American Nurses Association

Staffing Legislation Landscape Report

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The Power of Nurses™

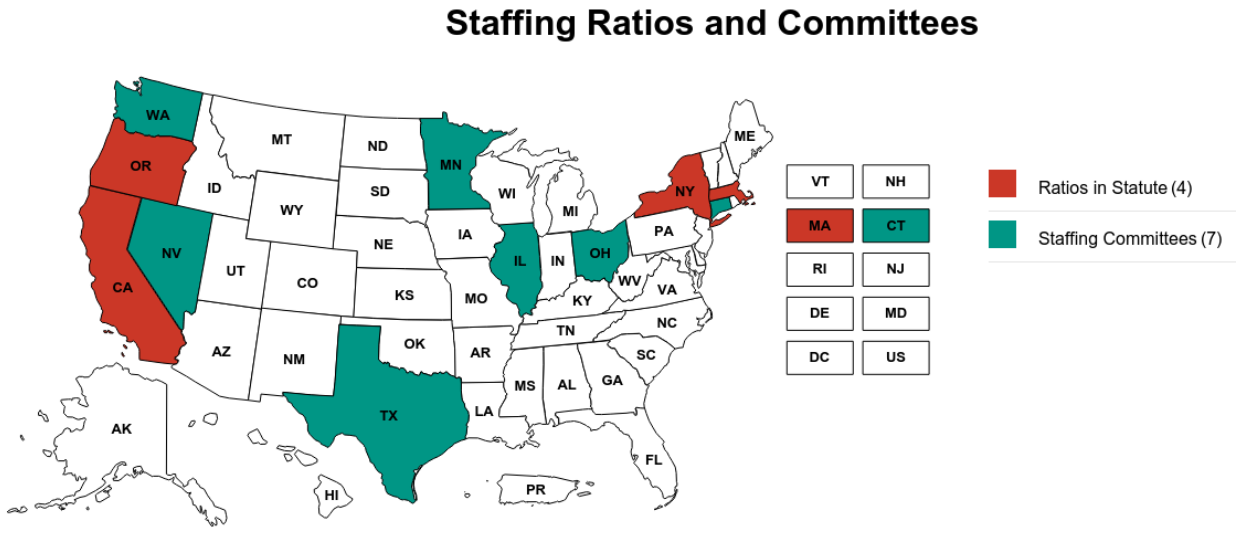
Safe Staffing Legislation Landscape Report

Executive Summary

Safe staffing is a cornerstone of effective health care delivery, directly impacting patient safety, quality of care, and the well-being of nursing professionals. Recognizing the critical role that appropriate staffing practices play in achieving positive health care outcomes, several states have introduced or enacted legislation aimed at setting minimum standards for nurse staffing. These laws aim to address issues such as nurse workload, turnover, and burnout—factors that ultimately affect patient care quality and hospital efficiency.

The American Nurses Association (ANA) has long advocated for safe staffing policies that prioritize both patient needs and nurse sustainability. This commitment to safe staffing aligns with ANA's broader mission to protect the interests of nurses and uphold the highest standards in health care. As such, this report serves as a resource for stakeholders—including policymakers, health care administrators, and nursing professionals—by analyzing existing staffing legislation across various states. Through this analysis, ANA seeks to provide a comparative understanding of current approaches, fostering a foundation for future legislative efforts that support safe, effective, and sustainable staffing levels.

In this report, we examine legislation from six states—**California**, **Connecticut**, **Massachusetts**, **Oregon**, **Texas,** and **Washington**. Rather than model legislation that prescribes a single solution, this analysis offers a snapshot of the statutory language that these states use regarding safe staffing ratios, staffing committees, and reporting and enforcement mechanisms. These three elements are widely regarded as fundamental components in creating effective staffing policies that balance workload demands with quality care standards. This report serves to illustrate the current landscape of state action on safe staffing legislation and highlight the successes and limitations of each approach.



Note – Oregon and California have both staffing committees and ratios.

Implications for Policy and Practice

While ANA continues to call for federal focus and action on enforceable safe staffing standards for nurses across the care continuum, state action remains critical to affect real progress to achieve safe nurse staffing. Policymakers and stakeholders can build on the existing state action to advance staffing initiatives in their respective states. This report encourages policymakers to consider the strengths of current state-level approaches while identifying areas for improvement that align with ANA's standards and principles for safe staffing. As healthcare delivery systems evolve and the demand for services grows, it is increasingly important to prioritize policies to address staffing challenges that support both patient safety and workforce well-being.

ANA's Approach to Safe Staffing

In 2022, Membership Assembly voted to support staffing ratios as a "tool in the toolbox" for addressing staffing. ANA views adequate staffing as essential to delivering high-quality, safe patient care and achieving optimal health outcomes. This includes implementing enforceable nurse-to-patient ratios where necessary, as well as promoting flexible, evidence-based staffing models tailored to different health care settings.

ANA has also worked collaboratively with other leading organizations through initiatives like the Nurse Staffing Think Tank, which developed actionable recommendations and strategies to address the nurse staffing crisis. These efforts emphasize the importance of fostering healthy work environments and prioritizing nurse well-being alongside patient safety. ANA remains committed to advocating for staffing solutions that meet patient needs and support the nursing workforce.

The Nurse Staffing Think Tank, convened by leading health care organizations, identified six priority areas to address the nurse staffing crisis:

1. **Healthy Work Environment**: Promoting a culture of safety and respect to enhance nurse well-being and patient care.
2. **Diversity, Equity, and Inclusion**: Building a diverse nursing workforce and leadership to reflect the communities served.
3. **Work Schedule Flexibility**: Implementing flexible scheduling to improve nurse satisfaction and retention.
4. **Stress Injury Continuum**: Addressing mental health and stress to support nurse resilience.
5. **Innovative Care Delivery Models**: Developing new care models to optimize nurse staffing and patient outcomes.
6. **Total Compensation**: Creating comprehensive compensation programs that include benefits like paid time off for self-care.

These priorities aim to create a sustainable nursing workforce and improve patient care quality.

Building on ANA's priorities and principles, the following analysis examines how different states have approached safe staffing legislation, focusing on ratios, committees, and enforcement mechanisms.

High-Level Findings

This comparative analysis reveals several legislative trends across the five states, as well as gaps where additional measures could be beneficial. Common trends include a focus on maintaining minimum staffing ratios, empowering nurses through staffing committees, and implementing enforcement mechanisms that hold health care providers accountable. However, certain gaps remain in achieving the ideal standards advocated by ANA, particularly in areas related to enforcement consistency and staff input.

Components of the Analysis

Ratios

Staffing ratios refer to the mandated or recommended minimum number of nursing staff required per number of patients in a specific health care setting. These ratios are established to ensure that patients receive adequate care and that nurses are not overburdened, promoting both patient safety and nurse well-being. Safe staffing ratios are designed to ensure that nurses can manage their workloads effectively, which is essential for delivering safe and quality care. This report examines the language on ratios in state statute.

- **California**: Implemented in 2004, California's law mandates the State Department of Public Health to determine minimum nurse-to-patient ratios across various hospital units. For

example, in medical-surgical units, the ratio is 1 nurse to 5 patients, while in intensive care units (ICUs), it's 1:2.

- **Massachusetts**: Since 2014, Massachusetts requires a 1:1 or 1:2 nurse-to-patient ratio in ICUs, determined by patient stability and assessed using a standardized acuity tool.
- **Oregon**: In June 2023, Oregon passed legislation establishing specific nurse-to-patient ratios in 12 acute care settings, such as a 1:2 ratio in ICUs and a 1:4 ratio in medical-surgical units.
- **New York**: Enacted in 2021, New York's Safe Staffing for Quality Care Act requires a 1:2 nurse-to-patient ratio in ICUs and mandates hospitals to provide on-call coverage to maintain these ratios.

Committees

Staffing committees are formal groups established within health care organizations, typically hospitals, to develop, implement, and monitor staffing plans. They aim to ensure adequate nurse staffing levels that align with patient care needs, staff well-being, and operational efficiency. Staffing committees are vital mechanisms that allow nurses to participate directly in staffing decisions, promoting transparency and responsiveness to staff needs. By involving nurses in the staffing process, committees empower health care professionals to advocate for working conditions that support both the provision of effective patient care and workforce sustainability. This analysis reviews how states have structured and empowered these committees within safe staffing legislation.

- **Connecticut**: Implemented in 2009, Connecticut General Statutes § 19a-89e requires hospitals to establish staffing plans that include input from direct care nurses.
- **Illinois**: Effective January 1, 2008, the Hospital Licensing Act (210 ILCS 85/10.10) mandates hospitals to create staffing plans with input from nursing care committees.
- **Minnesota**: Enacted in 2013, Minnesota Statutes § 144.7055 requires hospitals to have a core staffing plan for each patient care unit, developed under the direction of the hospital's chief nursing executive.
- **Nevada**: Effective July 1, 2009, Nevada Revised Statutes § 449.242 mandates hospitals to establish staffing committees responsible for developing and evaluating nurse staffing plans.
- **New York**: The requirement to establish clinical staffing committees was signed into law in June 2021, with implementation beginning January 1, 2022.
- **Ohio**: Effective September 12, 2008, Ohio Revised Code § 3727.51 requires hospitals to create nursing care committees to assist in the development of hospital-wide staffing plans.
- **Oregon**: The Oregon Nurse Staffing Law was revised in 2015, establishing a Nurse Staffing Advisory Board within the Oregon Health Authority. The board first met on February 24, 2016.
- **Texas**: Implemented in 2009, Texas Health and Safety Code § 257.004 requires hospitals to establish nurse staffing committees as standing committees responsible for developing nurse staffing plans.

- **Washington**: The original law requiring nurse staffing committees was passed in 2008 and updated in 2017. Further amendments were made in 2023, with significant portions taking effect on January 1, 2024.

Reporting and Enforcement

Effective enforcement mechanisms are essential for ensuring compliance with safe staffing standards. This includes penalties for non-compliance and protections for whistleblowers who report unsafe staffing conditions. Enforcement provisions vary by state, with some states incorporating rigorous penalties, while others provide whistleblower protections to encourage transparency. This section outlines these differences, highlighting the role of enforcement in maintaining high staffing standards.

- **Texas** legislation lacks coordination between the reporting agency and the enforcement agency, potentially hindering effective enforcement.
- In **Oregon,** regulatory agencies set definitions, as opposed to explicit statutory language, which may pose challenges for enforcement clarity.

To provide actionable insights, the remainder of this report highlights statutory language across key themes, offering examples of legislative frameworks from leading states.

State Statute Text

The remainder of this report compiles legislative text from California, Connecticut, Massachusetts, Oregon, Texas, and Washington state statutes related to nurse staffing plans, organized into key themes such as Definitions, Staffing Plan, Staffing Committee, Reporting, and others. Each theme includes relevant subsections; for example, the “Meeting Requirement” under Staffing Committee outlines provisions on how often these committees must meet. The aim is not to provide an exhaustive list of ideas or clauses but to offer states insights into existing approaches and potential options for enactment. These are the options for you to potentially choose from and does not mean that every single consideration needs to be in the legislation.

Definitions

Hospital

"Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals.[1]

(A) a general hospital or special hospital, as those terms are defined by Section 241.003, including a hospital maintained or operated by this state; or
(B) a mental hospital licensed under Chapter 577.[2]

Unit

"Patient care unit" means a unit or area of a hospital in which registered nurses provide patient care.[3]

Hospital Unit

As used in this subdivision, “hospital unit” means a critical care unit, burn unit, labor and delivery room, postanesthesia service area, emergency department, operating room, pediatric unit, step-down/intermediate care unit, specialty care unit, telemetry unit, general medical care unit, subacute care unit, and transitional inpatient care unit.[4]

Critical Care Unit

“Critical care unit” as used in this section means a unit that is established to safeguard and protect patients whose severity of medical conditions requires continuous monitoring, and complex intervention by licensed nurses.[5]

Intensive Care Unit

For the purposes of this section, the term ''intensive care units'' shall have the same meaning as defined in 105 CMR 130.020 and shall include intensive care units within a hospital operated by the commonwealth.[6]

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[1] CT PA 08-79 Sec 1(a)(2)
[2] TX HSC 257.001(3)
[3] TX HSC 257.001(4)
[4] CA HSC 1276.4(a)
[5] CA HSC 1276.4(c)
[6] MA Ch 111 Sec 231

Staffing Plan

Establishment

Each hospital [...] shall, upon request, make available to the department a prospective nurse staffing plan with a written certification that the nurse staffing plan is sufficient to provide adequate and appropriate delivery of health care services to patients in the ensuing period of licensure. Such plan shall promote a collaborative practice in the hospital that enhances patient care and the level of services provided by nurses and other members of the hospital's patient care team.[7]

The governing body of a hospital shall adopt, implement, and enforce a written nurse staffing policy to ensure that an adequate number and skill mix of nurses are available to meet the level of patient care needed.[8]

Each hospital shall implement a written hospital-wide staffing plan for nursing services that:
(a) Meets the requirements of this section and ORS 441.762, 441.764, 441.765, 441.766, 441.767 and 441.768;[9]
(b) Includes any staffing-related terms and conditions that were previously adopted through any applicable collective bargaining agreement, including meal breaks and rest breaks, unless a term or condition is in direct conflict with an applicable statute or administrative rule; and
(c) Has been developed and approved by the hospital nurse staffing committee under ORS 441.762.[10]

Considerations

In evaluating the effectiveness of the official nurse services staffing plan, the committee shall consider patient needs, nursing-sensitive quality indicators, nurse satisfaction measures collected by the hospital, and evidence-based nurse staffing standards.[11]

Development and oversight of an annual patient care unit and shift-based hospital staffing plan, based on the needs of patients, to be used as the primary component of the staffing budget. The hospital staffing committee shall use a uniform format or form, created by the department in consultation with the advisory committee established in RCW 43.70.855 and the department of

[7] CT PA 08-79 Sec 1(b)
[8] TX HSC 257.003(a)
[9] These clauses are: Hospital nurse staffing committee (441.762), Annual review of nurse staffing plan (441.764), Staffing ratios for direct care registered nurses (441.765), Exceptions to direct care registered nurse staffing ratios (441.766), Staffing plans for psychiatric units (441.767), Staffing ratios for certified nursing assistants (441.768)
[10] ORS 441.763(1)
[11] TX HSC 257.004(h)

labor and industries, for complying with the requirement to submit the annual staffing plan. The uniform format or form must allow for variations in service offerings, facility design, and other differences between hospitals, but must allow patients and the public to clearly understand and compare staffing plans. Hospitals may include a description of additional resources available to support unit-level patient care and a description of the hospital, including the size and type of facility. [12]

Census

Factors to be considered in the development of the plan should include, but are not limited to: (i) Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers;[13]

the hospital nurse staffing committee:
(a) May consider: [...]
(B) The size of the hospital and a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit;
(C) The unit's general and predominant patient population as defined by the Medicare Severity Diagnosis-Related Groups adopted by the Centers for Medicare and Medicaid Services, or by other measures for patients who are not classified in the Medicare Severity Diagnosis-Related Groups;[14]

Patient Acuity

Factors to be considered in the development of the plan should include, but are not limited to: [...] (ii) Patient acuity level, intensity of care needs, and the type of care to be delivered on each shift;[15]

the hospital nurse staffing committee:
(a) May consider: [...]
(E) Differences in patient acuity;[16]

[12] WA RCW 70.41.420(4)(a)
[13] WA RCW 70.41.420(4)(a)(i)
[14] ORS 441.763(2)(a)(B)-(C)
[15] WA RCW 70.41.420(4)(a)(ii)
[16] ORS 441.763(2)(a)(E)

Skill Mix

Such plan shall [...] include the minimum professional skill mix for each patient care unit in the hospital, including, but not limited to, inpatient services, critical care and the emergency department[17]

Factors to be considered in the development of the plan should include, but are not limited to: [...]
(iii) Skill mix;
(iv) Level of experience and specialty certification or training of nursing and patient care staff providing care;[18]

the hospital nurse staffing committee:
(a) May consider:
(A) The specialized qualifications and competencies of the nursing staff and the skill mix and level of competency needed to ensure that the hospital is staffed to meet the health care needs of patients;[19]

Temporary & Travel Nurses

Such plan shall [...] identify the hospital's employment practices concerning the use of temporary and traveling nurses[20]

Other Staff

Factors to be considered in the development of the plan should include, but are not limited to: [...]
(viii) Availability of other personnel and patient care staff supporting nursing services on the unit;[21]

Non-Direct Care Tasks

the hospital nurse staffing committee:
(a) May consider: [...]
(F) Tasks not related to providing direct care;[22]

[17] CT PA 08-79 Sec 1(c)(1)
[18] WA RCW 70.41.420(4)(a)(iii)-(iv)
[19] ORS 441.763(2(a)(A)
[20] CT PA 08-79 Sec 1(c)(2)
[21] WA RCW 70.41.420(4)(a)(viii)
[22] ORS 441.763(2)(a)(F)

Equipment and Geography

Factors to be considered in the development of the plan should include, but are not limited to: [...]
(v) The need for specialized or intensive equipment;
(vi) The architecture and geography of the patient care unit, including but not limited to placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;[23]

Administrative Staffing

Such plan shall [...] set forth the level of administrative staffing in each patient care unit of the hospital that ensures direct care staff are not utilized for administrative functions[24]

Professional Association Guidelines

Factors to be considered in the development of the plan should include, but are not limited to: [...]
(vii) Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations;[25]

the hospital nurse staffing committee:
(a) May consider: [...]
(D) Nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations, if any;[26]

On-Call Staff

A hospital must maintain and post, in a physical location or online, a list of on-call nursing staff or staffing agencies to provide replacement nursing staff in the event of a vacancy. The list of on-call nursing staff or staffing agencies must be sufficient to provide for replacement nursing staff.[27]

CBA Compliance

Factors to be considered in the development of the plan should include, but are not limited to: (ix) Compliance with the terms of an applicable collective bargaining agreement, if any, and relevant

[23] WA RCW 70.41.420(4)(a)(v)-(vi)
[24] CT PA 08-79 Sec 1(c)(3)
[25] WA RCW 70.41.420(4)(a)(vii)
[26] ORS 441.763(2)(a)(D)
[27] ORS 441.763(3)

state and federal laws and rules, including those regarding meal and rest breaks and use of overtime and on-call shifts;[28]

(a) An employer may not impose upon unionized nursing staff any changes in wages, hours or other terms and conditions of employment pursuant to a staffing plan unless the employer first provides notice to and, upon request, bargains with the union as the exclusive collective bargaining representative of the nursing staff in the bargaining unit.
(b) A staffing plan does not create, preempt or modify a collective bargaining agreement or require a union or employer to bargain over the staffing plan while a collective bargaining agreement is in effect.[29]

Direct Input

Such plan shall [...] include the hospital's mechanism of obtaining input from direct care staff, including nurses and other members of the hospital's patient care team, in the development of the nurse staffing plan[30]

Primary responsibilities of the hospital staffing committee shall include [...] Review, assessment, and response to staffing variations or complaints presented to the committee.[31]

Hospital Finances

In addition to the factors listed in subsection (4)(a) of this section, hospital finances and resources must be taken into account in the development of the hospital staffing plan.[32]

Regulatory Notice

A hospital shall submit to the Oregon Health Authority a nurse staffing plan adopted in accordance with this section and ORS 441.766 and submit any changes to the plan no later than 30 days after approval of the changes by the hospital nurse staffing committee.[33]

Exceptions

A type A or a type B hospital may vary from the requirements of ORS 441.765 if the hospital nurse staffing committee of the hospital has voted to approve the variance. A type A hospital or type B

[28] WA RCW 70.41.420(4)(a)(ix)
[29] ORS 441.763(4)
[30] CT PA 08-79 Sec 1(c)(5)
[31] WA RCW 70.41.420(4)(c)
[32] WA RCW 70.41.420(5)
[33] ORS 441.763(5)

hospital shall notify the authority of the variance through the authority's website. The notification to the authority shall include a statement signed by the cochairs of the committee, confirming that the committee voted to approve the variance. The variance becomes effective upon the submission of the notification to the authority and remains in effect for two years. A type A or type B hospital may renew a variance or notify the authority of a new variance as provided in this subsection.[34]

Staffing Committee

Establishment

Each hospital shall establish a hospital staffing committee to assist in the preparation of the nurse staffing plan [...].[35]

A hospital shall establish a nurse staffing committee as a standing committee of the hospital.[36]

each hospital shall establish a hospital staffing committee, either by creating a new committee or assigning the functions of the hospital staffing committee to an existing nurse staffing committee.[37]

For each hospital there shall be established a hospital nurse staffing committee.[38]

Composition

Registered nurses employed by the hospital whose primary responsibility is to provide direct patient care shall account for not less than fifty per cent of the membership of each hospital's staffing committee.[39]

(b) The committee shall be composed of members who are representative of the types of nursing services provided in the hospital.
(c) The chief nursing officer of the hospital is a voting member of the committee.
(d) At least 60 percent of the members of the committee must be registered nurses who:
    (1) provide direct patient care during at least 50 percent of their work time; and
    (2) are selected by their peers who provide direct patient care during at least 50 percent of their work time.[40]

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[34] ORS 441.763(6)
[35] CT PA 08-79 Sec 1(c)
[36] TX HSC 257.004(a)
[37] WA RCW 70.41.420(1)
[38] ORS 441.762(1)(a)
[39] CT PA 08-79 Sec 1(c)
[40] TX HSC 257.004

Hospital staffing committees must be comprised of:

(a) At least 50 percent of the voting members of the hospital staffing committee shall be nursing staff, who are nonsupervisory and nonmanagerial, currently providing direct patient care. The selection of the nursing staff shall be according to the collective bargaining representative or representatives if there is one or more at the hospital. If there is no collective bargaining representative, the members of the hospital staffing committee who are nursing staff providing direct patient care shall be selected by their peers.

(b) 50 percent of the members of the hospital staffing committee shall be determined by the hospital administration and shall include but not be limited to the chief financial officer, the chief nursing officers, and patient care unit directors or managers or their designees.[41]

Each hospital nurse staffing committee shall:

(A) Consist of an equal number of hospital nurse managers and direct care staff;

(B) For the portion of the committee composed of direct care staff, consist entirely of direct care registered nurses, except for one position to be filled by a direct care staff member who is not a registered nurse and whose services are covered by a written hospital-wide nurse staffing plan; and

(C) Include at least one direct care registered nurse from each hospital nurse specialty or unit.[42]

the hospital staffing committee shall file with the department a charter that must include, but is not limited to: [...]

(b) Roles, responsibilities, and processes by which the hospital staffing committee functions, including which patient care staff job classes will be represented on the committee as nonvoting members, how many members will serve on the committee, processes to ensure adequate quorum and ability of committee members to attend, and processes for replacing members who do not regularly attend;[43]

Selection of Committee Members

(b) If any of the direct care registered nurses who work at a hospital have an exclusive representative, the exclusive representative shall select the direct care registered nurse members of the committee.

(c) If the direct care staff member who is not a registered nurse who works at a hospital has an exclusive representative, the exclusive representative shall select the direct care staff member of the committee who is not a registered nurse.

(d) If none of the direct care registered nurses who work at a hospital are represented by an exclusive representative, the direct care registered nurses belonging to a hospital nurse

[41] WA RCW 70.41.420(2)
[42] ORS 441.762(1)(a)
[43] WA RCW 70.41.420(11)(b)

specialty or unit shall select the members of the committee who are direct care registered nurses from the specialty or unit to serve on the committee.

(e) If none of the direct care staff working at the hospital who are not registered nurses are represented by an exclusive representative, the direct care registered nurses who are members of the staffing committee shall select the direct care staff who are not registered nurses to serve on the committee.[44]

Meeting Requirement

The committee shall meet at least quarterly.[45]

A hospital nurse staffing committee shall meet:
(a) At least once every four months; and
(b) At any time and place specified by either cochair.[46]

the hospital staffing committee shall file with the department a charter that must include, but is not limited to: [...] (c) Schedule for monthly meetings with more frequent meetings as needed that ensures committee members have 30 days' notice of meetings;[47]

Committee is Work Time

Participation on the committee by a hospital employee as a committee member is part of the employee's work time, and the hospital shall compensate that member for that time accordingly. The hospital shall relieve a committee member of other work duties during committee meetings.[48]

Participation in the hospital staffing committee by a hospital employee shall be on scheduled work time and compensated at the appropriate rate of pay. Hospital staffing committee members shall be relieved of all other work duties during meetings of the committee. Additional staffing relief must be provided if necessary to ensure committee members are able to attend hospital staffing committee meetings.[49]

A hospital shall release a member of a hospital nurse staffing committee described in subsection (1)(a) of this section from the member's assignment, and provide the member with paid time, to attend committee meetings.[50]

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[44] ORS 441.762(1)(b)-(e)
[45] TX HSC 257.004(e)
[46] ORS 441.762(6)
[47] WA RCW 70.41.420(11)(c)
[48] TX HSC 257.004(f)
[49] WA RCW 70.41.420(3)
[50] ORS 441.762(9)

Duties

(1) develop and recommend to the hospital's governing body a nurse staffing plan that meets the requirements of Section 257.003;
(2) review, assess, and respond to staffing concerns expressed to the committee;
(3) identify the nurse-sensitive outcome measures the committee will use to evaluate the effectiveness of the official nurse services staffing plan;[51]

A hospital nurse staffing committee shall develop a written hospital-wide nurse staffing plan in accordance with this section and ORS 441.763, 441.764, 441.765, 441.766, 441.767 and 441.768. The committee's primary goals in developing the staffing plan shall be to ensure that the hospital is staffed to meet the health care needs of patients. The committee shall review and modify the staffing plan in accordance with ORS 441.764.[52]

The committee shall produce the hospital's annual hospital staffing plan.[53]

Quorum and Voting

A majority of the members of a hospital nurse staffing committee constitutes a quorum for the transaction of business.[54]

A decision made by a hospital nurse staffing committee must be made by a vote of a majority of the members of the committee. If a quorum of members present at a meeting comprises an unequal number of hospital nurse managers and direct care staff, only an equal number of hospital nurse managers and direct care staff may vote.[55]

The committee shall propose by a 50 percent plus one vote a draft of the hospital's annual staffing plan which must be delivered to the hospital's chief executive officer or their designee by July 1, 2024, and annually thereafter.[56]

Leadership

A hospital nurse staffing committee shall have two cochairs. One cochair shall be a hospital nurse manager elected by the members of the committee who are hospital nurse managers and one

[51] TX HSC 257.004(g)
[52] ORS 441.762(2)
[53] WA RCW 70.41.420(6)(a)
[54] ORS 441.762(3)
[55] ORS 441.762(5)
[56] WA RCW 70.41.420(6)(c)

cochair shall be a direct care registered nurse elected by the members of the committee who are direct care staff.[57]

the hospital staffing committee shall file with the department a charter that must include, but is not limited to:
(a) A process for electing cochairs and their terms[58]

Anti-Retaliation

(9) A hospital may not retaliate against or engage in any form of intimidation or otherwise take any adverse action against:
    (a) An employee for performing any duties or responsibilities in connection with the hospital staffing committee; or
    (b) An employee, patient, or other individual who notifies the hospital staffing committee or the hospital administration of his or her concerns on nurse staffing.[59]

Evaluation Period

(4) evaluate, at least semiannually, the effectiveness of the official nurse services staffing plan and variations between the plan and the actual staffing; and
(5) submit to the hospital's governing body, at least semiannually, a report on nurse staffing and patient care outcomes, including the committee's evaluation of the effectiveness of the official nurse services staffing plan and aggregate variations between the staffing plan and actual staffing.[60]

Such plan shall [...] set forth the hospital's process for internal review of the nurse staffing plan[61]

the hospital staffing committee shall file with the department a charter that must include, but is not limited to: [...] (g) Processes for the hospital staffing committee to conduct quarterly reviews of: Staff turnover rates including new hire turnover rates during first year of employment; anonymized aggregate exit interview data on an annual basis; and hospital plans regarding workforce development;[62]

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[57] ORS 441.762(4)
[58] WA RCW 70.41.420(11)(a)
[59] WA RCW 70.41.420(9)
[60] TX HSC 257.004(g)
[61] CT PA 08-79 Sec 1(c)(4)
[62] WA RCW 70.41.420(11)(g)

Primary responsibilities of the hospital staffing committee shall include [...] Semiannual review of the staffing plan against patient need and known evidence-based staffing information, including the nursing sensitive quality indicators collected by the hospital;[63]

Annual review of nurse staffing plan.

(1) A hospital nurse staffing committee established pursuant to ORS 441.762 shall review the nurse staffing plan:
    (a) At least once every year; and
    (b) At any other date and time specified by either cochair of the committee.
(2) In reviewing a staffing plan, a hospital nurse staffing committee shall consider:
    (a) Patient outcomes
    (b) Complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing;
    (c) The number of hours of nursing care provided through a hospital unit compared with the number of patients served by the hospital unit during a 24-hour period;
    (d) The aggregate hours of mandatory overtime worked by the nursing staff;
    (e) The aggregate hours of voluntary overtime worked by the nursing staff;
    (f) The percentage of shifts for each hospital unit for which staffing differed from what is required by the staffing plan;
    (g) The number of meal breaks and rest breaks missed by direct care staff; and
    (h) Any other matter determined by the committee to be necessary to ensure that the hospital is staffed to meet the health care needs of patients.
(3) Upon reviewing a staffing plan, a hospital nurse staffing committee may modify the staffing plan.[64]

Staffing Complaints

the hospital staffing committee shall file with the department a charter that must include, but is not limited to: [...]

(d) Processes by which all staffing complaints will be reviewed, investigated, and resolved, noting the date received as well as initial, contingent, and final disposition of complaints and corrective action plan where applicable;
(e) Processes by which complaints will be resolved within 90 days of receipt, or longer with majority approval of the committee, and processes to ensure the complainant receives a letter stating the outcome of the complaint;[65]

[63] WA RCW 70.41.420(4)(b)
[64] ORS 441.764
[65] WA RCW 70.41.420(11)(d)-(e)

Unreasonable Burdens

(10)This section is not intended to create unreasonable burdens on critical access hospitals under 42 U.S.C. Sec. 1395i-4. Critical access hospitals may develop flexible approaches to accomplish the requirements of this section that may include but are not limited to having hospital staffing committees work by videoconference, telephone, or email.[66]

Openness and Records of Committee

(7) (a) Subject to paragraph (b) of this subsection, a hospital nurse staffing committee meeting must be open to:
(A) The hospital nursing staff as observers; and
(B) Upon invitation by either cochair, other observers or presenters.
(b) At any time, either cochair may exclude persons described in paragraph (a) of this subsection from a committee meeting for purposes related to deliberation and voting.
(8) Minutes of hospital nurse staffing committee meetings must:
(a) Include motions made and outcomes of votes taken;
(b) Summarize discussions; and
(c) Be made available in a timely manner to hospital nursing staff and other hospital staff upon request.[67]

the hospital staffing committee shall file with the department a charter that must include, but is not limited to: [...] (f) Processes for attendance by any employee, and a labor representative if requested by the employee, who is involved in a complaint;[68]

the hospital staffing committee shall file with the department a charter that must include, but is not limited to: [...]
(h) Standards for hospital staffing committee approval of meeting documentation including meeting minutes, attendance, and actions taken;
(i) Policies for retention of meeting documentation for a minimum of three years and consistent with each hospital's document retention policies;
(j) Processes for the hospital to provide the hospital staffing committee with information regarding patient complaints involving staffing made to the hospital through the patient grievance process required under 42 C.F.R. 482.13(a)(2); and
(k) Processes for how the information from the reports required under subsection (7) of this section will be used to inform the development and semiannual review of the staffing plan.[69]

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[66] WA RCW 70.41.420(10)
[67] ORS 441.762(7)-(8)
[68] WA RCW 70.41.420(11)(f)
[69] WA RCW 70.41.420(11)(h)-(k)

Staffing Plan Feedback and Disputes

(c) The chief executive officer or their designee must provide written feedback to the hospital staffing committee on the proposed annual staffing plan. The feedback must:

(i) Identify those elements of the proposed staffing plan the chief executive officer requests to be changed to address elements identified by the chief executive officer, including subsection (4)(a) of this section, that could cause the chief executive officer concern regarding financial feasibility, concern regarding temporary or permanent closure of units, or patient care risk; and

(ii) Provide a status report on implementation of the staffing plan including nursing sensitive quality indicators collected by the hospital, patient surveys, and recruitment and retention efforts, including the hospital's success over the previous six months in filling approved open positions for employees covered by the staffing plan.

(d) The committee must review and consider any feedback required under (c)(i) of this subsection prior to approving by a 50 percent plus one vote a revised hospital staffing plan to provide to the chief executive officer.

(e) If this revised proposed staffing plan is not adopted by the hospital, the most recent of the following remains in effect:

(i) The staffing plan that was in effect January 1, 2023; or

(ii) The staffing plan last approved by a 50 percent plus one vote of a duly constituted hospital staffing committee and adopted by the hospital, in accordance with all standards under this section.

(f) Beginning January 1, 2025, each hospital shall submit its final staffing plan to the department and thereafter on an annual basis and at any time in between that the plan is updated.[70]

(a) (A) If the hospital nurse staffing committee does not adopt a nurse staffing plan under subsection (2) of this section, either cochair of the committee may invoke the commencement of a 60-day period during which the committee shall continue to develop the staffing plan.

(B) If by the end of the 60-day period, the hospital nurse staffing committee does not adopt a nurse staffing plan, the members of the committee may extend deliberations for one additional 60-day period only by a majority vote of the members of the committee.

(C) If a quorum of members present at a meeting comprises an unequal number of nursing staff and managers, only an equal number of staff and managers may vote.

(b) If by the end of the initial 60-day period of deliberations or by the end of the second 60-day period of deliberations, if deliberations are extended under subsection (3)(a)(B) of this section, the hospital nurse staffing committee does not adopt a nurse staffing plan, the cochairs of the committee shall submit the disputed plan or parts of the plan, as applicable, to the Oregon Health Authority, and the authority shall initiate expedited binding arbitration.

[70] WA RCW 70.41.420(6)

(c) The arbitrator shall be selected using alternating strikes by the cochairs or their designees from a list of seven drawn from the interest arbitrator panel maintained by the State Conciliation Service.
(d) Arbitration must be scheduled by mutual agreement no later than 30 calendar days after the cochairs submit the disputed nurse staffing plan or the disputed parts of the plan to the authority except as, by mutual agreement, the time may be extended.
(e) The arbitrator shall issue a decision on the nurse staffing plan or the disputed parts of the plan, as applicable, based on the written submissions of evidence and arguments and may not conduct an evidentiary hearing or allow discovery. The arbitrator's decision must be based on and within the parameters of the versions of the plan or the disputed parts of the plan submitted by the cochairs and must be within the staffing parameters.
(f) The arbitrator shall issue a decision no later than 60 days after the submission of evidence and written arguments.
(g) The hospital shall pay for the cost of the arbitrator. [71]

Reporting

(a) A hospital shall annually report to the department on:
    (1) whether the hospital's governing body has adopted a nurse staffing policy as required by Section 257.003;
    (2) whether the hospital has established a nurse staffing committee as required by Section 257.004 that meets the membership requirements of that section;
    (3) whether the nurse staffing committee has evaluated the hospital's official nurse services staffing plan as required by Section 257.004 and has reported the results of the evaluation to the hospital's governing body as provided by that section; and
    (4) the nurse-sensitive outcome measures the committee adopted for use in evaluating the hospital's official nurse services staffing plan.
(b) Information reported under Subsection (a) is public information.
(c) To the extent possible, the department shall collect the data required under Subsection (a) as part of a survey required by the department under other law.[72]

(a) Beginning July 1, 2025, each hospital shall implement the staffing plan and assign nursing staff to each patient care unit in accordance with the plan except in instances of unforeseeable emergent circumstances.
(b) Each hospital shall document when a patient care unit nursing staff assignment is out of compliance with the adopted hospital staffing plan. For purposes of this subsection, out of compliance means the number of patients assigned to the nursing staff exceeds the patient

[71] ORS 441.766(3)
[72] TX HSC 257.005

care unit assignment as directed by the nurse staffing plan. The hospital must adopt written policies and procedures under this subsection no later than October 1, 2024.

(i) Each hospital must report to the department on a semiannual basis the accurate 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 2026, semiannual reports are due on July 31st and January 31st each year. The first report is due January 31, 2026, and must cover the last six months of 2025.

(ii) Beginning July 1, 2025, if a hospital is in compliance for less than 80 percent of the nurse staffing assignment in a month, the hospital must, within seven calendar days following the end of the month in which the hospital was out of compliance, report to the department regarding lack of compliance with the nurse staffing patient care unit assignments in the hospital staffing plan.

(iii) The department must develop a form or forms for the report to be made under this subsection by October 1, 2024. The form must include a checkbox for either cochair of the hospital staffing committee to indicate their belief that the validity of the report should be investigated by the department. If the checkbox on the form has been checked, the department may initiate an investigation as to the validity of the semiannual report under (b)(i) of this subsection.

(iv) This subsection (7)(b) does not apply to:

(A) Hospitals certified as critical access hospitals;

(B) Hospitals with fewer than 25 acute care licensed beds;

(C) Hospitals certified by the centers for medicare and medicaid services as sole community hospitals that are not owned or operated by a health system that owns or operates more than one acute hospital licensed under chapter **70.41** RCW; and

(D) Hospitals located on an island operating within a public hospital district in Skagit county.

(c) A nursing staff may report to the hospital staffing committee any variations where the nursing staff assignment in a patient care unit is not in accordance with the adopted staffing plan and may make a complaint to the committee based on the variations.

(d) Shift-to-shift adjustments in staffing levels required by the plan may be made by the appropriate hospital personnel overseeing patient care operations. If nursing staff on a patient care unit objects to a shift-to-shift adjustment, the nursing staff may submit the complaint to the hospital staffing committee.

(e) Hospital staffing committees shall develop a process to examine and respond to data submitted under (c) and (d) of this subsection, including the ability to determine if a specific complaint is resolved or dismissing a complaint based on unsubstantiated data. All written complaints submitted to the hospital staffing committee must be reviewed by the staffing committee, regardless of what format the complainant uses to submit the complaint.

(f) In the event of an unforeseeable emergent circumstance lasting for 15 days or more, the hospital incident command shall report within 30 days to the cochairs of the hospital staffing committee an assessment of the staffing needs arising from the unforeseeable emergent circumstance and the hospital's plan to address those identified staffing needs. Upon receipt of the report, the hospital staffing committee shall convene to develop a contingency staffing plan to address the

needs arising from the unforeseeable emergent circumstance. The hospital's deviation from its staffing plan may not be in effect for more than 90 days without the review of the hospital staffing committee. Within 90 days of an initial deviation under this section the hospital must report to the department the basis for the deviation and must report to the department again once the deviation under this section is no longer in effect.

(g) A direct care registered nurse or direct care nursing assistant-certified may not be assigned by hospitals to a nursing unit or clinical area unless that nurse has first received orientation in that clinical area sufficient to provide competent care to patients in that area and has demonstrated current competence in providing care in that area. The hospital must adopt written policies and procedures under this subsection no later than July 1, 2025.[73]

(8) Each hospital shall post, in a public area on each patient care unit, the staffing plan and the staffing schedule for that shift on that unit, as well as the relevant clinical staffing for that shift. The staffing plan and current staffing levels must also be made available to patients and visitors upon request. The hospital must also post in a public area on each patient care unit any corrective action plan relevant to that patient care unit as required under RCW **70.41.425**(4).[74]

Existing Plans

Note: Sections 15 and 32 (2), chapter 507, Oregon Laws 2023, provide:
Sec. 15. Notwithstanding ORS 441.155 [renumbered 441.763], prior to June 1, 2024, a hospital nurse staffing committee established under ORS 441.154 [renumbered 441.762] may approve a staffing plan that is:

(1) Consistent with nationally recognized nurse staffing standards or benchmarks;
(2) Consistent with a tool that measures patient acuity and intensity and that has been calibrated to the hospital unit, as defined by the hospital nurse staffing committee; or
(3) Approved after the hospital nurse staffing committee has considered:
    (a) The specialized qualifications and competencies of the staff in the unit;
    (b) The historic acuity and intensity of the patients in the unit;
    (c) Nationally recognized nurse staffing standards, if any; and
    (d) Patients' access to care. [2023 c.507 §15]

Sec. 32. (2) Section 15 of this 2023 Act is repealed on June 2, 2024. [2023 c.507 §32(2)]

Note: Section 29, chapter 507, Oregon Laws 2023, provides:
Sec. 29.

(1) (a) A nurse staffing plan that is in effect on the effective date of this 2023 Act [September 1, 2023] that does not comply with ORS 441.152 to 441.177 [series became 441.761 to 441.795] continues in force until a hospital nurse staffing committee revises the plan or

[73] WA RCW 70.41.420(7)
[74] WA RCW 70.41.420(8)

develops a new plan. The committee shall revise the plan, or develop a new plan, to comply with ORS 441.152 to 441.177 no later than June 1, 2024.

(b) A hospital must be in compliance with section 6 of this 2023 Act [441.765] no later than June 1, 2024.

(c) A nurse staffing plan that is in effect on the effective date of this 2023 Act and that complies with ORS 441.152 to 441.177 remains in effect until revised in accordance with ORS 441.154 [renumbered 441.762].

(2) A hospital must establish a hospital professional and technical staffing committee and a hospital service staffing committee in accordance with sections 3 [441.775] and 4 [441.776] of this 2023 Act no later than December 31, 2024.

(3) (a) Except as provided in subsection (4) of this section, the Oregon Health Authority may begin the enforcement of:

(A) Sections 3 and 4 of this 2023 Act on the date specified in subsection (2) of this section;

(B) Section 6 of this 2023 Act on the date specified in subsection (1) of this section; and

(C) The amendments to ORS 441.020, 441.151 [renumbered 441.760], 441.152 [renumbered 441.761], 441.154, 441.155 [renumbered 441.763], 441.156 [renumbered 441.764], 441.164 [renumbered 441.778], 441.165 [renumbered 441.769], 441.171 [renumbered 441.791], 441.173 [renumbered 441.780], 441.175 [renumbered 441.793] and 441.177 [renumbered 441.783] by sections 1, 13, 14, 16, 18, 19 and 21 to 26 of this 2023 Act on the effective date of this 2023 Act.

(b) The authority shall adopt rules to implement the process for receiving complaints under ORS 441.171 and section 12 of this 2023 Act [441.790] no later than January 1, 2024. Complaints may be filed for any violation occurring on or after the effective date of this 2023 Act.

(4) The authority may not impose civil penalties under section 20 of this 2023 Act [441.792] for violations that occur before June 1, 2025. [2023 c.507 §29][75]

Ratios

Ratios Determined by Agency

By January 1, 2002, the State Department of Public Health shall adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250. The State Department of Public Health shall adopt these regulations in accordance with the department's licensing and certification regulations as stated in Sections 70053.2, 70215, and

[75] ORS 441.763 (not actually that section, but just after)

70217 of Title 22 of the California Code of Regulations, and the professional and vocational regulations in Section 1443.5 of Title 16 of the California Code of Regulations.[76]

Ratios Determined by Statute

With respect to direct care registered nurses, a nurse staffing plan must ensure that at all times:

(a) In an emergency department:
    (A) A direct care registered nurse is assigned to not more than one trauma patient; and
    (B) The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time. Direct care registered nurses assigned to trauma patients may not be taken into account in determining the average ratio.
(b) In an intensive care unit, a direct care registered nurse is assigned to no more than two patients.
(c) In a labor and delivery unit, a direct care registered nurse is assigned to no more than:
    (A) Two patients if the patients are not in active labor or experiencing complications; or
    (B) One patient if the patient is in active labor or if the patient is at any stage of labor and is experiencing complications.
(d) In a postpartum, antepartum and well-baby nursery, a direct care registered nurse is assigned to no more than six patients, counting mother and baby each as separate patients.
(e) In a mother-baby unit, a direct care registered nurse is assigned to no more than eight patients, counting mother and baby each as separate patients.
(f) In an operating room, a direct care registered nurse is assigned to no more than one patient.
(g) In an oncology unit, a direct care registered nurse is assigned to no more than four patients.
(h) In a post-anesthesia care unit, a direct care registered nurse is assigned to no more than two patients.
(i) In an intermediate care unit, a direct care registered nurse is assigned to no more than three patients.
(j) In a medical-surgical unit, a direct care registered nurse is assigned to no more than five patients.
(k) In a cardiac telemetry unit, a direct care registered nurse is assigned to no more than four patients.
(L) In a pediatric unit, a direct care registered nurse is assigned to no more than four patients.[77]

A hospital may not assign a certified nursing assistant to more than seven patients at a time during a day or evening shift or to more than 11 patients at a time during a night shift.[78]

Notwithstanding any general or special law to the contrary, in all intensive care units the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as

[76] CA HSC 1276.4(a)
[77] ORS 441.765(2)
[78] ORS 441.766

assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager's designee when needed to resolve a disagreement.[79]

Classification of Patient

Notwithstanding subsection (2) of this section, the direct care registered nurse-to-patient ratio for an individual patient shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.[80]

The acuity tool shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff and shall be certified by the department. The health policy commission shall promulgate regulations governing the implementation and operation of this section including: the formulation of an acuity tool; the method of reporting to the public on staffing compliance in hospital intensive care units; and the identification of 3 to 5 related patient safety quality indicators, which shall be measured and reported by hospitals to the public.[81]

Periodic Review

The department shall review these regulations five years after adoption and shall report to the Legislature regarding any proposed changes.[82]

Flexibility/Exceptions

Direct care registered nurse-to-patient staffing ratios under ORS 441.765 do not apply to the care of:

(a) Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee;
(b) Emergency department patients who are in critical condition, until they are stable;
(c) Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services;
(d) Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record;
(e) Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record;

[79] MA Ch. 111 Sec 231
[80] ORS 441.765(3)
[81] MA Ch. 111 Sec 231
[82] CA HSC 1276.4(a)

(f) Patients in outpatient units that operate under a hospital's license; or
(g) Patients in psychiatric units.[83]

Rural

Flexibility shall be considered by the department for rural general acute care hospitals in response to their special needs. [84]

Psychiatric Units

The regulations adopted by the department for health facilities licensed under subdivision (b) of Section 1250 that are not operated by the State Department of State Hospitals shall take into account the special needs of the patients served in the psychiatric units.[85]

Innovative Care Models

With the approval of a majority of the members of the hospital nurse staffing committee, a unit can deviate from the direct care registered nurse-to-patient ratios in subsection (2) of this section, in pursuit of innovative care models that were considered by the committee, by allowing other clinical care staff to constitute up to 50 percent of the registered nurses needed to comply with the applicable nurse-to-patient ratio. The staffing in an innovative care model must be reapproved by the committee every two years.[86]

Timeframe

Each hospital unit may deviate from a nurse staffing plan, except with respect to meal breaks and rest breaks, including the applicable registered nurse-to-patient ratios under this section, within a period of 12 consecutive hours, no more than six times during a rolling 30-day period, without being in violation of the nurse staffing plan. The unit manager must notify the hospital nurse staffing committee no later than 10 days after each deviation. Each subsequent deviation during the 30-day period constitutes a separate violation under ORS 441.792.

Plan for the Exceptions

For patients described in subsection (1) of this section, the hospital nurse staffing committee established under ORS 441.762 shall adopt a nurse staffing plan that is:
(a) Consistent with nationally recognized nurse staffing standards or benchmarks;
(b) Consistent with a tool that measures patient acuity and intensity and that has been calibrated to the applicable unit; or

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[83] ORS 441.766(1)
[84] CA HSC 1276.4(a)
[85] CA HSC 1276.4(k)
[86] ORS 441.765(4)

(c) Approved after the committee has considered:
    (A) The specialized qualifications and competencies of the staff in the unit;
    (B) Historic acuity and intensity of the patients in the unit;
    (C) Nationally recognized nurse staffing standards, if any; and
    (D) Ensuring patient access to care.[87]

Emergency Department Distinctions

The regulation addressing the emergency department shall distinguish between regularly scheduled core staff licensed nurses and additional licensed nurses required to care for critical care patients in the emergency department.[88]

Ratios Clarification

These ratios shall constitute the minimum number of registered and licensed nurses that shall be allocated. Additional staff shall be assigned in accordance with a documented patient classification system for determining nursing care requirements, including the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan and the ability for self-care, and the licensure of the personnel required for care.[89]

A hospital may not require a direct care registered nurse to be assigned to more patients than as specified in this section or in the nurse staffing plan approved by the hospital nurse staffing committee, as applicable.[90]

Conflict-of-Laws

(i) The regulations adopted by the department shall augment and not replace existing nurse-to-patient ratios that exist in regulation or law for the intensive care units, the neonatal intensive care units, or the operating room.
(j) The regulations adopted by the department shall not replace existing licensed staff-to-patient ratios for hospitals operated by the State Department of State Hospitals. [91]

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[87] ORS 441.766(2)
[88] CA HSC 1276.4(a)
[89] CA HSC 1276.4(b)
[90] ORS 441.765(7)
[91] CA HSC 1276.4(i)-(j)

Teaching Hospitals

The department may take into consideration the unique nature of the University of California teaching hospitals as educational institutions when establishing licensed nurse-to-patient ratios. The department shall coordinate with the Board of Registered Nursing to ensure that staffing ratios are consistent with the Board of Registered Nursing approved nursing education requirements. This includes nursing clinical experience incidental to a work-study program rendered in a University of California clinical facility approved by the Board of Registered Nursing provided there will be sufficient direct care registered nurse preceptors available to ensure safe patient care.[92]

Appropriate Training

(d) All health facilities licensed under subdivision (a), (b), or (f) of Section 1250 shall adopt written policies and procedures for training and orientation of nursing staff.
(e) No registered nurse shall be assigned to a nursing unit or clinical area unless that nurse has first received orientation in that clinical area sufficient to provide competent care to patients in that area, and has demonstrated current competence in providing care in that area.
(f) The written policies and procedures for orientation of nursing staff shall require that all temporary personnel shall receive orientation and be subject to competency validation consistent with Sections 70016.1 and 70214 of Title 22 of the California Code of Regulations.
(g) Requests for waivers to this section that do not jeopardize the health, safety, and well-being of patients affected and that are needed for increased operational efficiency may be granted by the department to rural general acute care hospitals meeting the criteria set forth in Section 70059.1 of Title 22 of the California Code of Regulations.
(h) In case of conflict between this section and any provision or regulation defining the scope of nursing practice, the scope of practice provisions shall control.[93]

Other Staff

A charge nurse may:
(a) Take patient assignments, including patient assignments taken for the purpose of covering staff who are on meal breaks or rest breaks, in units with 10 or fewer beds;
(b) Take patient assignments, including patient assignments taken for the purpose of covering staff who are on meal breaks or rest breaks, in units with 11 or more beds with the approval of the hospital nurse staffing committee; and
(c) Be taken into account in determining the direct care registered nurse-to-patient ratio during periods when the charge nurse is taking patient assignments under this subsection.[94]

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[92] CA HSC 1276.4(l)
[93] CA HSC 1276.4 (d)-(h)
[94] ORS 441.765(8)

CBA Compliance

A hospital shall provide for meal breaks and rest breaks in accordance with ORS 653.261, and rules implementing ORS 653.261, and any applicable collective bargaining agreement.[95]

[95] ORS 441.765(5)