SENATE THIRD READING
SB 596 (Menjivar)
As Amended September 2, 2025
Majority vote

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 and prohibiting alleged violations of the nurse-to-patient ratios that occurred on different days from being counted as a single violation.

COMMENTS

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.

"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.

"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.

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.

Nurse-to-patient ratio enforcement. According to the Department of Public Health (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.

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 for the shift and unit where an alleged violation occurred, or nurses who are assigned to a regularly scheduled float pool shift to cover any shortage cross one or more specified units.

Arguments in 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.

Arguments in Opposition
The California Hospital Association (CHA) is opposed to this bill and states that this bill 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. CHA contends that 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 argues that for some hospitals, the bill's requirements would disrupt existing scheduling systems that are designed to schedule and track call lists dynamically and that 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 contends 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. 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 further argues 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. CHA concludes that increasing the number of on-call staff — without consideration of what the hospital and its patients actually need — would drive up staffing expenses.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, there are no state costs associated with this bill.

VOTES

SENATE FLOOR: 24-10-6
YES: Allen, Arreguín, Becker, Cabaldon, Caballero, Cervantes, Cortese, Durazo, Gonzalez, Grayson, Hurtado, Laird, Limón, McGuire, McNerney, Menjivar, Padilla, Pérez, Richardson, Rubio, Smallwood-Cuevas, Stern, Wahab, Wiener
NO: Alvarado-Gil, Choi, Dahle, Grove, Jones, Niello, Ochoa Bogh, Seyarto, Strickland, Valladares
ABS, ABST OR NV: Archuleta, Ashby, Blakespear, Reyes, Umberg, Weber Pierson

ASM HEALTH: 12-2-2
YES: Bonta, Addis, Aguiar-Curry, Caloza, Carrillo, Mark González, Krell, Patel, Celeste Rodriguez, Schiavo, Sharp-Collins, Stefani
NO: Patterson, Sanchez
ABS, ABST OR NV: Chen, Flora

ASM APPROPRIATIONS: 10-4-1
YES: Wicks, Arambula, Calderon, Caloza, Elhawary, Fong, Mark González, Ahrens, Pellerin, Solache
NO: Sanchez, Dixon, Ta, Tangipa
ABS, ABST OR NV: Pacheco

UPDATED

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