HOUSE BILL REPORT
HB 1868

As Reported by House Committee On:
Labor & Workplace Standards

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: 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:
Committee Activity:
Labor & Workplace Standards: 1/19/22, 1/28/22 [DPS].

Brief Summary of Substitute 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.
- Provides administrative enforcement and a private cause of action for violations.

HOUSE COMMITTEE ON LABOR & WORKPLACE STANDARDS

Majority Report: The substitute bill be substituted therefor and the substitute bill do 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 4 members: Representatives Sells, Chair; Berry, Vice Chair; Bronoske and Ortiz-Self.

Minority Report: Do not pass. Signed by 2 members: Representatives Hoff, Ranking Minority Member; Harris.

Minority Report: Without recommendation. Signed by 1 member: Representative Mosbrucker, Assistant Ranking Minority Member.

Staff: Trudes Tango (786-7384).

Background:

Nurse Staffing Committees.
Hospitals are required to have nurse staffing committees, whose membership consist of: (a) at least one-half who are registered nurses providing direct patient care; and (b) up to one-half who are determined by the hospital administration. Nurse staffing committees develop and review annual staffing plans and respond to staffing variations and complaints presented to the nurse staffing committee. "Hospital" means any institution that provides accommodations, facilities, and services over a continuous period of 24 hours or more for observation, diagnosis, or care. "Hospital" does not include nursing homes, birthing centers, or institutions specifically intended for the care of those suffering from mental illness or intellectual disability.

When developing the annual staffing plan (staffing plan), the nurse staffing committee (staffing 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 staffing plans annually to the Department of Health (DOH).

Registered nurses may submit complaints to the staffing committee about variations to the staffing plan and shift-to-shift adjustments. The DOH may investigate complaints about violations of the nurse staffing statutes, as well as complaints related to failure to: establish a staffing committee; submit a staffing plan annually; conduct semiannual reviews of the plan; and follow nursing assignments or shift-to-shift adjustments.

The DOH may investigate complaints of nursing personnel assignments and shift-to-shift adjustments only if the complainant submits evidence of data showing a continuing pattern of unresolved violations for a minimum 60-day continuous period. If the complaint is substantiated, the DOH will issue the hospital a statement of deficiencies. The hospital has 45 days to submit a corrective action plan. If the hospital fails to submit or follow the corrective action plan, the DOH may impose a civil penalty of $100 per day.

The DOH may not investigate complaints in the event of unforeseeable emergency circumstances or if the hospital made reasonable efforts to obtain staffing but was unable to do so. "Unforeseeable emergency circumstance" is defined as: (1) any unforeseen national, state, or municipal emergency; (2) when a hospital disaster plan is activated; (3) any unforeseen disaster or catastrophic event that substantially affects the need for health care services; or (4) when a hospital is diverting patients to another hospital or receiving diverted patients from another hospital.

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

Meal and Rest Breaks.
Generally, hospitals must provide certain employees with uninterrupted meal and rest breaks. This rule does not apply:

- in a case of an unforeseeable emergent circumstance; or
- in a clinical circumstance that may lead to a significant adverse effect on the patient: (1) without the knowledge, skill, or ability of the employee; or (2) due to an unforeseen or unavoidable event requiring immediate action.

"Unforeseeable emergent circumstance" means: (1) any unforeseen declared national, state, or municipal emergency; (2) when a health care facility disaster plan is activated; or (3) any unforeseen disaster or other catastrophic event that substantially effects or increases the need for health care services.

In the case of a clinical circumstance, if a rest break is interrupted by the employer before 10 complete minutes, the employee must be given an additional 10 minute uninterrupted rest break at the earliest reasonable time during the work period.

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
- is a licensed practical nurse, registered nurse, surgical technologist, diagnostic radiologic technologist, cardiovascular invasive specialist, respiratory care practitioner, or a nursing assistant-certified.

Overtime Restrictions.
Hospitals and other health care facilities (such as hospices, rural health care facilities, and facilities operated by the Department of Corrections) are prohibited from requiring certain employees to work overtime. The definition of "employee" is the same as used in the meal and rest break statutes.

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

- because of any unforeseeable emergent circumstance;

- because of prescheduled on-call time, subject to certain limitations;
- when the employer documents that 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.

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

Department of Labor and Industries.
The Department of Labor and Industries (Department) enforces the meal and rest break and overtime provisions, as well as other wage and hour laws and workplace health and safety standards. The Department has procedures for investigating complaints, issuing citations and notices of assessments, handling appeals, and imposing civil penalties.

Summary of Substitute Bill:

Staffing Committees and Staffing Standards.
The staffing committee statutes are recodified to be under the jurisdiction of the Department, rather than the DOH. The expiration date of the various provisions related to staffing committees and agency investigations is repealed.

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-to-patient ratios):

a. Emergency department: 1:3 nontrauma/noncritical care patients and 1:1 trauma/critical care patients;
b. Intensive care units: 1:2 or 1:1 depending on the stability of the patient as assessed by the nurse;
c. Labor and delivery: 1:2 and 1:1 patient for active labor and in all stages of labor for patients with complications;
d. Postpartum, antepartum, and well-baby nursery: 1:6 (mother and baby count as separate patients);
e. Operating room: 1:1;
f. Oncology: 1:4;
g. Postanesthesia care unit: 1:2;
h. Progressive care unit, intensive specialty care unit, or stepdown unit: 1:3;
i. Medical-surgical unit: 1:4;
j. Telemetry unit: 1:3;
k. Psychiatric unit: 1:6; and
l. Pediatrics: 1:3.

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

a. Intensive care units: 1:8;
b. Cardiac unit: 1:4;
c. Labor and delivery: 1:8 and 1:4 patients for active labor and in all stages of labor for patients with complications;
d. Oncology: 1:7;
e. Postanesthesia care unit: 1:8;
f. Progressive care unit, intensive specialty care unit, or stepdown unit: 1:8;
g. Medical-surgical unit: 1:8;
h. Telemetry unit: 1:8;
i. Psychiatric unit: 1:7;
j. Pediatrics: 1:13;
k. Emergency department: 1:7;
l. Telesitting unit: 1:8; and
m. Cardiac monitoring unit: 1:50.

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, except 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.

Staffing Committees: Hospitals must have hospital staffing committees whose members must consist of: (1) at least 50 percent direct care nursing and ancillary health care personnel who are nonsupervisory and nonmanagerial; and (2) up to 50 percent who 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.

Changes are made to the factors the staffing committee must consider when developing the staffing plan. Changes are made regarding the adoption of the staffing plan. 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 $10,000. 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 report on and file complaints to the staffing committee on

variations of personnel assignments in patient care units. All complaints submitted to the staffing committee must be reviewed, regardless of what format the complainant uses to submit the complaint.

Staffing Committee Charters: Staffing committees must file a charter with the Department 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 60 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.

The staffing committee must submit their staffing plan using a form created by the Department. The Department 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.

The Department must investigate submitted 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. However, after an investigation, 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. What constitutes an "unforeseeable emergent circumstance" is amended to remove: (a) unforeseen disasters or other catastrophic events; and (b) when a hospital diverts patients or receives diverted patients.

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.

The administrative civil penalty for not following a corrective action plan, after a violation has been determined, is increased from $100 per day, to $10,000 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 the Department may reduce the accumulated fine.

The Department must post staffing plans, charters, and violations on its website.

Meal and Rest Breaks and Overtime Restrictions.
Provisions that allowed certain "clinical circumstances" to exempt hospitals from meal and rest break requirements are removed.

The definition of "employee" is broadened, thereby applying the meal and rest break provisions and overtime restrictions to an employee who: (1) is involved in direct patient care activities or clinical services; and (2) 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: (1) the prescheduled on-call time must not exceed more than 20 hours per week; and (2) 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.

Department of Labor and Industries.
A person may file a complaint with the Department 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. The Department must enforce the overtime restrictions using citations and notices of assessments for violations rather than by civil infractions.

Unless different amounts are provided in specific provisions, the Department 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.

Civil Cause of Action.
Any employee of a health care facility, for purposes of meal and rest breaks and overtime restrictions; and any direct care nurse or direct care nursing assistant-certified, for purposes of staffing standards; and any exclusive bargaining representative, may bring a civil action for damages for violations of the chapter. A court may order to the plaintiff an award ranging from $100 to $10,000 per violation per day, plus reasonable attorneys' fees, and other equitable relief.

Substitute Bill Compared to Original Bill:

The substitute bill: (1) removes the state hospitals for the mentally ill from the hospitals that must comply with minimum staffing standards; (2) delays the effective date of the bill to January 1, 2023; (3) changes the date for which hospitals must establish hospital staffing committees from September 1, 2022, to September 1, 2023; (4) requires the Department to

post on its website the hospital's staffing plans and staffing committee charters; (5) removes the requirement for the Department to maintain records of license suspensions; and (6) makes various corrections to terminology and definitions for consistency throughout the bill.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

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

Staff Summary of Public Testimony:

(In support) Staffing shortages started long before COVID-19 and hospitals have set the stage for this crisis by systemically under-staffing for years. Staffing shortages are the main reasons health care workers burn out and leave the profession. Staffing shortages increase the chances of patient death. Relying on travel nurses is not the answer and travel nurses do not know the community. Hospitals did not honor the staffing committees' concerns. Some hospitals do not even submit the required staffing plans. Hospitals abused the flexibility they were given. It is time for legislative intervention. It is a myth that there are not enough nurses. Short staffing prolongs hospital stays and prevents timely discharges of patients.

(Opposed) The bill is highly prescriptive and reduces local flexibility needed to address complex needs. The ratios make it impossible to maintain the level of service needed and treat nurses and patients as numbers rather than people with different needs and skill levels. California has staffing ratios and still faces staffing shortages. There is a nation-wide shortage and thousands of vacancies. This bill will worsen the staffing crisis and will lead to delays and denial of care. Hospitals are paying collectively bargained wages, bonuses, and tuition reimbursements and still have difficulty finding enough nurses. The bill removes the narrow circumstances for when uninterrupted rest breaks are not required. These exceptions were designed to address unforeseen emergencies and they were negotiated in 2019. There will be an impact on small rural hospitals. The private cause of action creates litigation costs and will not solve the problem.

(Other) Amendments are needed to help the Department implement provisions of the bill. There will be fiscal impact to the Department.

Persons Testifying: (In support) Representative Marcus Riccelli, prime sponsor; Nicholas Gullickson, South King County Professional Firefighters; Stephanie Wahlgren; Ade Adeyemo; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Kelli Johnson; Julia Barcott; Jim Freeburg, Patient Coalition of Washington; Jane Hopkins, Service Employees International Union Healthcare 1199NW; Rhonda Gallert; Dustin

Weddle; Alice Westphal; Kristin Ang, Faith Action Network; Sam Hatzenbeler, Economic Opportunity Institute; Maria Goodall; David Keepnews; Tim Jennings; Whitney Powers; Sybill Hyppolite, Washington State Labor Council; John Gustafson; Travis Nelson; Ron Cole; Judi Shoesmith; Vanessa Patricelli; Aimee Oien; Anthony Cantu; and Anne Powers.

(Opposed) Jeannie Eylar, Pullman Regional Hospital; Robert Battles, Association of Washington Business; Mike Martinoli, Ferry County Memorial Hospital; Melissa Strong, Mason General Hospital; Cassie Sauer and Lisa Thatcher, Washington State Hospital Association; Lisa Morten, Overlake Medical Center; Jennifer Culbertson, Swedish Medical Center-Edmonds; Katy Ericksen, MultiCare Health System; Susan Stacey, Providence Health and Services; Brenda Sharkey, Ocean Beach Hospital and Medical Clinics; Mike Battis, Washington Ambulance Association; Harold Kelly, Puget Sound Kidney Centers; Lauri St. Ours, Washington Health Care Association and LeadingAge Washington; and John Bramhall,Washington State Medical Association.

(Other) Tammy Fellin, Department of Labor and Industries.

Persons Signed In To Testify But Not Testifying: None.