SB2795

LRB10334815SPS64670b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB2795

Introduced 1/17/2024, by Sen. Michael W. Halpin

SYNOPSIS AS INTRODUCED:

See Index

Creates the Safe Patient Limits Act. Provides the maximum number of patients that may be assigned to a registered nurse in specified situations. Provides that nothing shall preclude a facility from assigning fewer patients to a registered nurse than the limits provided in the Act. Provides that the maximum patient assignments may not be exceeded, regardless of the use and application of any patient acuity system. Requires the Department of Public Health to adopt rules governing the implementation and administration of the Act. Provides that all facilities shall adopt written policies and procedures for the training and orientation of nursing staff and that no registered nurse shall be assigned to a nursing unit or clinical area unless that nurse has, among other things, demonstrated competence in providing care in that area. Provides requirements for the Act's implementation. Establishes recordkeeping requirements. Provides rights and protections for nurses. Contains a severability provision and other provisions. Amends the Hospital Licensing Act. Provides that a hospital shall not mandate that a registered professional nurse delegate nursing interventions. Makes changes concerning staffing plans. Amends the Nurse Practice Act. Requires the exercise of professional judgment by a direct care registered professional nurse in the performance of his or her scope of practice to be provided in the exclusive interests of the patient. Ratifies and approves the Nurse Licensure Compact, which allows for the issuance of multistate licenses that allow nurses to practice in their home state and other compact states. Provides that the Compact does not supersede existing State labor laws. Provides that the State may not share with or disclose to the Interstate Commission of Nurse Licensure Compact Administrators or any other state any of the contents of a nationwide criminal history records check conducted for the purpose of multistate licensure under the Nurse Licensure Compact.

LRB103 34815 SPS 64670 b

A BILL FOR

AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Safe Patient Limits Act.

Section 5. Definitions. In this Act:

"Couplet" means one postpartum patient and one baby.

"Critical trauma patient" means a patient who has an injury to an anatomic area that (i) requires life-saving interventions or (ii) in conjunction with unstable vital signs, poses an immediate threat to life or limb.

"Department" means the Department of Public Health.

"Direct care registered professional nurse" means a registered professional nurse who has accepted a hands-on, in-person patient care assignment and whose primary role is to provide hands-on, in-person patient care.

"Facility" means a hospital licensed under the Hospital Licensing Act or organized under the University of Illinois Hospital Act, a private or State-owned and State-operated general acute care hospital, an LTAC hospital as defined in Section 10 of the Long Term Acute Care Hospital Quality Improvement Transfer Program Act, an ambulatory surgical treatment center as defined in Section 3 of the Ambulatory

Surgical Treatment Center Act, a freestanding emergency center licensed under the Emergency Medical Services (EMS) Systems Act, a birth center licensed under the Birth Center Licensing Act, an acute psychiatric hospital, an acute care specialty hospital, or an acute care unit within a health care facility.

"Health care emergency" means an emergency that is declared by an authorized person within federal, State, or local government and is related to circumstances that are unpredictable and unavoidable, affect the delivery of medical care, and require an immediate or exceptional level of emergency or other medical services at the specific facility. "Health care emergency" does not include a state of emergency that results from a labor dispute in the health care industry or consistent understaffing.

"Health care workforce" means personnel employed by or contracted to work at a facility that have an effect upon the delivery of quality care to patients, including, but not limited to, registered nurses, licensed practical nurses, unlicensed assistive personnel, service, maintenance, clerical, professional, and technical workers, and other health care workers.

"Immediate postpartum patient" means a patient who has given birth within the previous 2 hours.

"Nursing care" means care that falls within the scope of practice described in Section 55-30 or 60-35 of the Nurse Practice Act or is otherwise encompassed within recognized

standards of nursing practice.

"Rapid response team" means a team of health care providers that provide care to patients with early signs of deterioration to prevent respiratory or cardiac arrest.

"Registered nurse" or "registered professional nurse" means a person who is licensed as a registered professional nurse under the Nurse Practice Act and practices nursing as described in Section 60-35 of the Nurse Practice Act.

"Specialty care unit" means a unit that is organized, operated, and maintained to provide care for a specific medical condition or a specific patient population.

Section 10. Maximum patient assignments for registered nurses.

(a) The maximum number of patients assigned to a registered nurse in a facility shall not exceed the limits provided in this Section. However, nothing shall preclude a facility from assigning fewer patients to a registered nurse than the limits provided in this Section. The requirements of this Section apply at all times during each shift within each clinical unit and each patient care area. For the purposes of this Act, a patient is assigned to a registered nurse if the registered nurse accepts responsibility for the patient's nursing care.

(b) In all units with critical care or intensive care patients, including, but not limited to, coronary care, acute

respiratory care, medical, burn, pediatric, or neonatal intensive care patients, the maximum patient assignment of critical care patients to a registered nurse is one.

(c) In all units with step-down or intermediate intensive care patients, the maximum patient assignment of step-down or intermediate intensive care patients to a registered nurse is 3.

(d) In all units with postanesthesia care patients, regardless of the type of anesthesia administered, the maximum patient assignment of postanesthesia care patients or patients being monitored for the effects of any anesthetizing agent to a registered nurse is one.

(e) In all units with operating room patients, the maximum patient assignment of operating room patients to a registered nurse is one, provided that a minimum of one additional person serves as a scrub assistant for each patient.

(f) In the emergency department:

(1) In a unit providing basic emergency services or comprehensive emergency services, the maximum patient assignment at any time to a registered nurse is 3.

(2) The maximum assignment of critical care emergency patients to a registered nurse is one. A patient in the emergency department shall be considered a critical care patient when the patient meets the criteria for admission to a critical care service area within the facility.

(3) The maximum assignment of critical trauma patients

in an emergency unit to a registered nurse is one.

(4) At least one direct care registered professional nurse shall be assigned to triage patients. The direct care registered professional nurse assigned to triage patients shall be immediately available at all times to triage patients when they arrive in the emergency department. The direct care registered professional nurse assigned to triage patients shall perform triage functions only and may not be assigned the responsibility of the base radio. Triage, radio, or flight registered nurses shall not be counted in the calculation of direct care registered nurse staffing levels.

(g) In all units with maternal child care patients the maximum patient assignment:

(1) to a registered nurse of antepartum patients requiring continuous fetal monitoring is 2;

(2) of other antepartum patients who are not in active labor to a registered nurse is 3;

(3) of active labor patients to a registered nurse is one;

(4) of patients with medical or obstetrical complications during the initiation of epidural anesthesia or during circulation for a caesarean section delivery to a registered nurse is one;

(5) during birth is one registered nurse responsible for the patient in labor and, for each newborn, one

registered nurse whose sole responsibility is that newborn patient;

(6) of postpartum patients when the parent has given birth within the previous 2 hours is one registered nurse for each couplet, and in the case of multiple births, one registered nurse for each additional newborn;

(7) of couplets to a registered nurse is 2;

(8) of patients receiving postpartum or postoperative gynecological care to a registered nurse is 4 when the registered nurse has been assigned only to patients receiving postpartum or postoperative gynecological care;

(9) of newborn patients when the patient is unstable, as assessed by a direct care registered professional nurse, to a registered nurse is one; and

(10) of newborn patients to a registered nurse is 2 when the patients are receiving intermediate care or the nurse has been assigned to a patient care unit that receives newborn patients requiring intermediate care, including, but not limited to, an intermediate care nursery.

(h) In all units with pediatric patients, the maximum patient assignment of pediatric patients to a registered nurse is 3.

(i) In all units with psychiatric patients, the maximum patient assignment of psychiatric patients to a registered nurse is 4.

(j) In all units with medical and surgical patients, the maximum patient assignment of medical or surgical patients to a registered nurse is 4.

(k) In all units with telemetry patients, the maximum patient assignment of telemetry patients to a registered nurse is 3.

(l) In all units with observational patients, the maximum patient assignment of observational patients to a registered nurse is 3.

(m) In all units with acute rehabilitation patients, the maximum patient assignment of acute rehabilitation patients to a registered nurse is 4.

(n) In all units with conscious sedation patients, the maximum patient assignment of conscious sedation patients to a registered nurse is one.

(o) In any unit not otherwise listed in this Section, including all specialty care units not otherwise listed in this Section, the maximum patient assignment to a registered nurse is 4.

Section 15. Use of rapid response teams as first responders prohibited. A rapid response team's registered nurse shall not be given direct care patient assignments while assigned as a registered nurse who is responsible for responding to a rapid response team request.

Section 20. Implementation by a facility.

(a) A facility shall implement the patient limits established under Section 10 without diminishing the staffing levels of the facility's health care workforce. A facility may not lay off licensed practical nurses, licensed psychiatric technicians, certified nursing assistants, or other ancillary support staff to meet the patient limits under Section 10.

(b) Each patient shall be assigned to a direct care registered professional nurse who shall directly provide the comprehensive patient assessment, development of a plan of care, and supervision, implementation, and evaluation of the nursing care provided to the patient at least every shift and who has the responsibility for the provision of care to a particular patient within the registered nurse's scope of practice.

(c) There shall be no averaging of the number of patients and the total number of registered nurses in each clinical unit or patient care area in order to meet the patient limits under Section 10.

(d) Only registered nurses providing direct patient care shall be considered when evaluating compliance with the patient limits under Section 10. Ancillary staff and unlicensed personnel shall not be considered when evaluating compliance with the patient limits under Section 10.

(e) The hours in which a nurse administrator, nurse supervisor, nurse manager, charge nurse, and other licensed

nurse provides patient care shall not be considered when evaluating compliance with the patient limits under Section 10 and with the patient assignment requirement under subsection (b) unless the registered nurse:

(1) has a current and active direct patient care assignment;

(2) provides direct patient care in compliance with this Act;

(3) has demonstrated the registered nurse's competence in providing care in the registered nurse's assigned unit to the facility; and

(4) has the principal responsibility of providing direct patient care and has no additional job duties during the time period during which the nurse has a patient assignment.

(f) The hours in which a nurse administrator, nurse supervisor, nurse manager, charge nurse, or other licensed nurse provides direct patient care may be considered when evaluating compliance with the patient limits under Section 10 and with the patient assignment requirement under subsection (b) only if he or she is providing relief for a direct care registered professional nurse during breaks, meals, and other routine and expected absences from that unit.

(g) At all times during each shift within a facility unit, clinical unit, or patient care area of a facility, and with the full complement of ancillary support staff, at least 2 direct

care registered nurses shall be physically present in each facility unit, clinical unit, or patient care area where a patient is present.

(h) Identifying a clinical unit or patient care area by a name or term other than those listed in this Act does not affect a facility's requirement to staff the unit consistent with the patient limits identified for the level of intensity or type of care described in this Act.

(i) A registered nurse providing direct care to a patient has the authority to determine if a change in the patient's status places the patient in a different category requiring a different patient limit under Section 10.

(j) A facility shall assign direct care professional registered nurses in a patient care unit in accordance with Section 10 in order to meet the highest level of intensity and type of care provided in the patient care unit. If multiple assignments described under Section 10 apply to a patient, the facility shall assign a direct care professional registered nurse in accordance with the lowest numerical patient assignment under that Section.

(k) A facility shall provide staffing of direct care registered professional nurses above the number of direct care registered professional nurses required to comply with the patient levels under Section 10, or additional staffing of licensed practical nurses, certified nursing assistants, or other licensed or unlicensed ancillary support staff, based on

the direct care registered professional nurse's assessment of each assigned individual patient, the individual patient's nursing care requirements, and the individual patient's nursing care plan.

(l) A facility shall not employ video monitors, remote patient monitoring, or any form of electronic visualization of a patient as a substitute for the direct in-person observation required for patient assessment by a registered nurse or for patient protection. Video monitors or any form of electronic visualization of a patient shall not constitute compliance with the patient limits under Section 10.

(m) A facility must provide relief by a direct care registered professional nurse with unit-specific education, training, and competence during another direct care registered professional nurse's meal periods, breaks, and routine absences as part of the facility's obligation to meet the patient limits under Section 10 at all times.

Section 25. Changes in patient census.

(a) A facility shall plan for routine fluctuations in its patient census, including, but not limited to, admissions, discharges, and transfers.

(b) If a health care emergency causes a change in the number of patients in a clinical care unit or patient care area, the facility must be able to demonstrate that immediate and diligent efforts were made to maintain required staffing

levels under this Act.

(c) A facility shall immediately notify the Department if a health care emergency described under subsection (b) causes a change in the number of patients in a clinical care unit or patient care area and shall report to the Department efforts made to maintain staffing levels required under this Act.

Section 30. Record of staff assignments.

(a) A facility shall keep a record of the actual direct care registered professional nurse, licensed practical nurse, certified nursing assistant, and other ancillary staff assignments to individual patients documented on a day-to-day, shift-by-shift basis, shall submit copies of its records to the Department quarterly, and shall keep copies of its staff assignments on file for a period of 7 years.

(b) The documentation required under subsection (a) shall be submitted to the Department as a mandatory condition of licensure. The documentation shall be submitted with a certification by the chief nursing officer of the facility that the documentation completely and accurately reflects registered nurse staffing levels by the facility for each shift in each facility unit, clinical unit, and patient care area in which patients receive care. The chief nursing officer shall execute the certification under penalty of perjury and the certification must contain an expressed acknowledgment that any false statement constitutes fraud and is subject to

criminal and civil prosecution and penalties.

Section 35. Implementation by the Department. The Department shall adopt rules governing the implementation and administration of this Act, including methods for facility staff, facility staff's collective bargaining representatives, and the public to file complaints regarding violations of this Act with the Department. The Department shall conduct periodic audits to ensure compliance with this Act.

Section 40. Nursing staff education, training, and orientation.

(a) A facility shall adopt written policies that include, but are not limited to:

(1) procedures for the education, training, and orientation of nursing staff to each clinical area where the nursing staff will work; and

(2) criteria for the facility to use in determining whether a registered nurse has demonstrated current competence in providing care in a clinical area.

(b) A registered nurse shall not be assigned to a facility unit, clinical unit, or patient care area unless the registered nurse has first received education, training, and orientation in that clinical area that is sufficient to provide safe, therapeutic, and competent care to patients in that clinical area and has demonstrated competence in

providing care in that clinical area.

(c) A registered nurse shall not be assigned to relieve a direct care professional registered nurse during breaks, meals, and routine absences from a facility unit, clinical unit, or patient care area unless that registered nurse has first received education, training, and orientation in that clinical area that is sufficient to provide safe, therapeutic, and competent care to patients in that clinical area and has demonstrated competence in providing care in that clinical area.

(d) A health care facility may not assign any nursing personnel from a temporary nursing agency to the facility's unit, clinical unit, or patient care area unless the nursing personnel have first received education, training, and orientation in that clinical area that is sufficient to provide safe, therapeutic, and competent care to patients in that clinical area and have demonstrated competence in providing care in that clinical area.

Section 45. Enforcement.

(a) In addition to any other penalty prescribed by law, the Department may impose a civil penalty against a facility that violates this Act of up to $25,000 for each violation, except that the Department shall impose a civil penalty of at least $25,000 for each violation if the Department determines that the health care facility has a pattern of violation. A

separate and distinct violation shall be deemed to have been committed on each day during which any violation continues after receipt of written notice of the violation from the Department by the facility.

(b) The Department shall post on its website the names of facilities against which civil penalties have been imposed under this Act, the violation for which the penalty was imposed, and additional information as the Department deems necessary.

(c) A facility's failure to adhere to the patient assignment limits under Section 10, any other violation of this Act, or any violation of Section 10.10 of the Hospital Licensing Act shall be reported by the Department to the Attorney General for enforcement, for which the Attorney General may bring action in a court of competent jurisdiction seeking injunctive relief and civil penalties.

(d) It is a defense to an enforcement action under this Act if the facility demonstrates that a health care emergency was in force at the time of the alleged violation and that the facility made immediate and diligent efforts to maintain staffing levels required under this Act.

Section 50. Nurse rights and protections.

(a) A registered professional nurse may object to or refuse to participate in any activity, practice, assignment, or task if:

(1) in good faith, the registered nurse reasonably believes it to be a violation of the direct care registered professional nurse maximum patient assignments or any other provision established under this Act or a rule adopted by the Department under this Act;

(2) the registered nurse, based on the registered nurse's nursing judgment, reasonably believes the registered nurse is not prepared by education, training, or experience to fulfill the assignment without compromising the safety of any patient or jeopardizing the license of the registered nurse; or

(3) in the registered nurse's nursing judgment, the activity, policy, practice, assignment or task would be outside the registered nurse's scope of practice or would otherwise compromise the safety of any patient or the registered nurse.

(b) A facility shall not retaliate, discriminate, or otherwise take adverse action in any manner with respect to any aspect of a nurse's employment, including discharge, promotion, compensation, or terms, conditions, or privileges of employment, based on the nurse's refusal to complete an assignment under subsection (a).

(c) A facility shall not file a complaint against a registered professional nurse with the Board of Nursing based on the nurse's refusal to complete an assignment under subsection (a).

(d) A facility shall not retaliate, discriminate, or otherwise take adverse action in any manner against any person or with respect to any aspect of a nurse's employment, including discharge, promotion, compensation, or terms, conditions, or privileges of employment, based on that nurse's or that person's opposition to any facility policy, practice, or action that the nurse in good faith believes violates this Act.

(e) A facility shall not retaliate, discriminate, or otherwise take adverse action against any patient or employee of the facility or any other individual on the basis that the patient, employee, or individual, in good faith, individually or in conjunction with another person or persons, has presented a grievance or complaint, initiated or cooperated in any investigation or proceeding of any governmental entity, regulatory agency, or private accreditation body, made a civil claim or demand, or filed an action relating to the care, services, or conditions of the facility or of any affiliated or related facility.

(f) A facility shall not:

(1) interfere with, restrain, or deny the exercise of, or attempt to deny the exercise of, a right conferred under this Act; or

(2) coerce or intimidate any individual regarding the exercise of, or an attempt to exercise, a right conferred under this Act.

Section 97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

Section 110. The Hospital Licensing Act is amended by changing Section 10.10 as follows:

(210 ILCS 85/10.10)

(Text of Section before amendment by P.A. 103-211)

Sec. 10.10. Nurse staffing by patient acuity.

(a) Findings. The Legislature finds and declares all of the following:

(1) The State of Illinois has a substantial interest in promoting quality care and improving the delivery of health care services.

(2) Evidence-based studies have shown that the basic principles of staffing in the acute care setting should be based on the complexity of patients' care needs aligned with available nursing skills to promote quality patient care consistent with professional nursing standards.

(3) Compliance with this Section promotes an organizational climate that values registered nurses' input in meeting the health care needs of hospital patients.

(b) Definitions. As used in this Section:

"Acuity model" means an assessment tool selected and

implemented by a hospital, as recommended by a nursing care committee, that assesses the complexity of patient care needs requiring professional nursing care and skills and aligns patient care needs and nursing skills consistent with professional nursing standards.

"Department" means the Department of Public Health.

"Direct patient care" means care provided by a registered professional nurse with direct responsibility to oversee or carry out medical regimens or nursing care for one or more patients.

"Nursing care committee" means a hospital-wide committee or committees of nurses whose functions, in part or in whole, contribute to the development, recommendation, and review of the hospital's nurse staffing plan established pursuant to subsection (d).

"Registered professional nurse" means a person licensed as a Registered Nurse under the Nurse Practice Act.

"Written staffing plan for nursing care services" means a written plan for the assignment of patient care nursing staff based on multiple nurse and patient considerations that yield minimum staffing levels for inpatient care units and the adopted acuity model aligning patient care needs with nursing skills required for quality patient care consistent with professional nursing standards.

(c) Written staffing plan.

(1) Every hospital shall implement a written

hospital-wide staffing plan, prepared 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, including inpatient emergency departments. If the staffing plan prepared by the nursing care committee is not adopted by the hospital, or if substantial changes are proposed to it, the chief nursing officer shall either: (i) provide a written explanation to the committee of the reasons the plan was not adopted; or (ii) provide a written explanation of any substantial changes made to the proposed plan prior to it being adopted by the hospital. The written hospital-wide staffing plan shall include, but need not be limited to, the following considerations:

(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 patient 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 and technology, the skill 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 patient acuity levels and nursing staff needed shall be routinely made by the unit nurse manager or his or her designee.

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

(2) In order to provide staffing flexibility to meet patient needs, every hospital shall identify an acuity model for adjusting the staffing plan for each inpatient care unit.

(2.5) Each hospital shall implement the staffing plan and assign nursing personnel to each inpatient care unit, including inpatient emergency departments, in accordance with the staffing plan.

(A) A registered nurse may report to the nursing care committee any variations where the nurse personnel assignment in an inpatient care unit is not in accordance with the adopted staffing plan and may make a written report to the nursing care committee based on the variations.

(B) Shift-to-shift adjustments in staffing levels required by the staffing plan may be made by the appropriate hospital personnel overseeing inpatient care operations. If a registered nurse in an inpatient care unit objects to a shift-to-shift adjustment, the registered nurse may submit a written report to the nursing care committee.

(C) The nursing care committee shall develop a process to examine and respond to written reports submitted under subparagraphs (A) and (B) of this paragraph (2.5), including the ability to determine if a specific written report is resolved or should be dismissed.

(3) The written staffing plan shall be posted, either by physical or electronic means, in a conspicuous and accessible location for both patients and direct care staff, as required under the Hospital Report Card Act. A copy of the written staffing plan shall be provided to any member of the general public upon request.

(d) Nursing care committee.

(1) Every hospital shall have a nursing care committee that meets at least 6 times per year. A hospital shall appoint members of a committee whereby at least 55% of the members are registered professional nurses providing direct inpatient care, one of whom shall be selected annually by the direct inpatient care nurses to serve as

co-chair of the committee.

(2) (Blank).

(2.5) A nursing care committee shall prepare and recommend to hospital administration the hospital's written hospital-wide staffing plan. If the staffing plan is not adopted by the hospital, the chief nursing officer shall provide a written statement to the committee prior to a staffing plan being adopted by the hospital that: (A) explains the reasons the committee's proposed staffing plan was not adopted; and (B) describes the changes to the committee's proposed staffing or any alternative to the committee's proposed staffing plan.

(3) A nursing care committee's or committees' written staffing plan for the hospital shall be based on the principles from the staffing components set forth in subsection (c). In particular, a committee or committees shall 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 items described in subdivisions (c)(1) and (c)(2) of this

Section.

(D) Review the nurse staffing plans for all inpatient areas and current acuity tools and measures in use. The nursing care committee's review shall consider:

(i) patient outcomes;

(ii) complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing;

(iii) the number of hours of nursing care provided through an inpatient hospital unit compared with the number of inpatients served by the hospital unit during a 24-hour period;

(iv) the aggregate hours of overtime worked by the nursing staff;

(v) the extent to which actual nurse staffing for each hospital inpatient unit differs from the staffing specified by the staffing plan; and

(vi) any other matter or change to the staffing plan determined by the committee to ensure that the hospital is staffed to meet the health care needs of patients.

(4) A nursing care committee must issue a written report addressing the items described in subparagraphs (A) through (D) of paragraph (3) semi-annually. A written copy of this report shall be made available to direct inpatient

care nurses by making available a paper copy of the report, distributing it electronically, or posting it on the hospital's website.

(5) A nursing care committee must issue a written report at least annually to the hospital governing board that addresses items including, but not limited to: the items described in paragraph (3); changes made based on committee recommendations and the impact of such changes; and recommendations for future changes related to nurse staffing.

(e) Nothing in this Section 10.10 shall be construed to limit, alter, or modify any of the terms, conditions, or provisions of a collective bargaining agreement entered into by the hospital.

(f) No hospital may discipline, discharge, or take any other adverse employment action against an employee solely because the employee expresses a concern or complaint regarding an alleged violation of this Section or concerns related to nurse staffing.

(g) Any employee of a hospital may file a complaint with the Department regarding an alleged violation of this Section. The Department must forward notification of the alleged violation to the hospital in question within 10 business days after the complaint is filed. Upon receiving a complaint of a violation of this Section, the Department may take any action authorized under Section ~~Sections~~ 7 or 9 of this Act.

(Source: P.A. 102-4, eff. 4-27-21; 102-641, eff. 8-27-21; 102-813, eff. 5-13-22; revised 9-26-23.)

(Text of Section after amendment by P.A. 103-211)

Sec. 10.10. Nurse staffing by patient acuity.

(a) Findings. The Legislature finds and declares all of the following:

(1) The State of Illinois has a substantial interest in promoting quality care and improving the delivery of health care services.

(2) Evidence-based studies have shown that the basic principles of staffing in the acute care setting should be based on the complexity of patients' care needs aligned with available nursing skills to promote quality patient care consistent with professional nursing standards.

(3) Compliance with this Section promotes an organizational climate that values registered nurses' input in meeting the health care needs of hospital patients.

(b) Definitions. As used in this Section:

"Acuity model" means an assessment tool selected and implemented by a hospital, as recommended by a nursing care committee, that assesses the complexity of patient care needs requiring professional nursing care and skills and aligns patient care needs and nursing skills consistent with professional nursing standards.

"Department" means the Department of Public Health.

"Direct patient care" means care provided in person by a registered professional nurse with direct responsibility to oversee or carry out medical regimens or nursing care for one or more patients.

"Nursing care committee" means a hospital-wide committee or committees of nurses whose functions, in part or in whole, contribute to the development, recommendation, and review of the hospital's nurse staffing plan established pursuant to subsection (d).

"Registered professional nurse" means a person licensed as a Registered Nurse under the Nurse Practice Act.

"Written staffing plan for nursing care services" means a written plan for the assignment of patient care nursing staff based on multiple nurse and patient considerations that ensures the facility meets the maximum patient assignment limits under Section 10 of the Safe Patient Limits Act and the adopted method to adjust the staffing plan for each inpatient care unit when additional staff are needed to fulfill the care needs of each individual patient as determined by the patient's assigned direct care registered professional nurse ~~yield minimum staffing levels for inpatient care units and the adopted acuity model aligning patient care needs with nursing skills required for quality patient care consistent with professional nursing standards~~.

(c) Written staffing plan.

(1) Every hospital shall implement a written hospital-wide staffing plan, prepared 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 and~~, including inpatient~~ emergency department ~~departments~~. If the staffing plan prepared by the nursing care committee is not adopted by the hospital, or if substantial changes are proposed to it, the chief nursing officer shall either: (i) provide a written explanation to the committee of the reasons the plan was not adopted; or (ii) provide a written explanation of any substantial changes made to the proposed plan prior to it being adopted by the hospital. The written hospital-wide staffing plan shall include, but need not be limited to, the following considerations:

(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 patient 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 and technology, the skill 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 patient acuity levels, as determined by the direct care registered professional nurse responsible for each patient's care, and nursing staff needed shall be routinely made by the unit nurse manager or the unit nurse manager's ~~his or her~~ designee.

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

(F) Ensuring that patient limits under Section 10 of the Safe Patient Limits Act to a registered nurse are not exceeded.

(2) In order to provide staffing flexibility to meet patient needs, every hospital shall include in its staffing plan a method to adjust the staffing plan for each inpatient care unit when the maximum patient assignment under Section 10 of the Safe Patient Limits Act should be reduced or additional staff are needed to fulfill the care needs of each individual patient as determined by the patient's assigned direct care

registered professional nurse ~~identify an acuity model for adjusting the staffing plan for each inpatient care unit~~.

(2.5) Each hospital shall implement the staffing plan and assign nursing personnel to each inpatient care unit and emergency department~~, including inpatient emergency departments,~~ in accordance with the staffing plan.

(A) A registered nurse may report to the nursing care committee any variations where the nurse personnel assignment in an inpatient care unit is not in accordance with the adopted staffing plan and may make a written report to the nursing care committee based on the variations.

(B) Shift-to-shift adjustments in staffing levels required by the staffing plan may be made by the appropriate hospital personnel overseeing inpatient care operations. If a registered nurse in an inpatient care unit objects to a shift-to-shift adjustment, the registered nurse may submit a written report to the nursing care committee.

(C) The nursing care committee shall develop a process to examine and respond to written reports submitted under subparagraphs (A) and (B) of this paragraph (2.5), including the ability to determine if a specific written report is resolved or should be dismissed.

(3) The written staffing plan shall be posted, either

by physical or electronic means, in a conspicuous and accessible location for both patients and direct care staff, as required under the Hospital Report Card Act. A copy of the written staffing plan shall be provided to any member of the general public upon request.

(4) The written staffing plan shall be updated on an annual basis and submitted to the Department.

(5) Any acuity model, or other method, software, or tool used to create or evaluate a staffing plan adopted by a facility, shall be transparent in all respects, including disclosure of detailed documentation of the methodology used to determine nurse staffing and identifying each factor, assumption, and value used in applying the methodology. This documentation shall be submitted to the Department and made available to facility staff, facility staff's collective bargaining representatives, and the public upon request. The patient limits under Section 10 of the Safe Patient Limits Act shall not be exceeded regardless of the use and application of any acuity model.

(d) Nursing care committee.

(1) Every hospital shall have a nursing care committee that meets at least 6 times per year. A hospital shall appoint members of a committee whereby at least 55% of the members are registered professional nurses providing direct inpatient care, one of whom shall be selected

annually by the direct inpatient care nurses to serve as co-chair of the committee.

(2) (Blank).

(2.5) A nursing care committee shall prepare and recommend to hospital administration the hospital's written hospital-wide staffing plan. If the staffing plan is not adopted by the hospital, the chief nursing officer shall provide a written statement to the committee prior to a staffing plan being adopted by the hospital that: (A) explains the reasons the committee's proposed staffing plan was not adopted; and (B) describes the changes to the committee's proposed staffing or any alternative to the committee's proposed staffing plan.

(3) A nursing care committee's or committees' written staffing plan for the hospital shall be based on the principles from the staffing components set forth in subsection (c). In particular, a committee or committees shall provide input and feedback on the following:

(A) Selection, implementation, and evaluation of minimum staffing levels consistent with the maximum patient limits under the Safe Patient Limits Act ~~for inpatient care units~~.

(B) Selection, implementation, and evaluation of a method to increase staffing as needed to meet patient care needs ~~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 items described in subdivisions (c)(1) and (c)(2) of this Section.

(D) Review the nurse staffing plans for all inpatient areas and current acuity tools and measures in use. The nursing care committee's review shall consider:

(i) patient outcomes;

(ii) complaints regarding staffing, including complaints about a delay in direct care nursing or an absence of direct care nursing;

(iii) the number of hours of nursing care provided through an inpatient hospital unit compared with the number of inpatients served by the hospital unit during a 24-hour period;

(iv) the aggregate hours of overtime worked by the nursing staff;

(v) the extent to which actual nurse staffing for each hospital inpatient unit differs from the staffing specified by the staffing plan; and

(vi) any other matter or change to the staffing plan determined by the committee to ensure that the hospital is staffed to meet the health care needs of patients.

(4) A nursing care committee must issue a written report addressing the items described in subparagraphs (A) through (D) of paragraph (3) semi-annually. A written copy of this report shall be made available to direct inpatient care nurses by making available a paper copy of the report, distributing it electronically, or posting it on the hospital's website.

(5) A nursing care committee must issue a written report at least annually to the hospital governing board that addresses items including, but not limited to: the items described in paragraph (3); changes made based on committee recommendations and the impact of such changes; and recommendations for future changes related to nurse staffing.

(6) A nursing care committee must annually notify the hospital nursing staff of the staff's rights under this Section. The annual notice must provide a phone number and an email address for staff to report noncompliance with the nursing staff's rights as described in this Section. The notice must be provided by email or by regular mail in a manner that effectively facilitates receipt of the notice. The Department shall monitor and enforce the requirements of this paragraph (6).

(e) Nothing in this Section 10.10 shall be construed to limit, alter, or modify any of the terms, conditions, or provisions of a collective bargaining agreement entered into

by the hospital.

(f) No hospital may discipline, discharge, or take any other adverse employment action against an employee solely because the employee expresses a concern or complaint regarding an alleged violation of this Section or concerns related to nurse staffing.

(g) Any employee of a hospital may file a complaint with the Department regarding an alleged violation of this Section. The Department must forward notification of the alleged violation to the hospital in question within 10 business days after the complaint is filed. Upon receiving a complaint of a violation of this Section, the Department may take any action authorized under Section ~~Sections~~ 7 or 9 of this Act.

(h) Delegation of nursing interventions by a registered professional nurse must be in accordance with the Nurse Practice Act.

(i) A hospital shall not mandate that a registered professional nurse delegate any element of the nursing process, including, but not limited to, nursing interventions, medication administration, nursing judgment, comprehensive patient assessment, development of the plan of care, or evaluation of care. A delegation of a nursing intervention by a registered professional nurse shall not be delegated again to another person.

(j) The Department shall establish procedures to ensure that the documentation submitted under this Section is

available for public inspection in its entirety.

(k) Nothing in this Section shall be construed to limit, alter, or modify the requirements of the Safe Patient Limits Act.

(Source: P.A. 102-4, eff. 4-27-21; 102-641, eff. 8-27-21; 102-813, eff. 5-13-22; 103-211, eff. 1-1-24; revised 9-26-23.)

Section 115. The Nurse Practice Act is amended by adding Section 50-15.15 and Article 85 as follows:

(225 ILCS 65/50-15.15 new)

Sec. 50-15.15. Nursing judgment.

(a) The General Assembly finds that:

(1) Performance of the scope of practice of a direct care registered professional nurse requires the exercise of nursing judgment in the exclusive interests of the patient.

(2) The exercise of nursing judgment, unencumbered by the commercial or revenue-generation priorities of a hospital, long-term acute care hospital, ambulatory surgical treatment center, or other employing entity of a direct care registered professional nurse is necessary to ensure safe, therapeutic, effective, and competent treatment of patients and is essential to protect the health and safety of the people of Illinois.

(b) The exercise of nursing judgment by a direct care

registered professional nurse in the performance of the scope of practice of the registered professional nurse under Section 60-35 or the scope of practice of the advanced practice registered nurse under Section 65-30 shall be provided in the exclusive interests of the patient and shall not, for any purpose, be considered, relied upon, or represented as a job function, authority, responsibility, or activity undertaken in any respect for the purpose of serving the business, commercial, operational, or other institutional interests of the employer.

(c) A hospital, long-term acute care hospital, ambulatory surgical treatment center, or other health care facility shall not adopt a policy that:

(1) limits a direct care registered professional nurse in performing duties that are part of the nursing process, including, but not limited to, full exercise of nursing judgment in assessing, planning, implementing, and evaluating care;

(2) substitutes recommendations, decisions, or outputs of health information technology, algorithms used to achieve a medical or nursing care objective at a facility, systems based on artificial intelligence or machine learning, or clinical practice guidelines for the independent nursing judgment of a direct care registered professional nurse or penalize a direct care registered professional nurse for overriding the technology or

guidelines if, in that registered nurse's judgment, and in accordance with that registered nurse's scope of practice, it is in the best interest of the patient to do so; or

(3) limits a direct care registered professional nurse in acting as a patient advocate in the exclusive interests of the patient.

(225 ILCS 65/Art. 85 heading new)

ARTICLE 85. NURSE LICENSURE COMPACT

(225 ILCS 65/85-5 new)

Sec. 85-5. Nurse Licensure Compact. The State of Illinois ratifies and approves the following Compact:

ARTICLE I

Findings and Declaration of Purpose

a. The party states find that:

1. The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;

2. Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;

3. The expanded mobility of nurses and the use of

advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;

4. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;

5. The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states; and

6. Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

b. The general purposes of this Compact are to:

1. Facilitate the states' responsibility to protect the public's health and safety;

2. Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;

3. Facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;

4. Promote compliance with the laws governing the practice of nursing in each jurisdiction;

5. Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care

is rendered through the mutual recognition of party state licenses;

6. Decrease redundancies in the consideration and issuance of nurse licenses; and

7. Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

ARTICLE II

Definitions

As used in this Compact:

a. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

b. "Alternative program" means a non-disciplinary monitoring program approved by a licensing board.

c. "Coordinated licensure information system" means an integrated process for collecting, storing and sharing information on nurse licensure and enforcement activities

related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

d. "Current significant investigative information" means:

1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

2. Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

e. "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

f. "Home state" means the party state which is the nurse's primary state of residence.

g. "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

h. "Multistate license" means a license to practice as a registered or a licensed practical/vocational nurse (LPN/VN) issued by a home state licensing board that authorizes the licensed nurse to practice in all party

states under a multistate licensure privilege.

i. "Multistate licensure privilege" means a legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse (RN) or LPN/VN in a remote state.

j. "Nurse" means RN or LPN/VN, as those terms are defined by each party state's practice laws.

k. "Party state" means any state that has adopted this Compact.

l. "Remote state" means a party state, other than the home state.

m. "Single-state license" means a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

n. "State" means a state, territory or possession of the United States and the District of Columbia.

o. "State practice laws" means a party state's laws, rules and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. "State practice laws" do not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

ARTICLE III

General Provisions and Jurisdiction

a. A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), under a multistate licensure privilege, in each party state.

b. A state must implement procedures for considering the criminal history records of applicants for initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

c. Each party state shall require the following for an applicant to obtain or retain a multistate license in the home state:

1. Meets the home state's qualifications for licensure or renewal of licensure, as well as, all other applicable state laws;

2. i. Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program; or

ii. Has graduated from a foreign RN or LPN/VN

prelicensure education program that (a) has been approved by the authorized accrediting body in the applicable country and (b) has been verified by an independent credentials review agency to be comparable to a licensing board-approved prelicensure education program;

3. Has, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing and listening;

4. Has successfully passed an NCLEX-RN® or NCLEX-PN® Examination or recognized predecessor, as applicable;

5. Is eligible for or holds an active, unencumbered license;

6. Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records;

7. Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;

8. Has not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined

on a case-by-case basis;

9. Is not currently enrolled in an alternative program;

10. Is subject to self-disclosure requirements regarding current participation in an alternative program; and

11. Has a valid United States Social Security number.

d. All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

e. A nurse practicing in a party state must comply with the state practice laws of the state in which the client is located at the time service is provided. The practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board,

the courts and the laws of the party state in which the client is located at the time service is provided.

f. Individuals not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this Compact shall affect the requirements established by a party state for the issuance of a single-state license.

g. Any nurse holding a home state multistate license, on the effective date of this Compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:

1. A nurse, who changes primary state of residence after this Compact's effective date, must meet all applicable Article III.c. requirements to obtain a multistate license from a new home state.

2. A nurse who fails to satisfy the multistate licensure requirements in Article III.c. due to a disqualifying event occurring after this Compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the Interstate Commission of Nurse Licensure Compact Administrators ("Commission").

ARTICLE IV

Applications for Licensure in a Party State

a. Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.

b. A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

c. If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the Commission.

1. The nurse may apply for licensure in advance of a change in primary state of residence.

2. A multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home

state and satisfies all applicable requirements to obtain a multistate license from the new home state.

d. If a nurse changes primary state of residence by moving from a party state to a non-party state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

ARTICLE V

Additional Authorities Invested in Party State Licensing Boards

a. In addition to the other powers conferred by state law, a licensing board shall have the authority to:

1. Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

i. Only the home state shall have the power to take adverse action against a nurse's license issued by the home state.

ii. For purposes of taking adverse action, the home state licensing board shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

2. Issue cease and desist orders or impose an

encumbrance on a nurse's authority to practice within that party state.

3. Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

4. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as, the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.

5. Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based

information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions.

6. If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.

7. Take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.

b. If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

c. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the

nurse's participation in an alternative program.

ARTICLE VI

Coordinated Licensure Information System and Exchange of Information

a. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

b. The Commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.

c. All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications (with the reasons for such denials) and nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.

d. Current significant investigative information and

participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

e. Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

f. Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

g. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

h. The Compact administrator of each party state shall furnish a uniform data set to the Compact administrator of each other party state, which shall include, at a minimum:

1. Identifying information;

2. Licensure data;

3. Information related to alternative program participation; and

4. Other information that may facilitate the administration of this Compact, as determined by Commission rules.

i. The Compact administrator of a party state shall provide all investigative documents and information requested by another party state.

ARTICLE VII

Establishment of the Interstate Commission of Nurse Licensure Compact Administrators

a. The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators.

1. The Commission is an instrumentality of the party states.

2. Venue is proper, and judicial proceedings by or against the Commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a

waiver of sovereign immunity.

b. Membership, Voting and Meetings

1. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this Compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the Administrator is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

2. Each administrator shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the commission.

4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article VIII.

5. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

i. Noncompliance of a party state with its obligations under this Compact;

ii. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

iii. Current, threatened or reasonably anticipated litigation;

iv. Negotiation of contracts for the purchase or sale of goods, services or real estate;

v. Accusing any person of a crime or formally censuring any person;

vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

viii. Disclosure of investigatory records compiled for law enforcement purposes;

ix. Disclosure of information related to any reports prepared by or on behalf of the Commission for the purpose of investigation of compliance with this

Compact; or

x. Matters specifically exempted from disclosure by federal or state statute.

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

c. The Commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

i. For the establishment and meetings of other committees; and

ii. Governing any general or specific delegation

of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;

4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the Commission; and

6. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of this

Compact after the payment or reserving of all of its debts and obligations;

d. The Commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the Commission.

e. The Commission shall maintain its financial records in accordance with the bylaws.

f. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

g. The Commission shall have the following powers:

1. To promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all party states;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any licensing board to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;

5. To cooperate with other organizations that administer state compacts related to the regulation of nursing, including but not limited to sharing administrative or staff expenses, office space or other

resources;

6. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

7. To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety or conflict of interest;

8. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, whether real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;

9. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, whether real, personal or mixed;

10. To establish a budget and make expenditures;

11. To borrow money;

12. To appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives,

and consumer representatives, and other such interested persons;

13. To provide and receive information from, and to cooperate with, law enforcement agencies;

14. To adopt and use an official seal; and

15. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of nurse licensure and practice.

h. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

2. The Commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule that is binding upon all party states.

3. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the party states, except by, and with the authority of, such party state.

4. The Commission shall keep accurate accounts of all

receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

i. Qualified Immunity, Defense and Indemnification

1. The administrators, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional, willful or wanton misconduct of that person.

2. The Commission shall defend any administrator, officer, executive director, employee or representative of the Commission in any civil action seeking to impose

liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

ARTICLE VIII

Rulemaking

a. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this Compact.

b. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

c. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:

1. On the website of the Commission; and

2. On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

d. The notice of proposed rulemaking shall include:

1. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment, and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit

notice to the Commission of their intention to attend the public hearing and any written comments.

e. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

f. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

g. The Commission shall publish the place, time and date of the scheduled public hearing.

1. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

2. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

h. If no one appears at the public hearing, the Commission may proceed with promulgation of the proposed rule.

i. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

j. The Commission shall, by majority vote of all administrators, take final action on the proposed rule and

shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

k. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in this Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety or welfare;

2. Prevent a loss of Commission or party state funds; or

3. Meet a deadline for the promulgation of an administrative rule that is required by federal law or rule.

l. The Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a

rule. A challenge shall be made in writing, and delivered to the Commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

ARTICLE IX

Oversight, Dispute Resolution and Enforcement

a. Oversight

1. Each party state shall enforce this Compact and take all actions necessary and appropriate to effectuate this Compact's purposes and intent.

2. The Commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities or actions of the Commission, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

b. Default, Technical Assistance and Termination

1. If the Commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

i. Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default or any other action to be taken by the Commission; and

ii. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state's membership in this Compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in this Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board and each of the party states.

4. A state whose membership in this Compact has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or whose membership in this Compact has been terminated unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

c. Dispute Resolution

1. Upon request by a party state, the Commission shall attempt to resolve disputes related to the Compact that arise among party states and between party and non-party states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.

3. In the event the Commission cannot resolve disputes among party states arising under this Compact:

i. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the Compact administrator in each of the affected party states and an individual mutually agreed upon by the Compact administrators of all the party states involved in the

dispute.

ii. The decision of a majority of the arbitrators shall be final and binding.

d. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

ARTICLE X

Effective Date, Withdrawal and Amendment

a. This Compact shall become effective and binding on the earlier of the date of legislative enactment of this Compact

into law by no less than twenty-six (26) states or December 31, 2018. All party states to this Compact, that also were parties to the prior Nurse Licensure Compact, superseded by this Compact, ("Prior Compact"), shall be deemed to have withdrawn from said Prior Compact within six (6) months after the effective date of this Compact.

b. Each party state to this Compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the Prior Compact until such party state has withdrawn from the Prior Compact.

c. Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

d. A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

e. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

f. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding

upon the party states unless and until it is enacted into the laws of all party states.

g. Representatives of non-party states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

ARTICLE XI

Construction and Severability

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable, and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held to be contrary to the constitution of any party state, this Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

(225 ILCS 65/85-10 new)

Sec. 85-10. State labor laws. The Nurse Licensure Compact does not supersede existing State labor laws.

(225 ILCS 65/85-15 new)

Sec. 85-15. Criminal history record checks. The State may not share with or disclose to the Interstate Commission of Nurse Licensure Compact Administrators or any other state any of the contents of a nationwide criminal history records check conducted for the purpose of multistate licensure under the Nurse Licensure Compact.

Section 995. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

INDEX

Statutes amended in order of appearance

New Act

210 ILCS 85/10.10

225 ILCS 65/50-15.15 new

225 ILCS 65/Art. 85

heading new

225 ILCS 65/85-5 new

225 ILCS 65/85-10 new

225 ILCS 65/85-15 new