SENATE BILL REPORT
E2SSB 5236

As Passed Senate, March 6, 2023

Title: An act relating to improving nurse and health care worker safety and patient care by establishing minimum staffing standards in hospitals, requiring hospital staffing committees to develop staffing plans, addressing mandatory overtime and meal and rest breaks, and providing for enforcement.

Brief Description: Concerning hospital staffing standards.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Robinson, Keiser, Conway, Frame, Hunt, Kauffman, Lovelett, Nguyen, Nobles, Pedersen, Shewmake, Stanford, Trudeau, Valdez and Wilson, C.).

Brief History:

Committee Activity: Labor & Commerce: 1/17/23, 2/07/23 [DPS-WM, DNP].
Ways & Means: 2/16/23, 2/24/23 [DP2S, DNP, w/oRec].

Floor Activity: Passed Senate: 3/6/23, 35-13.

Brief Summary of Engrossed Second Substitute Bill

- Modifies nurse staffing committee and staffing plan requirements.
- Amends the meal and rest breaks and overtime provisions for health care employees.

SENATE COMMITTEE ON LABOR & COMMERCE

Majority Report: That Substitute Senate Bill No. 5236 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Keiser, Chair; Conway, Vice Chair; Saldaña, Vice Chair; Robinson and Stanford.

Minority Report: Do not pass.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Signed by Senators King, Ranking Member; Braun, MacEwen and Schoesler.

Staff: Jarrett Sacks (786-7448)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5236 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Rolfes, Chair; Robinson, Vice Chair, Operating & Revenue; Mullet, Vice Chair, Capital; Billig, Conway, Dhingra, Hasegawa, Hunt, Keiser, Nguyen, Pedersen, Saldaña and Wellman.

Minority Report: Do not pass.

Signed by Senators Wilson, L., Ranking Member, Operating; Gildon, Assistant Ranking Member, Operating; Schoesler, Ranking Member, Capital; Warnick, Assistant Ranking Member, Capital; Boehnke, Braun, Muzzall, Torres, Van De Wege and Wagoner.

Minority Report: That it be referred without recommendation.

Signed by Senator Rivers, Assistant Ranking Member, Capital.

Staff: Amanda Cecil (786-7460)

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

- 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, 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 health care facility 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.

Summary of Engrossed Second Substitute Bill: Staffing Committees and Staffing Plans. By January 1, 2024, hospitals must establish a hospital staffing committee. The committee membership must be comprised of:
- 50 percent nursing staff, who are non-supervisory and non-managerial; and
- 50 percent members determined by hospital administration, including the chief financial officer, the chief nursing officer, and patient care unit directors or managers.

Additional staffing relief must be provided if necessary for committee members to attend the hospital staffing committee meetings. The committee must propose by a 50-percent-plus-one vote a draft of the annual staffing plan to the hospital's chief executive officer (CEO) by July 1, 2024 and annually thereafter. The CEO must provide written feedback on the staffing plan. The factors that must be addressed by the feedback are specified. The committee must review and consider the feedback prior to approving a revised staffing plan. If a revised staffing plan is not adopted by the committee, the most recent of the following remains in effect:
- the staffing plan in effect on January 1, 2023; or
- the last staffing plan approved by a 50-percent-plus-one vote by the staffing committee.

Beginning January 1, 2025, each hospital must submit its final staffing plan to DOH and annually thereafter, or after the plan is updated. Beginning July 1, 2025, each hospital must implement the staffing plan, except in the event of unforeseeable emergent circumstances.

Each hospital must document when a patient care unit nursing staff assignment is out of compliance with the adopted hospital staffing plan. Out of compliance means the number of patients assigned to the nursing staff exceeds the patient care unit assignment as directed by the nurse staffing plan. Each hospital must report to DOH on a semiannual basis the percentage of nurse staffing assignments where the assignment in a patient care unit is out of compliance with the adopted nurse staffing plan.

Beginning in 2025, if a hospital is in compliance for less than 80 percent of the nurse staffing assignment in a month, the hospital must report to DOH regarding lack of compliance with the nurse staffing patient care unit assignments in the hospital staffing plan. DOH must develop forms for the reports, and the forms must include a checkbox for

either co-chair of the staffing committee to indicate their belief that the validity of the report should be investigated by DOH. The reporting requirements do not apply to critical access hospitals, certain sole community hospitals, and hospitals with fewer than 25 acute care licensed beds, and hospitals located on an island operating within a public hospital district in Skagit County.

Nursing staff may make a complaint to the staffing committee on variations of personnel assignments. All written complaints submitted to the staffing committee must be reviewed, regardless of what format the complainant uses to submit the complaint.

In the event of an unforeseeable emergent circumstance last more than 15 days, the hospital incident command must report within 30 days to the hospital staffing committee an assessment of the staffing needs arising from the unforeseeable emergent circumstance and the plan to address those needs. After which, the staffing committee must convene and develop a contingency staffing plan. The hospital's deviation from its original staffing plan may not be in effect for more than 90 days without review of the staffing committee. Within 90 days of the initial deviation, the hospital must report to DOH on the basis for the deviation and once the deviation is no longer in effect.

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

An unforeseeable emergent circumstance is:

- any unforeseen declared national, state, or municipal emergency;
- when the hospital disaster plan is activated;
- any unforeseen disaster or other catastrophic event that substantially affects or increases the need for health care services; or
- when a hospital is diverting patients to another hospital or hospitals for treatment.

By July 1, 2024, the hospital staffing committee must file with DOH a charter that must include:

- roles, responsibilities, and processes by which the hospital staffing committee functions;
- the process for electing cochairs;
- meeting schedules;
- processes for reviewing, investigating, and resolving complaints;
- processes for reviewing staff turnover and workforce development plans;
- policies for the approving and retaining meeting documentation;
- processes for the hospital to provide the staffing committee with information regarding certain patient complaints made to the hospital; and

- processes for how the compliance reports will be used to inform the development and review of the staffing plan.

L&I and DOH must provide technical assistance to hospital staffing committees to assist in compliance with the bill. Technical assistance may not be provided during an inspection or during the time between when an investigation of a hospital has been initiated and when such investigation is resolved.

Beginning January 1, 2027, DOH must review all non-compliance reports and, in consultation with L&I. require corrective plans of action. DOH and L&I, pursuant to their formal agreement, must review and approve corrective plans of action, and must require revisions as necessary. . DOH may review corrective plans of action that adversely impact the provision of health care services or patient safety, and may require revisions. A corrective plan of action may include:

- exercising efforts to obtain additional staff;
- implementing actions to improve staffing plan variation or shift-to-shift adjustment planning;
- delaying the addition of new services;
- requiring minimum staffing standards;
- reducing hospital beds or services; or
- closing the hospital emergency department to ambulance transport, except for patients in need of critical care.

DOH must review hospital staffing plans to ensure they are received by the appropriate deadline and in the correct format. DOH must post staffing plans, charters, and violations on its website. The appropriate agency may take administrative action with penalties up to $10,000 per 30 days for failing to submit a staffing plan, charter, or corrective action plan. L&I may assess a penalty of $50,000 per 30 days for failing to follow a corrective action plan.

DOH must investigate complaints for failure to:

- form or establish a hospital staffing committee;
- conduct a semi-annual review of a staffing plan;
- submit an annual staffing plan and any updates; or
- follow nursing staff assignments in a patient care unit.

Based on their formal agreement, DOH and L&I must investigate complaints for failing to follow nursing staff assignments in a patient care unit. The departments may only investigate a complaint for complaints that remain unresolved for 60 days after receipt by the staffing committee.

The provision limiting investigations to complaints with evidence of a continuing pattern of unresolved violations is removed.

A hospital will not be found in violation of the nurse staffing committee and staffing plan requirements if an investigation determines that:

- there were unforeseen emergent circumstances and the process for handling emergent circumstances established in law was followed;
- the hospital, after consultation with the hospital staffing committee, documents that the hospital has made reasonable efforts to obtain and retain staffing to meet required personnel assignments but has been unable to do so; or
- an individual admission of a patient in need of critical care to sustain their life or prevent disability received from another hospital caused the staffing plan violation alleged in the complaint .

Reasonable efforts means that the employer exhausts and documents all of the following but is unable to obtain staffing coverage:

- seeks individuals to consent to work additional time from all available qualified staff who are working;
- contacts qualified employees who have made themselves available to work additional time;
- seeks the use of per diem staff; and
- seeks personnel from a contracted temporary agency when such staffing is permitted by law or an applicable collective bargaining agreement, and when the employer regularly uses a contracted temporary agency.

DOH and L&I may investigate and take appropriate enforcement action without any complaint if either department discovers data in the course of an investigation or inspection suggesting a violation of the staffing committee and staffing plan statute. After an investigation, if DOH and L&I, pursuant to their formal agreement, determine that there has been multiple unresolved violations of non-adherence to the staffing plan and shift-to-shift adjustments in staffing levels required by staffing plans, DOH must require the hospital submit a corrective plan of action within 45 days.

By July 1, 2024, L&I and DOH must establish a formal agreement that identifies the roles of each agency with respect to oversight and enforcement of the parts of the bill that require joint enforcement and, to the extent feasible, provide for enforcement by a single agency and to avoid multiple citations for the same violation.

Advisory Committee. DOH, in consultation with L&I, must establish an advisory committee on hospital staffing by September 1, 2023. The committee must include the following members:

- six members representing hospitals and hospital systems and their alternates, selected from a list of nominees submitted by the Washington State Hospital Association; and
- six members representing frontline hospital patient care staff and their alternates, selected from a list of nominees submitted by collective bargaining representatives of frontline hospital nursing staff.

The advisory committee on hospital staffing shall advise DOH on its development of the uniform hospital staffing plan form. After July 1, 2029, the advisory committee must discuss issues related to the applicability of the staffing plan compliance reports to the hospitals excluded from the requirements.

By December 1, 2023, WSIPP must survey hospitals and report to the advisory committee on hospital staffing on Washington hospitals' existing use of innovative hospital staffing and care delivery models.

Meal and Rest Breaks. 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 to an employee who is employed by a hospital; is involved in direct patient care activities or clinical services; and receives an hourly wage or is covered by a collective bargaining agreement.

The employer must provide a quarterly report to L&I of the total meal and rest periods missed and the total meal and rest periods required during the quarter. The reports are due to L&I within 30 calendar days after the conclusion of the quarter. L&I must enforce the meal and rest break requirements as well as the reporting requirement. Upon review of the report, if L&I determines that an employer is no 80 percent complaint with the meal and rest break requirements, or fails to file a report, L&I must provide technical assistance until June 30, 2026. After July 1, 2026, if L&I determines that an employer has exceed the quarterly threshold for missed meal and rest periods, L&I must impose a penalty.

The penalties assessed by L&I are:

- for critical access hospitals and hospitals with fewer than 25 licensed beds, $5,000;
- for hospitals with 26 to 99 licensed beds, $10,000;
- for hospitals with 100 to 299 beds, $15,000; and
- for hospitals with 300 or more beds, $20,000.

If L&I imposes a penalty in a third consecutive quarter, L&I must double the penalty. An employer may not retaliate against an employee for exercising any right under the meal and rest break law and L&I must investigate complaints of retaliation. L&I may order a payment of a civil penalty of $1,000 for an employer's first violation of the anti-retaliation provision, and nor more than $5,000 for subsequent violations. L&I may also order appropriate relief and order the employer to restore the employee to the position the employee held.

An employer must provide valid data to L&I and employees must be free from coercion into inaccurate recording of their meal and rest periods.

Mandatory Overtime. For the purposes of exemptions to the overtime restrictions for prescheduled on-call time, mandatory prescheduled on-call time may not be used to begin at a time when the duration of the procedure is expected to exceed the employee's regular scheduled hours of work, except for procedures which, in the judgment of the provider, a delay would cause a worse clinical outcome.

L&I must investigate complaints for violations of the prohibition on mandatory overtime and must issue either a citation and notice of assessment or a determination of compliance within 90 days of receiving the complaint. If a violation is found, L&I must order the employer to pay L&I a civil penalty. The maximum penalty is $1,000 for each violation, up to three violations. If there are four or more violations, the employer is subject to a civil penalty of $2,500 for the fourth violation, and $5,000 for each subsequent violation. A process for appealing a citation and notice of assessment is established.

WSIPP Study. WSIPP must conduct a study on hospital staffing standards for direct care registered nurses and direct care nursing assistants. WSIPP must review current and historical staffing plans filed with DOH and describe:

- timeliness and completeness of filed forms;
- format of filed forms;
- patient care unit nurse staff assignments related to the maximum number of patients to which a direct care nursing or nursing assistant may be assigned;
- descriptive statistics on submissions by hospital unit type;
- trends over time, if any;
- legal minimum staffing standards for registered nurses and nursing assistants in other jurisdictions; and
- relevant professional association guidance, recommendations, or best practices.

WSIPP must provide the report to L&I and the Legislature by June 30, 2024.

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony on Original Bill (Labor & Commerce): *The committee recommended a different version of the bill than what was heard.* PRO: This bill is just part of the discussion around how we staff health care and providing support for

health care workers. Inadequate staffing leads to worse patient outcomes. It also leads to seasoned nurses leaving. The current staffing crisis has lead to many nurses being burned out and leaving and there are not enough new nurses to replace them. There is not a shortage of nurses, there is a shortage of safe work environments. Hospitals are not short on money and some have larger reserves now than they did before the pandemic due to investments and federal aid. Current staffing plans are not adhered to, and the current law has no teeth. Ensuring nurses do not have excessive patient load ensures patients receive the care they need. Hospitals are understaffed by design.

CON: Hospitals are already closing various units and stopped performing certain procedures and the bill will only make that worse. Hospitals will have to close because they cannot find more nurses or pay the fines. L&I does not have the expertise to implement the bill. Unlike other industries hospitals cannot limit demand for their services and they cannot stop treating admitted patients. The cap on prescheduled on- call nurses will cause units to close. Ratios will stifle innovative staffing models. Hospitals cannot fill current staffing plans with enough nurses even with hiring expensive traveling nurses. California has ratios and the highest pay in the country and still has a nursing shortage. It also has the fewest nurses per capita in the country. Instead, we need legislation to train and develop new nurses. EMS and fire departments already have to wait to transfer patients and the bill will make that worse, now is not the time to pass the bill.

OTHER: To implement, L&I will need time to gather expertise and increase staff for the bill. The bill will also require an update to IT systems.

Persons Testifying (Labor & Commerce): PRO: Senator June Robinson, Prime Sponsor; Jennifer Gordon; Collin Greer, SEIU Healthcare 1199NW/Certified Nursing Assistant; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Nonie Kingma, Washington State Nurses Association; Nich Gullickson, South King County Professional Firefighters; Anna Nepomuceno, NAMI Washington; Kelli Johnson, UFCW 3000; Sam Hatzenbeler, Economic Opportunity Institute; Melissa Swetland, 1199 NW; Jim Freeburg, Patient Coalition of Washington; Zane Zuchowski.

CON: Darcy Jaffe, RN, Washington State Hospital Association; June Altaras, RN, MultiCare; Elizabeth Wako, MD, RN, Providence Swedish; Susan Scott, RN, Providence Holy Family Hospital; Mike Martinoli, RN, Ferry County Memorial Hospital; Beth Goetz, RN, Direct Care Nurse; Lisa Thatcher, Washington State Hospital Association; Matt Cowan, Shoreline Fire Department; Jeff Faucett, South Kitsap Fire & Rescue.

OTHER: Tammy Fellin, Labor & Industries.

Persons Signed In To Testify But Not Testifying (Labor & Commerce): PRO: Lisa Winchell; Kelsay Irby; Kainui Rapaport; Sara Gering; Evan Riley.

CON: Alyssa Odegaard, LeadingAge Washington; CHARLOTTE MORRIS, Trilogy; John Bramhall, Washington State Medical Association; Onora Lien, Northwest Healthcare

Response Network; Laci Johnson, Forks Comunity Hospital; William Johnson; Mike Battis, Washington Ambulance Association; Heidi Anderson, Forks Community Hospital; Licett Garbe, Greater Spokane Valley Chamber of Commerce; Carlton Heine, WA ACEP.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: Hospitals are not doing their best to solve the current nursing crisis. Carrots have been ineffective for too long, so it is time for the stick. Lots of new grads are being hired to replace the experienced nurses leaving in droves, which is not an equal replacement. Nursing turnover is expensive and dangerous. This bill will help rebuild trust in the healthcare system in a fiscally responsible way. Safe staffing ratios will allow nurses to deliver higher quality care and save patients from preventable death. If hospitals can afford to pay their CEOs millions, they can afford to improve standards for nurses.

CON: This bill introduces a rigid and authoritarian structure to staffing which is unsafe, as nurse placement needs to be flexible. This will lead to delays in access to care and will close hospitals in rural areas which will be devastating. The lack of prenatal care is associated with an increased likelihood that a woman will die of a pregnancy-related death by 3-4 times. These ratios will not work, as they have not worked in California. There are only about 3000 nurses who are unemployed in Washington, and there are more than 6000 unfilled positions. There are not enough nurses. This bill will not create more nurses, it will only increase costs and reduce the ability to respond to dynamic conditions and situations.

Persons Testifying (Ways & Means): PRO: Jennifer Gordon; Kainui Rapaport; Annika Hoogestraat, N/a; Evan Riley; Sara Gering RN BSN CCRN-CMC; Katy Roth RN; Natalie Fincher RN; Anita Dalton RN; Heidi Debauge RN; Sarah Gwin RN; Kathryn Lewandowsky, BSN, RN; James Harrigan; Lindsey Grad, 1199NW; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Sam Hatzenbeler, Economic Opportunity Institute; Laura Zaske; Nicole Johnson.

CON: John Bramhall, MD, Washington State Medical Association; Michael Moran, Confederated Tribes of the Colville Reservation; Jennifer Graham, RN, MultiCare Health System; Heidi Anderson, RN, Forks Community Hospital; Lisa Thatcher, Washington State Hospital Association; Jeff Faucett, Washington Fire Chiefs Association; Norma Sanchez, Confederated Tribes of the Colville Reservation; Bob Battles, Association of Washington Business (AWB); Kim Williams, Camano Island Fire and Rescure; Jeff Gombosky, Washington Health Care Association and LeadingAge Washington; Onora Lien, Northwest Healthcare Response Network.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.