Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 596 (Menjivar) – As Amended July 3, 2025

SENATE VOTE: 24-10

SUBJECT: Health facilities: administrative penalties.

SUMMARY: Makes changes to provisions of existing law related to the enforcement of the nurse-to-patient ratio requirements including: creating a definition of an on-call list and documentation that hospitals have used and exhausted that list before qualifying for an exemption from staffing violation penalties, prohibiting alleged violations of the nurse-to-patient ratios that occurred on different days from being counted as a single violation, and creating a clear timeline for violations to be investigated. Specifically, **this bill**:

1) Requires, when the California Department of Public Health (DPH) receives a complaint alleging a violation of the nurse-to-patient ratio regulations that does not involve a threat of imminent danger of death or serious bodily harm, DPH to commence an inspection or investigation within 10 business days, and to complete that investigation within 60 days.

2) Requires DPH to treat violations on separate days as separate violations.

3) Defines an "on-call list" to be comprised of nurses who are scheduled to be on call for the shift and unit where an alleged nurse-to-patient ratio violation occurred, or nurses who are assigned to a regularly scheduled float pool shift to cover any shortages across one or more specified units. Prohibits a hospital contacting, or attempting to contact, licensed nurses who are not scheduled to be on call and who are not assigned to a float pool for the unit and shift where an alleged violation occurred from being considered as exhausting an on-call list.

EXISTING LAW:

1) Licenses and regulates health facilities by DPH, including general acute care hospitals (GACHs), acute psychiatric hospitals (APHs), and special hospitals. [Health and Safety Code (HSC) § 1250 *et seq*.]

2) Requires DPH to adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios, by licensed nurse classification and by hospital unit, for hospitals, and requires these ratios to constitute the minimum number of registered and licensed nurses that must be allocated. [HSC § 1276.4]

3) Requires the regulations adopted for APHs that are not operated by the Department of State Hospitals (DSH) to take into account the special needs of the patients served in the psychiatric units. [HSC § 1276.4(k)]

4) Establishes, in regulations, required nurse-to-patient ratios by unit or clinical area in GACHs. These ratios range from a minimum of one nurse to two patients in critical care units (1:2), 1:4 in an emergency department, and 1:6 in a medical/surgical unit, among other ratios for specific units. [Title 22, California Code of Regulations (CCR) § 70217]

5) Permits DPH to assess an administrative penalty against a hospital, for a deficiency constituting an immediate jeopardy violation, as defined, up to a maximum of $75,000 for the first administrative penalty, up to $100,000 for the second administrative penalty, and up to $125,000 for the third and every subsequent administrative penalty. [HSC § 1280.3 (a)]

6) Permits DPH to assess an administrative penalty of up to $25,000 per violation for those not deemed to constitute immediate jeopardy. Prohibits DPH from assessing an administrative penalty for minor violations. [HSC § 1280.3 (b) and (c)]

7) Requires DPH, notwithstanding the penalty provisions for other violations as described in 5) and 6) above, to assess hospitals a $15,000 penalty for a first violation of nurse-to-patient staffing ratios, and $30,000 for the second and each subsequent violation. Specifies that a GACH is not subject to an administrative penalty if the hospital can demonstrate to the satisfaction of DPH all of the following:

   a) That any fluctuation in required staffing levels was unpredictable and uncontrollable;

   b) Prompt efforts were made to made to maintain required staffing levels; and,

   c) In making these efforts, the hospital immediately used and subsequently exhausted the hospitals on-call list of nurses and the charge nurse. [HSC § 1280.3(f)]

8) Requires DPH, when it receives a report or complaint that indicates an ongoing threat of imminent danger of death or serious bodily harm, to make an onsite inspection or investigation within 48 hours or two business days, whichever is greater, and to complete that investigation within 45 days. [HSC § 1279.2(a)]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown, ongoing costs for DPH to meet the requirements for licensing investigations (Licensing and Certification Fund).

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, the enactment of nurse-to-patient ratios in California more than twenty years ago has improved patient outcomes but more needs to be done to close some existing gaps. In an acknowledgement that hospitals can make a good faith effort and still have situations that result in a staffing shortage, the law provided that a hospital would not be subject to financial penalties if, among other things, hospitals "used and subsequently exhausted the hospital's on-call list of nurses and the charge nurse." However, there is no definition of what constitutes an "on-call list," and nurses have reported that hospitals have claimed that it "exhausted" an on-call list simply by calling a few nurses to see if they could cover a shift. The author states that is not anyone's definition of an on-call list, and was not the intent of the Legislature when passing the bill. This bill requires the on-call list to be comprised of nurses who are officially scheduled to be on call, and to be 10% of the nurse staff, a reasonable approximation of the flexibility a hospital should have to respond to an unexpected increase in patient volume as well as to cover nurses who cannot come into work for their regularly assigned shift. The author concludes that this bill also makes other clarifications to enforcement of nurse ratios, including clarifying that violations on separate days should be treated as separate violations,

and ensuring that nurses on the on-call list have verified competencies for the units for which they are on call.

2) BACKGROUND.

a) Nurse-to-patient ratios and patient classification systems. In 2004, regulations implementing nurse-to-patient ratios in California hospitals pursuant to AB 394 (Kuehl) Chapter 945, Statutes of 1999 went into effect. However, long before California had specific nurse-to-patient ratios, hospitals were required, by regulation, to establish a patient classification system. This patient classification system is a method by which hospitals establish staffing requirements by unit, patient, and shift, and includes a method by which the amount of nursing care needed for each category of patient is validated for each unit.

The regulations implementing the AB 394 nurse-to-patient ratios law set the minimum ratio of nurses to patient by unit. These regulations also incorporated the patient classification system requirement. In essence, the specific nurse-to-patient ratios establish the minimum number of nurses by unit, while the patient classification system determines whether there needs to be a higher level of staffing beyond the minimum ratio after taking into consideration factors such as the severity of the illness, the need for specialized equipment and technology, and the complexity of clinical judgment needed to evaluate the patient care plan, among other factors. The nurse-to-patient ratio regulations require that the minimum ratios must be met at all times. However, if a health care emergency causes a change in the number of patients on a unit, a hospital is required to demonstrate that prompt efforts were made to maintain required staffing levels.

b) "Float pools." A float pool is a group of staff who can be deployed to different units within a healthcare facility as needed. They can be nurses that are not assigned to a specific unit but are instead available to fill staffing gaps across various units, such as emergency rooms, intensive care units, or surgical wards. This model allows for greater flexibility in staffing and ensures that patient care remains uninterrupted during times of high demand or staff shortages. By utilizing float pool nurses, facilities can reduce reliance on external staffing agencies, leading to cost savings.

c) "On call" lists. Hospitals often use an on-call schedule to ensure that a specialist is available to deal with emergencies should the need arise. While ER doctors and nurses may work the night shift and provide care for the vast majority of the patients that come through the door, there may be issues that they cannot handle (for example, an acute case of appendicitis). In that case, they would contact the on-call surgeon, who would come in and perform the necessary procedure. Similarly, some hospitals maintain an "on call" list of nurses to contact when someone calls in sick, or the hospital is busier than expected.

d) Effectiveness of nurse-to-patient ratios. According to an early Nurse-to-Patient Ratio study by researchers at the University of Pennsylvania, "*Implications of the California Nurse Staffing Mandate for Other States*," 29% of nurses in California experienced high burnout, compared with 34% of nurses in New Jersey and 36% of nurses in Pennsylvania, states without minimum staffing ratios during the period of research. The study also found that 20% of nurses in California reported dissatisfaction with their jobs, compared with 26% and 29% in New Jersey and Pennsylvania. California nurse staffing ratios also accompanied a lower likelihood of in-patient death within 30 days of hospital admission

than in New Jersey or Pennsylvania; there was also a lower likelihood of death from failing to properly respond to symptoms.

e) Nurse-to-patient ratio enforcement. According to DPH, within the past three years, there were 1,328 complaints and facility-initiated incidents related to nurse-to-patient ratio violations. DPH notes that it can receive multiple complaints for the same violation, for example if three nurses at the same facility report the same understaffed shift. Each complaint is entered in the Electronic Licensing Management System, but district-level investigators may identify multiple complaints for the same violation and consolidate their investigation activities as appropriate. In this example, the system for tracking deficiencies will only reflect a single deficiency that was substantiated. Of the 1,328 complaints and facility-initiated incidents received in the past three years, 1,071 complaints and 28 facility-initiated incidents were substantiated with deficiencies, and all of these required a Plan of Correction. DPH imposed a fine for 25 of these violations, and five of those were issued in conjunction with a finding of harm to the patient. According to DPH, the most common units where staffing violations were found were the telemetry units (which is required to be at 1:5 nurse to patient ratio), medical/surgical units (1:5 ratio), and critical care units (1:2 ratio). DPH states that compliance with nurse staffing ratios is reviewed during the relicensing survey that is conducted every three years. Additionally, if a complaint is submitted, DPH will assign this to a nurse surveyor for investigation. According to DPH, nurse staffing was added to the statewide survey tool used during hospital inspections beginning in 2016. SB 227 (Leyva) Chapter 843, Statutes of 2019 provides fine authority specific to nurse-to-patient ratios, which is $15,000 for a first violation, and $30,000 for subsequent violations, with specified limitations.

AB 1063 (Gabriel) of 2024, among other provisions, would have required DPH to conduct an annual review of its enforcement of the nurse-to-patient ratios, and to submit a report to the Legislature on its findings, including the number of reports received alleging violations and the outcome of any investigations. The Governor vetoed this bill, and in his veto message, indicated that he was directing DPH to update their hospital citations tracking system to include a category specific to nurse-to-patient ratio violations, and to publish this on the Center for Health Care Quality's State Enforcement Tracking Dashboard (Dashboard).

On March 4, 2024, DPH updated the Electronic Licensing Management System to include a category specific to nurse-to-patient ratio violations, and that moving forward, this information (which is specific to when an administrative penalty has been assessed against a facility, and does not include all substantiated violations) will be available on the Dashboard. As of June 18, 2024, the Dashboard shows that there have been 13 enforcement actions related to nurse-to-patient ratios, which resulted in an administrative penalty (fine), totaling $345,000. The earliest citation that appears on the Dashboard was assessed in October of 2023, and the most recent was in May of this year. All assessments were either $15,000 for a first violation, or $30,000 for a repeat violation, pursuant to SB 227.

3) SUPPORT. The Service Employees International Union California State Council (SEIU) and United Nurses Associations of California/Union of Health Care Professionals (UNAC) are the cosponsors of this bill and state that this bill addresses critical issues related to

implementation of nurse-to-patient ratios by creating a common definition of on-call lists and documentation that hospitals have used and exhausted that list before qualifying for an exemption from staffing violation penalties, addressing the issue of complaint bundling, where hospitals reported that multiple complaints across multiple days are combined and treated as one violation, and creating a clear timeline for violations to be investigated.

4) **REMOVAL OF OPPOSITION**. The Association of California Health Care Districts (ACHD) writes to remove ACHD opposition to this bill, and states that as originally introduced, this bill would have imposed significant financial and logistical burdens that would have been untenable for these hospitals to meet. However, as amended to remove the 10% staffing requirement and to add clarity about what constitutes an on-call list, ACHD believes their concerns have largely been addressed. As now drafted, this bill is consistent with current law and does not expand existing staffing requirements.

5) **OPPOSITION**. The California Hospital Association (CHA) is opposed to this bill and states that as currently written this bill would disrupt current staffing processes and increase costs for all hospitals (including public hospitals), as well as the state of California. CHA continues that this bill would establish a specific definition of "on-call list" for registered nurse (RN) staff in the hospital, and would require an on-call list of nurses scheduled for a specific unit and shift. CHA contends that this does not consider how health care is currently provided — hospitals maintain on-call lists in various ways, tailored to best meet their patients' care needs and their unique operational dynamics. There is no one-size-fits-all answer for defining an on-call list, nor for determining who populates the list (be it scheduled on-call nurses, float pools, or nurse staffing agencies). CHA states that for some hospitals, the bill's requirements would disrupt existing scheduling systems that are designed to schedule and track call lists dynamically. Satisfying the bill's on-call list definition would be a significant administrative burden, requiring that hospitals either undergo major system redesigns or track on-call lists manually — both of which would be extremely problematic. CHA also argues that the variation in nursing specialties could make it difficult to have the appropriate specialty RNs on-call for each shift, given the differing needs and requirements of certain hospital units. CHA continues that it is also important to note that some hospitals' collective bargaining agreements include provisions related to assigned/scheduled on-call pay and status — and this bill would likely conflict with those provisions. CHA concludes that beyond operational and implementation challenges, this bill would significantly increase the cost of care at a time when California can least afford it. In most contracts, nurses receive 50% of their base hourly rate during on-call hours, and all call-back hours are compensated at time and a half. Increasing the number of on-call staff — without consideration of what the hospital and its patients actually need — would drive up staffing expenses.

   The Alliance of Catholic Health Care (ACHC) is opposed to this bill and states that nursing is essential in ACHC hospitals, and nurses are often required to be flexible and make real-time staffing decisions based on constantly changing conditions like patient acuity levels, emergencies, and operational challenges. Therefore, scheduling and staffing decisions should be entrusted to clinical professionals. ACHC contends that on-call staffing requirements are a rigid approach that fails to account for the dynamic nature and unique circumstances of healthcare and each patient. ACHC also notes that they concerned that the mandatory on-call shifts would increase rates of burnout for our nursing staff. Nurse burnout has become increasingly common within the last few years due to increased rules and regulations.

6) **RELATED LEGISLATION**. AB 116 (Committee on Budget) Chapter 21, Statutes of 2025, specifies that regulations for APHs not operated by DSH are deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare, and would require DPH to adopt emergency regulations for these facilities no later than January 31, 2026, and permanent regulations thereafter. Authorizes DPH to readopt the emergency regulations. Authorizes the emergency regulations to include, among other things, staffing standards specific to APHs.

7) **PREVIOUS LEGISLATION**.

   a) AB 2899 (Gabriel) of 2024 would have required DPH, when it transmits to a hospital the action to be taken on a substantiated violation of nurse to patient staffing ratios, to simultaneously transmit the same information to the person who filed the claim of violation, and if the action taken did not include a fine, to include a statement of reasoning for not imposing a fine. AB 2899 was vetoed by Governor Newsom, who stated: "Currently, DPH publicly posts detailed findings of its investigations of nurse-to-patient ratios on its Cal Health Find Database website and informs the complainant of the action. The publicly posted information includes a description of the investigation, DPH's determinations, and the evidence considered. The database also includes the number of penalties assessed against a facility for nurse-to-patient ratio violations. Nurse-to-patient ratios are important and DPH takes reports of potential violations seriously. However, the requirements of AB 2899 are duplicative."

   b) AB 1063 (Gabriel) of 2023 would have required DPH to conduct an annual review of its enforcement of the nurse-to-patient ratios, and to submit a report to the Legislature on its findings, including the number of reports received alleging violations and the outcome of any investigations. AB 1063 would have additionally required DPH, at least once every two years, to hold a public hearing to receive input from direct care nurses and other stakeholders, and requires the input to be summarized in the report along with a plan to implement the suggestions received, or an explanation as to why those suggestions were rejected. AB 1063 was vetoed by Governor Newsom, who stated: "I agree it is important to ensure nurse-to-patient staffing ratios are enforced properly for patient safety and maintaining the nursing workforce. However, much of the information this bill seeks to document is already publicly available. Further, this Administration prioritizes ongoing and open engagement with stakeholders. A biennial, public hearing is unnecessary for the state to receive input and make changes. I am directing DPH to continue actively consulting with nurses and their representative labor groups to identify additional opportunities to increase transparency and communication. Further, I have asked DPH to update their hospital citations tracking system to include a category specific to nurse-to-patient ratio violations, and to publish this on the State Enforcement Tracking Dashboard."

   c) AB 1422 (Gabriel), Chapter 716, Statutes of 2022 requires applications by health facilities for program flexibility to designate a bed in a critical care unit as requiring a lower level of care to be posted on DPH's website, and requires DPH to solicit public comment on the application for at least 30 days.

   d) SB 637 (Newman) of 2021, as passed by the Senate Health Committee, would have required hospitals to report weekly during a health-related state of emergency, and

monthly at all other times, information on whether the hospital is experiencing a staffing shortage of nurses, or has experienced any layoffs, furloughs, or repeated shift cancellations of nurses. SB 637 would have required hospitals to report weekly during a health-related state of emergency, and monthly at all other times, until January 1, 2025, information regarding COVID-19-positive staff, including number of staff and facility personnel who have tested positive, or are suspected positive, and total number of deaths of staff who are positive or suspected positive for COVID-19. Additionally, SB 637 would have required a licensed health facility to post any approval granted by DPH for program flexibility immediately adjacent to the health facility's license. These provisions were amended out of SB 637.

e) SB 227 (Leyva) Chapter 843, Statutes of 2019 requires periodic inspections of hospitals by DPH to include reviews of compliance with nurse staffing ratios, and establishes administrative penalties for nurse staffing ratio violations of $15,000 for a first violation, and $30,000 for each subsequent violation.

f) SB 455 (Hernandez) of 2013, would have codified existing regulations requiring hospitals to have a committee annually review the reliability of its patient classification system, including regulations requiring at least one-half of this committee be composed of registered nurses (RNs) who provide direct patient care. SB 455 would have required the RNs appointed to this committee to be selected by the collective bargaining agent, if any. SB 455 would have required DPH, during every periodic state inspection of a hospital, to inspect for compliance with nurse-to-patient ratios, as specified. SB 455 was vetoed by Governor Brown, who stated that it restated existing law, which requires DPH to inspect hospital compliance with nurse-to-patient rations, and that the bill directs decisions that are best left at the local level.

g) SB 360 (Yee) of 2009 would have required each new direct care registered nursing hire to receive and complete an orientation to the hospital and patient care unit in which they will be working. Under SB 360, nurses who have not completed this orientation would not be allowed to be assigned to direct patient care or be counted as staff in computing nurse-to-patient ratios. SB 360 was held on the Senate Appropriations suspense file.

h) AB 394 (Kuehl) Chapter 945, Statutes of 1999 requires DPH to adopt regulations specifying nurse-to-patient ratios, by unit, for GACHs, APHs and special hospitals. AB 394 requires hospitals to adopt written policies and procedures for nursing staff training. AB 394 requires the ratios to constitute the minimum number of registered and licensed nurses that must be provided; and, requires hospitals to assign additional staff in accordance with a documented patient classification system.

8) POLICY COMMENT. As noted above, this bill was recently amended to remove the 10% on-call staffing requirement and to add clarity about what constitutes an on-call list. However, as CHA notes in their opposition, not all hospitals use the same methods to create their on-call list and/or float pools. Moving forward, the author may wish to amend this bill to provide more flexibility to hospitals in how they meet the requirements of this bill.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Council of Service Employees International Union (co-sponsor)
United Nurses Associations of California/Union of Health Care Professionals (co-sponsor)

Opposition

Alliance of Catholic Health Care, Inc.
California Association of Public Hospitals & Health Systems
California Hospital Association
Valley Industry and Commerce Association (VICA)

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097