist

Nursing Shortage Indictors:

- Greater # of vacancies with great difficulty in filing positions

- Increased use of travel and agency nurses, especially in LTC

- Hiring of new grads in ICU settings and float positions

- Common use of mandatory bonuses to new hire signing/RN referrals

- Re-emergence of Baylor plan

Projected Shortage of Nurses:

- BSN: in the year 2000, 596,000 nurses are available; but 854,000 are needed. By 2010, 656,000 nurses will be available and 1 .4M needed. By 2020, 635,000 nurses will be available, but 1.75 million will be needed.

- The specialty nursing shortage is worse in rural areas than in urban areas. Average number of day to fill the vacant RN position in rural areas is up to 3 months!

- Lastly, the shortage extends to higher education, including masters' and doctorally prepared nurses. In 2000, there are 175,000 masters and doctorally prepared nurses available, but 377,000 are projected to be needed. By 2010, supply is expected to reach 250,000 while projected need is closer to 320,000. By 2020, we could be 500,000 nurses short of need in this country.

Our recommendations include the support of legislation, which brings new people into nursing and encourages and supports nurses to stay in the profession. Senator Moore will file legislation to put state money into the education of nurses, just as the General court has done to enhance the growth of the teaching profession. This is critically needed. We also need public private endeavors, which educate nurses for specialty areas. MNA has done that by joining with the Massachusetts Chapter of the Operating Room Nurses to train nurses for peri-operative nursing specialty practice. We need more innovation. The state must continue to find and continue to study the trends in the demographics of our state and nursing supply and demand. There are plans to do this though a Worcester State College initiative, but the process must be an on going one. We must match the needs of our citizens with the supply and specialty distribution of nurses. We absolutely must make available adequate funding for long term care to address the severe shortage of nurses in that area of practice. And we must do everything possible to prohibit the dangerous proliferation of reducing professional nursing into a simple series of tasks by allowing unlicensed persons. Danger of proliferation of the unsafe practice of medication administration by unlicensed persons from DMR and DMH into assisted and long~ term care is real and is extremelv poor public policy. Elders do Having unlicensed personnel administer medications as a means to

address the nursing shortage in long term care can and will have devastating effects, including preventable deaths. It will inevitably lead to increased costs through unanticipated hospitalizations from unrecognized drug interactions and errors. ER admissions from medication effects/side effects are already the largest single Medicare expenditure for elders. The Commission would be wise to share this message with your colleagues in the General Court. Do not extend the Medication Administration Program to long-term care.

Work Place Health and Safety:

The MNA and all of health care are still celebrating the successful passage of needlestick injury prevention legislation in Massachusetts. This law, singed in August by the Governor would not have been possible without the tenacity and leadership of Representative Canavan. Please accept our public grateful appreciation for making this a reality. There are more issues of workplace safety, which affect nursing retention. These include but are not limited to latex allergy and sensitivity, the quality of indoor air in our institutions, the lack of adherence to OSHA ergonomic standards. As the numbers of bedside nurses have decreased, the incidence of workplace injuries instance. Nurses need their work places to be more healthy and safe.

Workplace violence:

You have heard testimony at nearly every hearing related to the increased incidence of workplace violence. According to the Centers for Disease Control and NIOSH, nursing is one of the most dangerous occupations. For example, 73% of psychiatric nurses have been assaulted at least once. Colonial Insurance Company, the disability insurance carrier for the commonwealth reports actuarial data suggesting that the state employee nurse in Unit 7 have the highest incidence of traumatic injury in the workplace of all occupational groups covered. MNA will file legislation to address a comprehensive workplace violence prevention program and a package of commensurate retirement benefits for those licensed professionals who work for the State. We respectfully ask the Commission to make clear notation of those testimonies and to recommend the support of such

legislation.

Patient Advocacy:

The control of nursing practice must remain the domain of licensed nurses. This is the best mechanism to assure patient advocacy. Many have testified institutional decisions about how patient care will be delivered strips the nurse of that critical role. Any policy, which removes nursing from the bedside, wherever that bedside is, is flawed policy, which will not advocate for the patient. The examples you witnessed were: Medicaid policy which limits access to nursing in Long Term Care; Medicare policy which limits access to nursing in home care; managed care policies which limits access to nursing in acute care and in discharge planning. The list goes on and on.Our hope is that the nurse continues to play that pivotal role as advocate in this changing health care delivery environment and that your work will speak loud and clear to that role.

Thank you for this unique opportunity to provide testimony on behalf of the nurses and patients of Massachusetts.
