HEALTH CARE

Legal News Alert™

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Illinois Hospitals Face Conflicting Requirements Regarding Nurse Staffing

On October 19, 2007, the Illinois Department of Public Health (Department) published final rules (1) prohibiting mandatory overtime for nurses and (2) imposing staffing ratios based upon patient acuity and the capabilities of the nursing staff. The regulations mirror legislation passed by the Illinois General Assembly in 2005 and 2007, respectively.

Both regulations are reasonable when viewed in isolation, as they seek to improve quality of care. The prohibition on mandatory overtime seeks to reduce the potential for errors, or near misses, due to fatigue; while the staffing ratios aim to staff patient units at levels commensurate with patient acuity. However, in application, these two regulations are moving in opposite directions. The prohibition on mandatory overtime limits the hours hospitals can require nurses to work, which thereby limits staffing availability, while the staffing ratios require hospitals to staff patient units based upon acuity, which generally requires hospitals to provide more staffing. Given the current nursing shortage in Illinois, it may be very difficult for Illinois hospitals to comply simultaneously with both regulations.

The Mandatory Overtime Prohibition

On July 28, 2005, the Nurse Mandated Overtime Prohibition was signed into law. The purpose of the law was to stop the nursing shortage by addressing the mandatory overtime issue for nurses. The statute prohibits hospitals from requiring nurses to work mandated overtime "except in the case of an 'unforeseen emergent circumstance'[1] when such overtime is required only as a last resort." However, mandated overtime provides only limited relief as it can be used only in two narrowly construed circumstances; overtime hours are capped at four hours beyond a nurse's agreed-to predetermined shift.

Unforeseen emergent circumstances ***do not include*** situations in which the hospital fails to have sufficient nursing staff to the meet the ***reasonably predictable*** nursing needs of its patients. (Emphasis added.) Additionally, a hospital cannot retaliate against a nurse who refuses to work mandated overtime, and the statute significantly curtails hospitals' use of mandatory overtime. Furthermore, it exacerbates the current coverage gaps in nursing care as hospitals can no longer utilize mandatory overtime to alleviate regular coverage gaps in patient care.

[1] An "unforeseen emergent circumstance" is limited to the following:
1. Any declared national, state, or municipal disaster or other catastrophic event, or any implementation of a hospital's disaster plan, that will substantially affect or increase the need for health care services
2. Any circumstance in which patient care needs require specialized nursing skills through the completion of a procedure.

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In addition to prohibiting mandatory overtime, the statute also requires hospitals to provide nursing staff with sufficient off-duty time for shifts up to 12 hours. Specifically, the statute requires a hospital to provide a nurse with at least eight consecutive hours of off-duty time immediately following a shift where the nurse was mandated to work up to 12 consecutive hours.

A nurse required to work overtime against his or her will may file a complaint with the Department within 45 days of the date the employee was required to work overtime. The Department, after notice and hearing, may deny, suspend, or revoke a hospital's license if it finds there was clear and convincing evidence that the complainant was required to work overtime against his or her will and no unforeseen emergent circumstance existed.

On October 19, 2007, the Department published final rules regarding the prohibition of mandatory overtime. The regulations mirror the nurse-mandated overtime prohibition statute with the exception that the regulations also address mandatory on-call hours. Under the regulation, nurses who do not agree to on-call hours as a condition of employment cannot be subjected to retaliation, nor can they be discriminated against, dismissed, discharged, or penalized for refusing to agree to on-call availability. Additionally, the regulation requires the hospital's staffing plan to include an on-call policy for those patient units where on-call is required as a condition of employment. Finally, the regulation prohibits the use of on-call to fill chronic and foreseeable coverage gaps.

Nurse Staffing by Patient Acuity

On August 24, 2007, the Nursing Care and Quality Improvement Act was signed into law. The law, which goes into effect on January 1, 2008, amends the Hospital Licensing Act to better meet patients' needs by requiring hospitals to create and implement a written staffing plan that will strategically assign nurses and place restrictions on the number of patients a nurse can care for at any one time, based upon the patients' acuity and needs. Specifically, the statute requires every hospital "to implement a written hospital wide staffing plan, recommended by a nursing care committee or committees that provides for minimum direct care professional registered nurse-to-patient staffing needs for each inpatient care unit." (Emphasis added.) The staffing plan must include the following:

A. The complexity of complete care, assessment on patient admission; volume of patient admissions, discharges, and transfers; evaluation of the progress of a patient's problems; ongoing physical assessments; planning for a patient's discharge; assessment after a change in a patient's condition; and assessment of the need for patient referrals

B. The complexity of clinical professional nursing judgment needed to design and implement a patient's nursing care plan; the need for specialized equipment or technology; the skill or other mix of other personnel providing or supporting direct patient care and involvement in quality improvement activities; professional preparation; and experience

C. Patient acuity and the number of patients for whom care is being provided

D. The ongoing assessments of a unit's patients' acuity levels, and nursing staff needed, shall be routinely made by the unit nurse or his or her designee

E. The identification of additional registered nurses for direct patient care when patients' unexpected needs exceed the planned workload for direct care staff

Compliance with the requirement that hospitals identify additional registered nurses to provide direct patient care when patients' needs exceed the planned staffing levels will prove difficult for most hospitals. As discussed above, hospitals are prohibited from requiring nurses to work overtime except "in the case of an unforeseen emergent circumstance when such overtime is required only as a last resort." Because "unforeseen emergent circumstances" specifically exclude "situations in which the hospital fails to have enough nursing staff to meet the ***usual and reasonably predictable*** nursing needs of its patients," it is unclear whether patients' "unexpected needs" would constitute an unforeseen emergent circumstance. (Emphasis added.) Therefore, it is uncertain whether hospitals could require nurses to work overtime to provide the appropriate level of care to patients with "unexpected needs." Even if such a circumstance is considered to be

unforeseen emergent, the mandated overtime shift cannot exceed four hours. As a result, hospitals will still have to obtain coverage for the remaining four hours of the shift.

Because a hospital wide staffing plan must be recommended by the nursing care committee, and the statute requires each hospital to establish a nursing care committee, at least 50 percent of the members of the nursing care committee appointed by a hospital must be registered professional nurses providing direct patient care. The nursing care committee must develop a staffing plan based upon the staffing plan requirements set forth above, and the hospital must give significant weight to the nursing care committee's recommendation when adopting and implementing a staffing plan. Additionally, the nursing care committee must semi-annually provide input and feedback on the following:

A. Selection, implementation, and evaluation of minimum staffing levels for inpatient care units

B. Selection, implementation, and evaluation of an acuity model to provide staffing flexibility that aligns changing patient acuity with nursing skills required

C. Selection, implementation, and evaluation of a written staffing plan incorporating the staffing plan requirements set forth above

D. Review of nurse-to-patient staffing guidelines for all inpatient areas; and current acuity tools and measures in use

The staffing level regulation essentially implements a hospital's staffing plan. Specifically, the regulation requires: (a) the staffing ratio on each patient care unit to be consistent with patient acuity; (b) the capabilities of the nursing staff; and (c) patients' evaluations of each unit near the end of each shift based upon criteria developed by the nursing service — such as the hospital staffing plan — to determine the actual staffing required for the hospital and each patient unit. Additionally, nursing staff schedules must be available upon request at each patient care unit for the effective date of the schedule. Hospitals must maintain the nursing staff schedules for a period of five years from the date of their expiration. In addition, all nursing staff schedules and the methods for determining staffing levels must be made available to the public upon request, and must be maintained by the hospital for no less than five years. Finally, hospitals covered by the Hospital Report Card Act are prohibited from penalizing, discriminating, or retaliating against an employee who in good faith reports violations of the Hospital Licensing Act or the Hospital Report Card Act.

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