SENATE BILL REPORT
E2SHB 1868

As of February 21, 2022

Title: An act relating to improving worker safety and patient care in health care facilities by addressing staffing needs, overtime, meal and rest breaks, and enforcement.

Brief Description: Improving worker safety and patient care in health care facilities by addressing staffing needs, overtime, meal and rest breaks, and enforcement.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Riccelli, Volz, Berry, Fitzgibbon, Shewmake, Bateman, Berg, Bronoske, Callan, Cody, Davis, Duerr, Goodman, Gregerson, Johnson, J., Kirby, Macri, Peterson, Ramel, Ramos, Ryu, Santos, Sells, Senn, Sullivan, Simmons, Chopp, Bergquist, Graham, Valdez, Wicks, Dolan, Pollet, Ortiz-Self, Paul, Stonier, Donaghy, Ormsby, Slatter, Hackney, Taylor, Harris-Talley, Kloba and Frame).

Brief History: Passed House: 2/13/22, 55-43.
Committee Activity: Labor, Commerce & Tribal Affairs: 2/21/22.

Brief Summary of Bill

- Requires the Department of Labor and Industries to regulate and enforce hospital staffing committees and minimum staffing standards.
- Establishes minimum staffing standards for specific patient units.
- Amends the meal and rest breaks and overtime provisions for health care employees.

SENATE COMMITTEE ON LABOR, COMMERCE & TRIBAL AFFAIRS

Staff: Jarrett Sacks (786-7448)

Background: Nurse Staffing Committees. Hospitals are required to establish nurse staffing committees whose membership consists of:

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- at least one-half who are registered nurses providing direct patient care; and
- up to one-half who are determined by the hospital administration.

The responsibilities of the nurse staffing committee include:
- development and oversight of annual staffing plans;
- review of the staffing plan; and
- review, assessment, and response to staffing variations or concerns presented to the committee.

When developing the annual staffing plan, the committee must consider certain statutory factors, such as patient activity, intensity level, nature of care required, and level of experience of staff.

If the staffing plan is not adopted by the hospital, the chief executive officer must provide reasons why the plan was not adopted and either identify the changes to the plan prior to the hospital's adoption or prepare an alternative staffing plan that the hospital will adopt. Hospitals must submit their nurse staffing plans annually to the Department of Health (DOH).

DOH must investigate complaints related to the failure to establish a staffing committee, submit a nurse staffing plan annually, conduct a semi-annual review of the nurse staffing plan, or follow nursing assignments or shift-to-shift adjustments. There are statutory limitations on when DOH may investigate a complaint of a failure to follow nurse assignments or shift-to-shift adjustments.

After an investigation, if DOH determines there has been a violation, DOH must require the hospital to submit a corrective action plan within 45 days of the presentation of findings from DOH to the hospital. If the hospital fails to submit or follow the corrective action plan, DOH may impose a civil penalty of $100 per day.

Various provisions related to the staffing committees, including requirements for DOH to investigate complaints, is set to expire June 1, 2023.

Meal and Rest Breaks. In general, hospitals must provide employees with uninterrupted meal and rest breaks, except for:
- an unforeseeable emergent circumstance; or
- a clinical circumstance that may lead to a significant adverse effect on the patient's condition without the knowledge, specific skill, or ability of the employee on break, or due to an unforeseen or unavoidable event relating to patient care requiring immediate action that could not be planned for by an employer.

In the case of a clinical circumstance, if a rest break is interrupted before ten minutes by the employer, the employee must be given an additional ten minute uninterrupted rest break at the earliest reasonable time during the work period.

An unforeseeable emergent circumstance is:

- any unforeseen declared national, state, or municipal emergency;
- when a health care facility disaster plan is activated; or
- any unforeseen disaster or other catastrophic event which substantially affects or increases the need for health care services.

The meal and rest break provision applies to a hospital employee who is:

- involved in direct patient care activities or clinical services;
- receiving an hourly wage or covered by a collective bargaining agreement; and
- a licensed practical nurse, registered nurse, surgical technologist, diagnostic radiologic technologist, cardiovascular invasive specialist, respiratory care practitioner, or a nursing assistant-certified.

Health Care Facility Overtime. No employee of a health care facility may be required to work overtime and the acceptance by an employee of overtime is strictly voluntary.

The overtime restriction does not apply to overtime work that occurs because of:

- any unforeseeable emergent circumstance;
- prescheduled on-call time, subject to certain limitations;
- when the employer documents it has used reasonable efforts to obtain staffing; an employer has not used reasonable efforts if overtime work is used to fill vacancies resulting from chronic staff shortages; or
- when an employee must work overtime to complete a patient care procedure.

Health care facilities covered by the overtime restrictions include hospitals, hospices, rural health care facilities, psychiatric hospitals, and facilities owned and operated by the Department of Corrections.

A violation of the overtime provision is a class 1 civil infraction.

The Department of Labor and Industries (L&I) enforces the meal and rest break and overtime provisions, as well as other wage and hour laws and workplace health and safety standards.

Summary of Bill: Staffing Committees. The staffing committee statutes are recodified under the jurisdiction of L&I, rather than DOH. The expiration date of provisions related to staffing committees and investigations is repealed.

Instead of nurse staffing committees, hospitals are required to have hospital staffing committees whose membership consists of:

- 50 percent nursing and ancillary health care personnel, who are nonsupervisory and nonmanagerial, currently providing direct patient care; and
- up to 50 percent are determined by the hospital administration, and must include the

chief financial officer, the chief nursing officers, and patient care unit directors and managers, or their designees.

The hospital staffing committee must submit its annual staffing plan in compliance with the staffing standards established in the bill and submit the staffing plan using the uniform format established by L&I. Factors considered by the hospital staffing committee when developing the staffing plan are modified.

If the staffing plan is not adopted by consensus of the staffing committee, the prior staffing plan remains in effect and the hospital is subject to daily fines of $5,000. The daily fine is $100 for critical access hospitals, hospitals with fewer than 25 acute care beds, and certain sole community hospitals certified by the Centers for Medicare and Medicaid Services.

The chief executive officer must provide feedback to the staffing committee on a semiannual basis prior to the committee's semiannual review and adoption of the staffing plan.

Ancillary health care personnel, patients, collective bargaining representatives, and other individuals are allowed to file complaints to the staffing committee on variations of personnel assignments. All complaints submitted to the staffing committee must be reviewed, regardless of what format the complainant uses to submit the complaint.

Hospital staffing committees must file a charter with L&I that includes:

- roles, responsibilities, and processes related to the functioning of the staffing committee;
- schedule for monthly staffing committee meetings;
- processes for complaints to be reviewed and resolved within 90 days of receipt;
- processes for attendance by any nurse, ancillary health care personnel, collective bargaining representative, patient or other individual who is involved in a complaint;
- processes for quarterly reviews of staff turnover rates; and
- policies for documenting meetings and document retention.

L&I must review submitted staffing plans to ensure they are timely received and completed. Failure to timely submit a staffing plan or a charter will result in a violation and civil penalty of $25,000.

L&I must investigate complaints. The provision limiting investigations to complaints with evidence of a continuing pattern of unresolved violations is removed. Provisions prohibiting investigation of complaints in the event of unforeseeable emergency circumstances or where the hospital documents efforts to obtain staffing are also removed.

Hospitals will not be found in violation of the minimum staffing standards if there were unforeseeable emergent circumstances or the hospital documents that it made reasonable efforts to obtain and retain staffing.

An unforeseeable emergent circumstance means:

- any unforeseeable national, state, or municipal emergency; or
- when a hospital disaster plan is activated.

No later than 30 days after a hospital deviates from its staffing plan, the hospital incident command must provide the staffing committee an assessment of staffing needs arising from the emergency and the hospital's plan to address the staffing needs. The staffing committee must develop a contingency staffing plan. The hospital may not deviate from its staffing plan for more than 90 days without the approval of the staffing committee.

Failure to submit or follow a corrective action plan is increased from $100 per day, to $5,000 per day, except the $100 per day remains for critical access hospitals, hospitals with fewer than 25 acute care beds, and certain sole community hospitals certified by the Centers for Medicare and Medicaid Services. The fines apply until the hospital follows the corrective action plan for 90 days, after which L&I may reduce the accumulated fine.

Staffing Standards. Minimum staffing standards are established for hospitals. Direct care registered nurses may not be assigned more patients than the following for any shift—shown as nurse:patient ratios:

- emergency department: 1:3 non-trauma/non-critical care patients and 1:1 trauma or critical care patients;
- intensive care units: 1:2 or 1:1 depending on the stability of the patient as assessed by the nurse;
- labor and delivery: 1:2 and 1:1 patient for active labor and in all stages of labor for patients with complications;
- postpartum, antepartum, and well-baby nursery: 1:6; in this context, mother and baby count as separate patients;
- operating room: 1:1;
- oncology: 1:4;
- post-anesthesia care unit: 1:2;
- progressive care unit, intensive specialty care unit, or stepdown unit: 1:3;
- medical-surgical unit: 1:5;
- telemetry unit: 1:4;
- psychiatric unit: 1:6; and
- pediatrics: 1:3.

Direct care nursing assistants-certified may not be assigned more patients than the following for any shift:

- intensive care units: 1:8;
- cardiac unit: 1:4;
- labor and delivery: 1:8 and 1:4 patients for active labor and in all stages of labor for patients with complications;
- post-anesthesia care unit: 1:8;

- progressive care unit, intensive specialty care unit, or stepdown unit: 1:8;
- medical-surgical unit: 1:8;
- telemetry unit: 1:8;
- psychiatric unit: 1:8;
- pediatrics: 1:13;
- emergency department: 1:8; and
- telesitting unit: 1:8.

A direct care registered nurse or direct care nursing assistant-certified may not be assigned to a nursing unit or clinical area unless that nurse first received orientation sufficient to provide competent care and the nurse has demonstrated current competence in providing care in that area.

Hospitals must implement the minimum staffing standards no later than two years after the effective date of the bill. However, critical access hospitals, hospitals with fewer than 25 acute care beds, and certain sole community hospitals certified by the Centers for Medicare and Medicaid Services, have up to four years to implement the minimum staffing standards.

A process is created for hospitals to apply for, and L&I to grant, variances from the staffing standards for good cause. Good cause means situations where compliance with the staffing standards is infeasible and a variance does not have a significant harmful effect on the health, safety, and welfare of the employees and patients.

Meal and Rest Breaks and Overtime Restrictions. Combining meal and rest breaks is allowed for any work period in which an employee is entitled to one or more meal periods and more than one rest period.

Provisions that allowed certain clinical circumstances to exempt hospitals from meal and rest break requirements are amended. The requirement to provide uninterrupted meal and rest breaks does not apply when there is a clinical circumstance, as determined by the employee that may lead to a significant adverse effect on the patient's condition, unless the employer determines that the patient may suffer life-threatening adverse effects.

The definition of employee is broadened, applying the meal and rest break provisions and overtime restrictions to an employee who is involved in direct patient care activities or clinical services; and receives an hourly wage or is covered by a collective bargaining agreement.

Unforeseen disasters or other catastrophic events that substantially affect the need for health care services are removed from the definition of unforeseeable emergent circumstances.

For the purposes of exemptions to the overtime restrictions the prescheduled on-call time must not exceed more than 24 hours per week; and the health care facility's reasonable efforts to obtain staffing are not reasonable if overtime is used to fill vacancies from chronic

staff shortages that persist longer than three months.

Enforcement. A person may file a complaint with L&I alleging violations of the staffing provisions, meal and rest break requirements, and overtime restrictions. Procedures are established for the issuance of citations and notices of assessments, appeals, and other processes. Unless different amounts are provided in specific provisions, L&I may impose a maximum penalty of $1,000 for each violation, up to three violations; $2,500 for the fourth violation; and $5,000 for each subsequent
violation.

Department of Health. By November 1, 2023, DOH must submit a report to the Legislature assessing the state's alternatives to increase registered nurse licensure reciprocity. The report must include an assessment of current reciprocity laws, compacts, and rules and alternatives to those laws, and information on how military spouses may benefit from a compact or reciprocity.

Appropriation: The bill contains a null and void clause requiring specific funding be provided in an omnibus appropriation act.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill takes effect on The bill takes effect on January 1, 2023.

Staff Summary of Public Testimony: PRO: Staffing shortages are an issue that causes nurses to leave the profession, leading to even larger staffing shortages. Staffing committees do not involve the nurses and hospital administrations can veto the staffing plans without an explanation. Skilled staff are leaving and not being replaced. DOH does not hold hospitals accountable. Short staffing leads to a lack of quality of care and leads to transferring nurses to units without a proper orientation. Understaffed hospitals lead to backups in other emergency services. Hospitals have the money to make these changes.

CON: The bill would increase the equity gap for rural and remote pregnant mothers and could lead to the closure of obstetrical services at rural hospitals and increase the costs of other services. Ratios will make it even harder for rural hospitals to hire nurses and will lead to patients being turned away. The prescheduled on-call exception is necessary for patient safety. Low volume, highly specialized fields need people to be on-call. The bill will not ease the workforce shortage. California has ratios and still has a workforce shortage and worse patient outcomes. The bill will lead to patients waiting in emergency rooms to maintain ratios and will lead to deaths. Every hospital will need to apply for variances under the bill. The acuity of patients and nurse expertise go into ratios and it is not one size fits all.

Persons Testifying: PRO: Representative Marcus Riccelli, Prime Sponsor; Sam Hatzenbeler, Economic Opportunity Institute; Christiana Keeble; Kathryn Geren, RN; Stephanie Simpson, Bleeding Disorder Foundation of WA; Katie Roth, RN; Vicki Mikhailenko, RN; Michaela Roberts, Respiratory Therapist; Erica Rodvold, Respiratory Therapist; Nich Gullickson, WSCFF/EMT; Jen Holyfield, Tech; Kelli Johnson, RN.

CON: Alison Ball, Confederated Tribes of the Colville Reservation; Michael Moran; Terri Dow, retired RN; Mika Sinanan, MD, Washington State Medical Association; Dianne Aroh, RN, Virginia Mason Franciscan Health; Ramona Hicks, RN, Coulee Medical Center; Rachael Seekins, RN, Registered Nurse; Scott Eichelberger, RN, Pulse Heart Institute MultiCare; Darcy Jaffe, RN, Washington State Hospital Association; Mike Martinoli, RN, Ferry County Memorial Hospital; Karyn Mirante, RN, Staff Nurse; Lisa Thatcher, Washington State Hospital Association; Herbie Duber MD, WA Chapter - American College of Emergency Physicians; Robert Battles, Association of Washington Business (AWB).

Persons Signed In To Testify But Not Testifying: PRO: Dan James.

CON: Cody Staub, Emergency RN.

OTHER: Alyssa Odegaard, LeadingAge Washington; Tammy Fellin, Department of Labor and Industries.