Professional Agreement
between
Oregon Nurses Association
and
PeaceHealth Peace Harbor Medical Center

February 1, 2017
through
March 31, 2020
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THIS AGREEMENT is made and entered into by and between PeaceHealth Peace Harbor Medical Center (hereinafter referred to as “Employer”) and the Oregon Nurses Association (hereinafter referred to as “Association”).

ARTICLE 1 – RECOGNITION AND MEMBERSHIP

1.1 Bargaining Unit. The Employer recognizes the Association as the sole and exclusive bargaining agent for, and this Agreement shall cover, all employees employed by the Employer as registered nurses in the Employer’s Florence, Oregon medical center and in its Home Health and Hospice Department, excluding confidential employees, supervisors as defined in the National Labor Relations Act, and all other employees.

1.2 Association Membership.

1.2.1 Fair share. Bargaining unit members shall, as a condition of employment, on or after the 30th day following employment under this Agreement become and thereafter remain members in good standing of the Association or shall, instead of membership, make payment in-lieu-of dues to the Association. Payments in-lieu-of dues shall be less than or equal to the regular monthly Association dues as established by the Association.

1.2.2 Religious exemption. The Association recognizes the rights of employees based on bona fide religious tenets or teachings of a church or religious body of which such employee is a member to refrain from membership in the Association or from making payment to the Association in the form of payments in-lieu-of dues. In such instances, the employee shall pay an amount of money equivalent to regular Association dues and initiation fees, if any, to a non-religious charity or to another charitable organization mutually agreed upon by the employee affected and the representative of the Association. The employee shall furnish written proof to the Employer and the Association at least annually that this is being done.

1.2.3 Dues deduction. Upon written authorization, on the Association form provided by the Association to the Employer to be made available to
nurses, members of the Association and nurses making their payments in-lieu-of dues may have regular monthly dues or payments in-lieu-of dues deducted from their paychecks.

1.2.4 Remittance of dues. Deductions, when authorized, shall be made by the Employer and remitted monthly, together with an itemized statement to the Association.

1.2.5 Change of membership status. A nurse who desires to change his/her membership status must notify the Association of this decision in writing. Such requests must be mailed to Membership Coordinator, Oregon Nurses Association, 18765 SW Boones Ferry Road, Suite 200, Tualatin, OR 97062. If the nurse has elected payroll deduction, the Association will promptly mail a copy of the notification for status change to the Employer. Upon receipt, the Employer will adjust the amount to be deducted in accordance with the nurse’s changed membership status.

1.2.6 Failure to comply. The Employer will discharge a nurse who fails to become and remain an Association member, to make payments in-lieu-of dues, or to establish that he/she is a bona fide religious objector, including making the required payments to a non-religious charity. The Employer will discharge such nurse no later than seven (7) days after receiving written notice from the Association of the nurse’s delinquency and of the steps the Association has taken to cure the delinquency, so long as such discharge is lawful.

1.2.7 Indemnification. The Association agrees to indemnify and hold harmless the Employer and its agents for any loss or damage arising from the performance of these services.

ARTICLE 2 – ASSOCIATION REPRESENTATION

2.1 Access to Premises. Without interrupting normal Employer work and patient care routine, duly authorized representatives of the Association shall be permitted at reasonable times to enter the facility operated by the Employer for
the purposes of transacting Association business and observing conditions under which nurses are employed, provided that the representative first advises the Human Resources Director or designee via email of his/her presence. The Association may hold bargaining unit meetings in the hospital in connection with its collective bargaining responsibilities, in a location reasonably designated by the Employer, by scheduling such meetings with the Human Resources Director or designee and provided the nurses attending are not on duty time.

2.2 **Names of Representatives.** The Association agrees to keep the Employer informed in writing of the names of its authorized representatives.

2.3 **Bulletin Boards.** The Employer shall provide space for posting Association notices on a bulletin board in the surgery and home health nursing units. Additionally, the Employer agrees to provide bulletin board space of at least 2' x 3’ at a mutually agreed upon location for exclusive Association use. The notices posted shall not be harmful to a harmonious relationship and shall bear the signature of the authorized Association representative. Any notice posted outside these guidelines may be removed by the Employer.

2.4 **Roster.** The Employer shall provide to the Association, on an annual basis, a list of all bargaining unit nurses, with their name, mailing address, email address, telephone number (unless unlisted), nurse’s Oregon license number, unit and shift, job classification, date of hire, and seniority date. The Employer shall provide to the Association an updated list containing all such information on at least a monthly basis.

2.5 **Orientation of Newly Hired Nurses.** During the unit orientation of newly hired nurses, the Employer shall provide an Association representative with a 30-minute period to discuss the Association. This period will be paid time for the newly hired nurses, but will be on the Association representative’s own time. The Employer will cooperate in releasing an Association representative, if a nurse, from duty to attend such meeting, and the Association will cooperate to provide an alternate representative where such release would cause staffing problems for the Employer. The Employer may choose to have an Employer representative
attend such meeting as long as this does not cause undue delay in conducting the orientation.

2.6 **Time Off for Negotiations.** The parties will make every effort to schedule bargaining sessions as far in advance as possible to minimize disruptions to work schedules. The Employer shall make a good faith effort to grant requested time off for all Association local bargaining team members to attend contract negotiations sessions. The nurse must give reasonable advance notice to the Employer of any such requested time off. Nurses may elect, but shall not be required, to use PTO for such time off.

2.7 **Association’s Non-Waiver of Rights.** The Association’s failure to exercise any right, prerogative or function it may have, including but not limited to the processing of a grievance, an unfair labor practice complaint, or other assertion in a particular way, shall not be considered a waiver of the Association’s right to exercise such right, prerogative or function, or preclude it from exercising the same in some other way not in conflict with the expressed provisions of this Agreement.

2.8 **Policies and Procedures.** Human resources and nursing policies and procedures shall be readily available to Association representatives and bargaining unit nurses. The Employer will notify the Association of any policy changes that materially affect terms or conditions of employment of bargaining unit members.

**ARTICLE 3 – DEFINITIONS**

3.1 **Nurse.** A registered professional nurse covered by this Agreement who is currently licensed to perform professional nursing in Oregon.

3.2 **Full-Time Nurse.** A nurse regularly scheduled for forty (40) hours per week.

3.3 **Part-Time Nurse.** A nurse regularly scheduled for less than forty (40) but at least twenty (20) hours per week.
3.4 **Relief Nurse.** A nurse hired to provide coverage on an intermittent basis. Relief nurses must be available to work a minimum average of four (4) scheduled shifts, including one (1) scheduled weekend shift, per month, except that each relief nurse shall be allowed an annual six-week period of non-availability. This minimum availability is not required for any nurse who has been continuously employed at least five (5) consecutive years in a regularly scheduled position.

3.5 **Charge Nurse.** Nurses whose responsibilities routinely include the direction and/or scheduling of registered nurses shall be deemed charge nurses. Nurses whose positions routinely include assigned responsibilities of a charge nurse shall be paid a charge nurse differential for all compensated hours.

3.6 **Relief Charge Nurse.** Nurses who are assigned duties routinely performed by charge nurses, or who are assigned duties routinely performed by managers or supervisors, shall be deemed to be performing the duties of a relief charge nurse. The selection of nurses to perform relief charge nurse assignments shall be in the sole discretion of management. Such assignment shall require the consent of the nurse, unless there is no other qualified available nurse.

3.7 **Probationary Nurse.** A newly hired nurse shall be on probationary status during the first 120 days from date of hire. The probationary period of a nurse may be extended by mutual agreement between the Employer, the Association and the nurse for up to three (3) additional months. It is the Employer’s objective and desire that every newly hired nurse continue his/her employment beyond the probationary period. Nurses shall regularly receive feedback on their performance during the probationary period.

3.8 **Preceptor Nurse.** A Preceptor Nurse is defined as a nurse assigned by the Employer to mentor newly graduated nurses or a reentry nurse during the mentee’s preceptorship. Nurses shall also be deemed to be in a preceptor role when assigned by the Employer to mentor a student nurse, unless the nurse is receiving compensation for such activity from a third party. The selection of bargaining unit nurses and other individuals to perform the preceptor role shall be in the sole discretion of management. A preceptor shall have a reduced patient
assignment consistent with the performance of additional duties in the role of preceptor.

ARTICLE 4 – EQUAL OPPORTUNITY

4.1 Non-discrimination. The Employer and the Association agree not to discriminate against any nurse on the basis of race, color, age, religion, sex, disability or national origin, in accordance with applicable law. The Employer and the Association further agree that the Employer shall be permitted to take any and all actions necessary to comply with all laws requiring the reasonable accommodation of employees with legally protected conditions, including the Americans with Disabilities Act, and to avoid liability under said laws. If such actions necessitate a violation of any provision of this Agreement, then the parties shall bargain with regard to the effect of such action on bargaining unit employees.

4.2 Association Membership and Activities. The Employer and the Association agree not to discriminate against any nurse on the basis of membership or non-membership in the Association, or on the basis of any lawful activity on behalf of or opposed to the Association, provided such activities do not interfere with normal Employer routine or the duties of the nurse or with the duties of other persons working in the medical center.

ARTICLE 5 – MANAGEMENT RIGHTS

5.1 Management Rights. The Employer retains all the customary, usual and exclusive rights, decision making prerogatives, functions, and authority connected with or in any way incident to its responsibility to manage the affairs of the Employer or any part of it. The rights of employees in the bargaining unit and the Association are limited to those specifically set forth in this Agreement; and the Employer retains all prerogatives, functions and rights not specifically limited by the terms of this Agreement. These rights of management shall include, but not be limited to, the right to require standards of performance and to maintain order and efficiency; to direct nurses; to schedule staff to perform work; to determine materials and equipment to be used; to determine methods and means by which operations are to be conducted; to determine staffing
requirements; to extend, limit, curtail or subcontract all or any part of its operations; to establish new jobs, or eliminate or modify existing job classifications; to hire, promote, assign and retain nurses; to lay off nurses and to relieve nurses from duty because of lack of work; to recall nurses; and to promulgate rules, regulations and personnel policies. Any such management prerogative, function or right shall not require a nurse to violate the nurse’s licensure requirements under the Nurse Practice Act or to expose a patient or employee to unsafe treatment or working conditions.

5.2 **Employer’s Non-Waiver of Rights.** The Employer’s failure to exercise any right, prerogative or function hereby reserved to it, or the Employer’s exercise of any such right, prerogative or function in a particular way, shall not be considered a waiver of the Employer’s right to exercise such right, prerogative or function or preclude it from exercising the same in some other way not in conflict with the expressed provisions of this Agreement, or with the Employer’s rules, regulations and personnel policies.

**ARTICLE 6 – EMPLOYMENT STATUS**

6.1 **Disciplinary Action.** No non-probationary nurse shall be discharged or otherwise disciplined without just cause. Probationary nurses may be discharged or otherwise disciplined for reasons deemed sufficient in the sole discretion of the Employer, and such discharge or discipline shall not be subject to the Grievance Procedure. A probationary nurse shall have the right to grieve non-disciplinary actions.

6.2 **Disciplinary Notice.** The Employer shall advise a nurse in advance if it knows that a meeting may result in disciplinary action. The nurse will be provided an opportunity to have an Association representative present at the meeting. In the event that an Association representative is not available, a nurse witness will be allowed to be present.

6.3 **Personnel Files/Confidentiality.** Nurses shall have the opportunity to inspect and copy their personnel files. When any record is added to or deleted from a nurse’s personnel file, the nurse will be notified within a reasonable time and be
given an opportunity to add a written rebuttal to the file. Except as required by law, all personnel matters shall be confidential between the nurse, the nurse’s representative, and Employer management. Upon request from the nurse, written disciplinary notices for conduct other than (1) dishonesty, (2) conduct threatening or endangering patient or employee safety, (3) harassment or assault/violence against another person, (4) unlawful breach of confidentiality, or (5) violation of the Employer’s Substance-Free Workplace Policy, will be expunged from the nurse’s personnel file after 24 months, if there have been no further disciplinary occurrences of any kind during that period.

6.4 Substance-Free Workplace Policy. The Employer shall continue to maintain, administer and enforce a Substance-Free Workplace Policy, as that policy may be amended from time to time.

ARTICLE 7 – GRIEVANCE PROCEDURE

7.1 Definitions.

a. Grievance. A grievance is defined to be an alleged violation of this Agreement.

b. Grievant. “Grievant” as used herein shall be defined as one or more nurses. A nurse may be represented at any grievance meeting by any representative of the Association.

c. Days. Reference to days in this Article shall include all days except Saturdays, Sundays, and holidays listed in this Agreement.

7.2 Informal Settlement. When such alleged violations arise, an attempt shall be made by the grievant and his or her immediate supervisor to settle them informally. An alleged violation that cannot be resolved informally may be processed as a grievance in accordance with the formal procedure below.

7.3 Grievance Steps. Each grievance will be processed in the following manner:

Step 1 Within fifteen (15) days after the occurrence of the cause of the complaint or after the date when the grievant should have reasonably
become aware of such occurrence, the grievant involved will reduce
his or her grievance to writing, stating his or her understanding of the
reasons therefor, the provision violated, the date of occurrence, and
the relief requested, and will present it to his or her immediate
supervisor. Within ten (10) days after the grievance is submitted to the
immediate supervisor, the supervisor will respond with a decision in
writing to the grievant and the Association. A grievance meeting shall
be held if either party requests it. If such a meeting occurs, the
supervisor may require that the grievant attend. The grievant may be
represented at this meeting by any representative of the Association.

Step 2   If the grievant is not satisfied with the decision concerning his/her
grievance made by the immediate supervisor, he/she may, within five
(5) days of receipt of such decision, submit the grievance to the
Nursing Director. Within ten (10) ten days following such submission,
the Director or designee shall render his/her decision in writing to the
grievant and the Association. A grievance meeting shall be held if
either party requests it.

Step 3   If the grievant is not satisfied with the decision concerning his/her
grievance made by the Director, he/she may, within five (5) days of
his/her receipt of such decision, submit the grievance to the Chief
Administrative Officer (CAO). Within ten (10) days following such
submission, the CAO shall render his/her decision in writing to the
grievant and the Association. A grievance meeting shall be held if
either party requests it.

Step 4   If the grievant or the Association is not satisfied with the decision on
the grievance by the CAO, the Association may request within five (5)
days from receipt of the CAO’s decision that the grievance be brought
to arbitration. The Association shall request a list of five (5) arbitrators
from the Federal Mediation and Conciliation Service, and the parties
shall alternately strike one name from the list until only one name
remains. The order of striking shall be determined by lot. The one
name remaining shall be the arbitrator. The striking process shall be completed within five (5) days of receipt of the list of arbitrators.

7.4 **Association Grievance.** A grievance, as defined in Section 7.1, relating to occurrences actually involving at least three (3) nurses or arising under the Association Business article, may be initiated by the Association at Step 2 of the above-mentioned procedure by the filing of a written grievance, signed by a representative of the Association, within twenty-one (21) days from the date of occurrence. Such grievance shall describe the problem and the contract provisions thought to be violated.

7.5 **Arbitration Hearing.** The hearing under this procedure shall be kept informal and private, and shall include only such parties in interest and/or designated representatives. The power of the arbitrator shall be limited to interpreting this Agreement and determining if the disputed article or portion thereof has been violated. The arbitrator shall have no authority to alter, modify, vacate or amend any terms of this Agreement. The decision of the arbitrator within these stated limits shall be final and binding on all parties.

7.6 **Arbitration Costs.** Expenses for the arbitrator's services and the proceedings shall be borne equally by the parties. However, each party shall be completely responsible for all costs of preparing and presenting its own case, including compensating its own representative and witnesses. If either party desires a record of the proceedings, it shall bear the cost of such record.

7.7 **Untimely Grievances.** A grievance will be deemed untimely if the time limits set forth above for presentation of a grievance to Step 1 are not met, unless the parties agree in writing to extend such time limits. As a result of such untimeliness, the grievance shall be considered void and barred from further processing.

7.8 **Timeliness of Grievance Advancements and Responses.** Subsequent grievance advancements and responses will be deemed untimely if the time limits set forth above are not met, unless the parties mutually agree in good faith
to extend such time limits. The scheduling of a mutually agreeable meeting date shall serve as such an extension. Such extension shall be documented in writing if requested by either party. The parties shall make a good faith effort to meet and/or respond at each step of the grievance process. If, however, a grievance advancement is untimely, the Employer shall have the option of declaring in writing that the grievance is automatically advanced to the next step in the grievance process, or of notifying the grievant and the Association in writing of such untimeliness. In the event the grievance is still not advanced to the next step within five (5) days of such notification, the grievance shall be considered settled on the basis of the last response to the grievance. If the Employer fails to meet or answer any grievance within the applicable time limits, such grievance shall automatically advance to the next step.

7.9 Release Time. The grievant and the grievant’s Association Nurse Representative shall be granted release time without loss in pay or benefits to participate in grievance meetings under Section 7.3. It is understood that this does not require payment to nurses unless the grievance meeting is during the nurse’s working time. Release time without loss in pay or benefits is expressly prohibited from use in investigating or preparing for grievance meetings.

ARTICLE 8 – HOURS OF WORK

8.1 Work Schedules. Nurses’ regular hours of work shall be posted at least thirty (30) days in advance of their effective date. Once posted, the scheduled hours of a nurse may be changed only in the event of an emergency, reduction in force, low census, termination of employment, or by mutual agreement of the affected nurse(s) and the Employer. Nothing in this section or any part of this Agreement shall be construed as a guarantee of hours of work.

8.2 Meal and Rest Periods. The parties acknowledge the requirements and importance of rest and meal periods for nurses. The basic workday shall be eight (8) hours to be worked within eight and one-half (8 ½) hours, including a one-half (1/2) hour unpaid, duty free meal period, and one fifteen (15) minute paid rest period during each four (4) hour period of work. If a nurse is not able to take a 30 minute meal period, the nurse will be paid for such 30 minutes. Missed break or
meal periods due to patient care requirements or accurate reporting of missed meal or rest periods shall not constitute a basis for disciplinary action.

8.3 **Mandatory Overtime.** Per the Oregon Hospital Staffing Law, ORS 441.166 (4) (a & b), a nurse shall not be required to work beyond his/her regularly scheduled shift, except that the Employer may require an additional hour of work beyond the work authorized if a staff vacancy for the next shift becomes known at the end of the current shift or there is a potential harm to an assigned patient if the nursing staff member leaves the assignment or transfers care to another staff member. Mandatory overtime may not be assigned on a routine basis. The Association and the Employer agree that every reasonable effort should be made to obtain nurses for unfilled hours or shifts before requiring a nurse to work overtime, including filling known vacancies in the posted work schedule immediately prior to the start of the shift, offering premium pay and the utilization of agency nurses when available. As part of its effort to avoid mandatory overtime, the Employer will offer to bargaining unit nurses who are not already assigned to work the shift the highest incentive pay being paid on the unit and shift, without regard to incentive pay eligibility exclusions. The Employer will fully comply with Oregon State legislation that limits and regulates circumstances under which a nurse may be required to work overtime. The Employer shall provide a process for recording the nature of overtime work by a nurse voluntary or mandatory.

8.4 **Variable Shifts.** There shall be no more than six (6) full-time and part-time positions consisting of more than one shift at any one time in the bargaining unit. Other nurses may also be scheduled to work variable shifts with their consent.

8.5 **Alternate Length Shifts.** Alternate length shifts may be established by written mutual consent between the Employer and the individual nurse. In the event that the Employer contemplates movement to 9-hour, 10-hour or 12-hour shifts for several positions within a department or unit, mutual agreement with the individual nurse shall not be required; absent such mutual agreement, however, the Employer shall notify and meet with the Association, upon request, to bargain regarding such contemplated action. Notice shall be provided in writing at least sixty (60) days prior to implementation. The notice shall specify the number of
positions affected and how they will be affected. The Employer shall consider any alternatives the Association may present during bargaining.

a. Discontinuance of an alternate length shift shall be by mutual consent only, except that if a nurse scheduled in a complementary manner to one or more nurses vacates his or her schedule and the schedule is not readily filled, discontinuance of the complementary scheduled shifts may be initiated by the Employer at least twenty (20) days in advance of the posting of the next work schedule. Moreover, in the event the Employer contemplates discontinuance of several alternate length shifts or the remainder of such shifts within a department or unit, the Employer shall notify and meet with the Association, upon request, to bargain regarding such contemplated action. Notice shall be provided in writing at least sixty (60) days prior to implementation. The notice shall specify the number of positions affected and how they will be affected. The Employer shall consider any alternatives the Association may present during bargaining.

b. The Employer shall also have the right to establish new positions of ten (10) or twelve (12) hours.

c. A nurse shall not be scheduled for 12-hour shifts on more than three (3) consecutive days in a row without the nurse’s consent. A regular work week of forty (40) hours shall apply to any such position; pursuant to the provisions of Section 9.15.1, overtime shall not be payable until the conclusion of the nurse’s regularly scheduled shift.

8.6 Schedule Trades. Trades in schedules mutually agreed to by nurses will be subject to prior authorization by the Employer. The bases upon which the Employer, in its discretion, may withhold authorization are (1) lack of qualifications or orientation of the substituting nurse, or (2) the trade would result in a premium pay obligation which would not otherwise have existed and such premium pay is not waived by the nurse. Waiver of overtime which would violate state or federal law will not be an acceptable waiver under the preceding sentence.
8.7 **On-Call Practices.** The Employer shall have the right to implement permanent changes to current on-call scheduling policies and established practices only after having notified and bargained with the Association over such proposed changes. A nurse who is not scheduled to work from 0700 on Monday through 0700 on Saturday will not be scheduled to be on-call during the following weekend without the nurse’s consent.

8.8 **Repeated or Lengthy Call-Ins.** If a nurse experiences repeated or lengthy call-ins during an on-call shift immediately preceding a scheduled shift, and the nurse requests the scheduled shift off or reduced hours for that shift, then the Employer shall use its best efforts to accommodate the nurse’s request. The nurse shall make such request to the appropriate supervisor at his/her earliest opportunity. The nurse shall not be required to use PTO for the scheduled hours not worked.

8.9 **Providing Safe and Skilled Patient Care.** It is the responsibility of nurses not to make employment commitments as health care professionals outside the medical center that interfere with their ability to provide safe and skilled patient care while at work in the medical center. If the Employer believes a nurse has made such a commitment, it may raise the matter with the nurse, and the nurse and Employer shall then attempt to reach a mutually acceptable resolution to the situation.

It is the responsibility of the Employer not to schedule or work nurses in any way that interferes with their ability to provide safe and skilled patient care while at work at the Employer. If a nurse believes she/he has been scheduled or worked in such a way or if a nurse believes that another nurse has been scheduled or worked in this way, she/he may raise the matter with the Employer and the Employer shall then meet with the affected nurses and attempt to reach a mutually acceptable resolution to the situation.

**ARTICLE 9 – COMPENSATION**

9.1 **Wages.** The pay rates shall be as set forth in Appendix A, which shall be attached hereto and by this reference incorporated into and made part of this Agreement.
9.2 **Pay Steps.** The column headings in Appendix A denote the various steps in the pay range. The step placement of newly hired nurses shall be determined by the Employer consistent with the provisions of Section 9.3 below. Thereafter, advancement to the next step shall be made following the completion of years of service as specified in Appendix A.

9.3 **Credit for Prior Experience.** A nurse with at least two (2) years of full time equivalent (FTE) experience in an acute care hospital prior to hire will be started at not less than the applicable step indicated below:

<table>
<thead>
<tr>
<th>Years out of last</th>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 to 3 years</td>
<td>2</td>
</tr>
<tr>
<td>4 to 5 years</td>
<td>3</td>
</tr>
<tr>
<td>6 to 7 years</td>
<td>4</td>
</tr>
<tr>
<td>8 or more years</td>
<td>5</td>
</tr>
</tbody>
</table>

9.4 **Charge Nurse Differential.** A nurse in the classification of charge nurse shall receive a differential of $3.20 for all compensated hours. A relief charge nurse shall receive a differential of $2.25 for all hours worked in that capacity.

9.5 **Shift Differential.** A nurse who works more than half her/his shift between 1500 and 2300 hours shall receive a shift differential of $2.50. A nurse who works more than half his/her shift between 2300 and 0730 hours shall receive a shift differential of $6.70. Nurses who are given a patient care assignment on a shift adjoining their regularly scheduled shift shall receive the applicable differential for that shift or the differential received on their regularly scheduled shift, whichever is greater, for all hours worked on such shift. If a nurse is entitled to receive overtime or premium pay under this Agreement, and if the nurse is also entitled to receive shift differential under this paragraph, then the shift differential shall be included in the amount that is subject to the overtime or premium rate.

9.6 **Call Pay.** On-call compensation of $4.00 per hour, and $4.25 per hour on holidays, shall be paid when the Employer requires a nurse who is not on duty to remain available to report for work on short notice. A nurse placed on-call shall continue to receive said compensation for the remainder of her/his normal on call
shift duration. On-call compensation shall cease, however, in the event the nurse is called in to work.

9.6.1 **On-Call for Surgical Services.** In lieu of the amount in Article 9.6, regular and per diem nurses in surgical services who are on-call for more than eighty-four (84) hours in a four-week scheduled cycle will receive double the call rate for all on-call hours in excess of said eighty-four (84) hours.

9.6.2 **On-Call for Home Health and Hospice.** In lieu of the amount in Article 9.6, Home Health and Hospice nurses scheduled for more than sixty-four (64) hours on-call in a schedule five-week cycle will receive double the call rate for all on-call hours in excess of said sixty-four (64) hours. This provision shall not apply to nurses who volunteer for additional on-call time.

9.7 **Telephone Consultation by Home Health Nurses.** Telephone consultation by home health nurses, including documentation of telephone contact, that is necessary for supervision and guidance of personnel on duty, telephone conferences, and/or patient evaluation or advice that is in excess of fifteen (15) cumulative minutes while the nurse is on-call, shall be considered hours worked and shall be compensated at the applicable rate of pay. Nurses are responsible for duly and accurately recording all such working time. If the nurse makes a home call while on contact duty, Section 9.15.4 will apply.

9.8 **Mileage Reimbursement.** Nurses required to use their automobiles while on duty (other than for mileage equivalent to travel from home to the customary workplace and return) shall be paid mileage reimbursement equivalent to the existing allowable IRS rate per reimbursable mile for private car mileage incurred on behalf of the Employer.

9.9 **Weekend Differential.** For weekend work, including call-in from an on-call status, nurses shall be paid a weekend differential of $1.75 per hour worked. The differential shall be additional to, and not included within, any premium pay. The weekend differential shall apply to shifts commencing on Saturday and Sunday for the day and evening shifts, and to shifts commencing on Friday and Saturday
for the night shift.

9.10 **Certification Pay.** A nurse who obtains and maintains a nationally recognized nursing certification shall receive a differential of $1.00 per hour for all compensated hours. If initial certification is obtained during the prior calendar year, only those hours that are compensated beginning the first full payroll period subsequent to certification shall be considered. An approved certification list shall be established by mutual agreement between the PNCC and the nursing executive or designee and shall be updated on an annual basis.

9.10.1 **Eligibility.** To be eligible for the commencement of certification pay under this provision, the nurse must submit the document from the accrediting body, or testing facility, which indicates the nurse has successfully completed the certification requirements. For continued pay eligibility under this provision, the nurse must submit a document within 120 days following the commencement of certification that provides verification of the certification, the certification number, and the certification’s beginning and expiration date.

9.11 **Relief Nurse Differential.** A relief nurse shall be paid a differential of 15% of the nurse’s hourly wage in lieu of benefits. Under this Agreement, relief nurses are not entitled to benefits under Article 10, Article 15.1 or Article 9.15.3.

9.12 **Preceptor Pay.** Nurses assigned by the Employer to perform the role of preceptor, as defined in Section 3.8, shall receive a differential of $2.00 per hour for each hour that the nurse is assigned to perform the duties of a preceptor.

9.13 **Payment Above Contract Amounts.** The Association acknowledges that the Employer has the right to compensate nurses in excess of the terms and amounts set forth in this Agreement in response to needs for limited periods of time. Such excess compensation for an individual nurse shall not occur for more than one (1) posted work period at a time and shall not exceed three (3) posted work periods without the Association’s consent.

9.14 **Overtime.** If a nurse works in excess of forty (40) hours in a work week, he/she
shall receive overtime compensation for all such hours worked. A nurse and the Employer may mutually agree on an alternate work week constituting eighty (80) hours in a fourteen (14) day period, in which case overtime would be payable for hours worked in excess of eight (8) hours in a twenty-four (24) hour period or eighty (80) hours in the agreed upon fourteen (14) day period. Overtime compensation shall be at the rate of one and one-half (1½) times the nurse’s regular rate computed to the nearest fifteen (15) minutes. A nurse must receive prior approval before working overtime.

9.14.1 Notification of overtime. A nurse will notify his or her manager in the event that the nurse’s hours worked or scheduled to be worked in another department of the Employer or another PeaceHealth facility will result in the payment of overtime or premium pay.

9.15 Premium Pay at Time and One-Half. To the extent hours are compensated for at the overtime rate pursuant to Section 9.14 or at a premium rate under this section (other than holiday pay specified under Section 9.15.5), they shall not again be counted as hours worked under the same or any other provision of this Agreement. Except where double time is expressly provided for under this Agreement, overtime and premium pay calculations shall never result in pay at a rate greater than one and one-half (1 ½) times the regular rate of pay for the same hours worked or paid for under any of the terms of this Agreement.

Premium pay shall be payable at the rate of 1½ times the regular rate of pay in the following circumstances:

9.15.1 Work in excess of regularly scheduled shift. Hours worked in excess of the nurse’s regularly scheduled shift of at least eight (8) hours within a twenty-four (24) hour period following the beginning of the shift.

9.15.2 Consecutive weekends. All hours worked on a regularly scheduled nurse’s second (not regularly scheduled) consecutive weekend of work. The third consecutive weekend worked, if applicable, shall be paid at the regular rate of pay. A relief nurse who is working at least 20 hours per week during a sustained time period shall receive such premium pay on the nurse’s third consecutive weekend of work (and each third consecutive weekend of work thereafter). Nurses may agree in writing to
waive consecutive weekend premium pay.

9.15.3 **Unscheduled shifts.** All hours worked in excess of 32 hours in a workweek by regularly scheduled nurses as a result of volunteering for remaining unscheduled shifts after the schedule has been posted. For nurses who are regularly scheduled to work 30 hours per week, this threshold shall be 30 hours. The foregoing thresholds shall include low census hours. Regularly scheduled nurses who are specifically requested by the Employer to work shall also be entitled to this pay. Regularly scheduled nurses who are specifically requested by the Employer to work in excess of their regularly scheduled hours shall also be entitled to this pay.

Regularly scheduled and relief nurse volunteers sign-up is limited to three (3) shifts (24 hours) during the initial seven (7) calendar days following the posting of the work schedule. Nurses shall have unlimited sign-up following this first week.

9.15.4 **Call-in.** Hours worked by a nurse who is on call and required by the Employer to report to work. Call-in compensation shall be for a minimum of two (2) hours.

9.15.5 **Holidays.** Hours worked on any of the following holidays:

- New Year’s Day
- Memorial Day (last Monday in May)
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Eve Day
- Christmas Day

Holiday pay shall apply for all hours worked from 11:00 p.m. on the day preceding the holiday until 10:59 p.m. on the actual holiday.

9.16 **Premium Pay at Double Time.** Notwithstanding any other provision of this Agreement, a nurse shall be compensated at the rate of two (2) times the nurse’s
regular rate of pay in the following circumstances:

9.16.1 Four hours beyond scheduled shift. All hours worked in excess of twelve (12) consecutive hours for eight-hour posted shifts, in excess of fourteen (14) consecutive hours for ten-hour posted shifts, or in excess of sixteen (16) consecutive hours for twelve-hour posted shifts; or all hours worked in excess of the aforementioned number of hours on a non-consecutive basis, within a 24-hour period, following the commencement of such shift. When the excess work occurs before the nurse’s regularly scheduled hours, the double time rate will be applied to the non-regularly scheduled hours.

9.16.2 Call-in on holiday. Hours worked by a nurse who is on call and required by the Employer to report to work on any of the holidays listed in Section 9.15.5.

9.17 Report Pay. If the Employer is unable to utilize a nurse who reports for an assigned shift, he/she shall be paid three (3) hours at the straight time hourly rate of pay plus applicable shift differential. Nurses may elect to waive entitlement to this 3-hour guarantee. This guarantee shall not apply if (a) the reasons giving rise to non-utilization of the nurse are beyond the control of the Employer, such as utility failure or like occurrences, or (b) the Employer makes a reasonable effort to notify the nurse by telephone at least two (2) hours before the nurse’s scheduled shift that he/she shall not report.

9.18 Advanced Education Pay. Nurses holding a baccalaureate degree in nursing (BSN) will be compensated three percent (3%) above the applicable Appendix A rate. Nurses with a master’s degree in nursing (MSN) will be compensated four percent (4%) above the applicable Appendix A rate.

9.19 Care of Sexual Assault Victim. A nurse who is trained and/or certified in the care of a sexual assault patient shall receive $150 stipend per shift when they perform such an exam. Nurses who receive national certification pay for SANE pursuant to 9.10 shall not be eligible for this stipend. A nurse not already on shift who is called in to perform such an exam shall be paid the straight time rate in
addition to the $150 stipend.

ARTICLE 10 – PAID TIME OFF (PTO)

10.1 General. Paid Time Off (PTO) provides compensated time off for the nurse to use as he/she determines it best fits his/her own personal needs or desires, as set forth below for absences from work. PTO supersedes and is in lieu of provisions for vacations, holidays, and sick leave, except as specifically referred to below. All nurses at .5 FTE and above are eligible to accrue PTO. In addition, per Oregon Paid Sick Leave Law, all nurses are eligible for paid sick leave.

10.2 Accrual. PTO is accrued on the basis of hours compensated at the nurse’s Appendix A hourly rate or greater (excluding compensation resulting from cashout of PTO), and for hours for which the nurse was scheduled to work at such compensation levels but did not work because the nurse was on low census time, all of which are referred to as accrual base hours, at the accrual rates set forth below.

10.3 Accrual Rates. An eligible nurse shall accrue PTO as follows:

<table>
<thead>
<tr>
<th>Months of Continuous Employment</th>
<th>Accrual Per Accrual Base Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st through 48th</td>
<td>.10769 hours (approximately 28 PTO days [224 hours] per year for a full-time nurse)</td>
</tr>
<tr>
<td>49th through 108th</td>
<td>.12692 hours (approximately 33 PTO days [264 hours] per year for a full-time nurse)</td>
</tr>
<tr>
<td>109th through 168th</td>
<td>.14231 hours (approximately 37 PTO days [296 hours] per year for a full-time nurse)</td>
</tr>
<tr>
<td>169th through 228th</td>
<td>.1500 hours (approximately 39 PTO days [312 hours] per year for a full-time nurse)</td>
</tr>
<tr>
<td>229th or more</td>
<td>.15385 hours (approximately 40 PTO days [320 hours] per year for a full-time nurse)</td>
</tr>
</tbody>
</table>

Nurses who were at the highest level of PTO accrual (229th month or more) as of June 30, 2011, shall be grandfathered at the accrual rate of .1577 hours per accrual base hour (41 PTO days per year for a full-time nurse).
10.4 Use of PTO. PTO may be used as soon as it is earned, in accordance with the provisions of this section, except that time off for vacation purposes may not be taken until successful completion of the probationary period.

a. PTO scheduling is the final responsibility of the Employer. The Employer will grant requested PTO unless such time off would cause staffing problems. Once scheduled, the Employer will not change the scheduled PTO except by mutual agreement of the affected nurse(s) and the Employer.

b. Requests for PTO shall be made no earlier than the first (1st) of the month that is six (6) months prior to the month during which the PTO is to be taken. Such requests shall be made no later than the twentieth (20) of the month two months prior to the month during which the PTO is to be taken (e.g., January 20 would be the deadline for March requests). The nurse must submit a PTO request electronically to his or her manager or designee, who will respond to the request within fifteen (15) days of receipt.

c. In the event of conflict between requests for the same PTO dates, requests made in accordance with b above will be given preference, in order of receipt, by work week, by the Employer. If conflicting requests are received within the same work week, preference will be based on seniority, except that a nurse who obtained requested PTO based on seniority preference within the preceding 24 months may not use seniority preference. If the nurses involved in the conflict are all ineligible for seniority preference, preference will be decided by lot.

d. PTO may also be used for low census time during shifts for which nurses are regularly scheduled to meet their FTE requirement.

e. PTO use shall not be required in the event the nurse finds his/her own qualified part-time or full-time replacement, provided that (1) the substitution is approved by the Employer in advance based upon qualification, orientation and staffing needs, (2) the substitution does not
result in an overtime or premium pay obligation which would not otherwise have existed, and (3) a nurse regularly scheduled for 32 or more hours per week has not already been granted time off without pay pursuant to this clause for six (6) days during the calendar year, and a nurse regularly scheduled for less than 32 hours per week has not already been granted time off without pay pursuant to this clause for three (3) days during the calendar year.

If a nurse after diligent inquiry is unable to find a qualified part-time or full-time replacement, the nurse shall be allowed to seek a qualified relief replacement, provided that the nurse shall then present any such replacement to management for its necessary approval. PTO shall be required in the event management approves replacement of the nurse with relief personnel.

f. Except where stated otherwise in this Agreement or an exception is approved by the nurse’s manager, a nurse is required to use PTO for requested time off.

10.5 Minimum Expected Use. Absent unusual circumstances, full-time nurses are encouraged to use at least eighty (80) hours of PTO per year (prorated for part-time employees) for rest and relaxation.

10.6 Limitations and Time Off Without Pay. PTO may not be used in advance of its accrual, on regularly scheduled days off, or to claim pay for time lost due to tardiness. When requests for scheduled time off conflict with staffing requirements on a unit, preference will be given to PTO requests over requests for time off without pay.

10.7 Payment and Cashout. PTO will be paid at the time of use at the nurse’s Appendix A hourly wage rate on the nurse’s regularly scheduled shift and classification. All accrued but unused PTO will be paid upon termination. In addition, while a nurse is employed at the Employer, the nurse may cash out up to the full amount of PTO hours the nurse has accrued but not used during that
calendar year, provided that the nurse makes an irrevocable election of such cash out during open enrollment in the preceding year. Such cash out will be paid at any time after the PTO to be cashed out has accrued for the nurse during the calendar year, as a one-time lump sum payment or as a per pay period amount, but in no event later than December 31 of that year. The nurse must further designate when the one-time lump sum payment is to be paid by the Employer at least two (2) weeks prior to its disbursement. A nurse is not required to cash out accrued PTO and may allow it to accumulate for future use or payment upon termination, up to a maximum of 600 hours of PTO.

10.8 **Work on Holidays.** Nurses will be expected to share the responsibility for working on the above holidays. At least sixty (60) days prior to assigning nurses to work on the Thanksgiving Day, Christmas Eve Day, Christmas Day, and New Year’s Day holidays, the Employer will provide a means for nurses to indicate the order of their preferences for working such holidays. The Employer will try to accommodate such preferences and not to assign a nurse to the least preferred holiday if the nurse worked such holiday the previous year, except that all such assignments will be subject to the Employer’s staffing needs. Relief nurses shall be required to work at least one (1) holiday per year on this same basis. A nurse who is not scheduled or requested to work on a holiday due to closure of a unit may elect either to use PTO or to save PTO for later use.

10.9 **Donation of PTO.** A nurse may donate a minimum of one (1) hour and a maximum of 250 hours per year of his or her accrued PTO for the benefit of another employee who has a medical hardship. Any hours donated through this process shall be transferred to the other employee on an irrevocable basis.

a. **Donation for Negotiation Committee.** Hours donated for the benefit of members of the Association negotiating committee will be transferred by the Employer to committee members as designated by the Association and will be restricted to the time period of negotiations for a successor agreement.

**ARTICLE 11 – LEAVES OF ABSENCE**

11.1 **Absences Without Pay.**
11.1.1 **General.** A non-probationary nurse may be granted up to a twelve (12) month leave of absence without pay for personal or educational reasons. All requests for leave or renewal of leave must be presented in writing as far in advance as possible. Each case will be reviewed and considered for approval. A leave of absence protects a nurse’s accrued service record, but the nurse will not accrue benefits or seniority during the unpaid portion of the leave.

11.1.2 **Return to employment – general.** At the conclusion of a leave of absence of forty-five (45) days or less, the nurse will be returned to his/her former position on the same shift in the same nursing unit. If the leave is for forty-six (46) days or more, and the position has been filled by another nurse, the nurse may bid on any open position suitable to his/her qualifications and interests or, at the nurse’s option, be placed on the layoff/recall list and have recall rights for twelve (12) months from that date.

11.2 **Family and Medical Leave.** Family and medical leaves of absence will be administered by the Employer consistent with applicable federal and Oregon state laws except that a nurse may elect to exclude from such payment up to 50 percent of the nurse’s PTO accrued as of the beginning of such leave.

11.2.1 **Return to employment – FMLA or OFLA-designated leave.** Nurses who have been on an FMLA-designated or OFLA-designated family or medical leave will be reassigned to their former position or an equivalent position. If an FMLA-designated or OFLA-designated leave has extended beyond the statutory period allowed as FMLA or OFLA leave, and the position has been filled by another nurse, the nurse may bid on any open position suitable to his/her qualifications and interests or, at the nurse’s option, be placed on the layoff/recall list and have recall rights for twelve (12) months from that date.

11.3 **Qualification on Right to Reinstatement When Layoff Has Occurred During Leave.** Notwithstanding the provisions of Sections 11.1.2 and 11.2.1, the Employer will not be required to reinstate returning nurses to their former
positions if the nurses would not have kept their positions even if they had been employed during the leave, provided that the nurses receive proper notification of layoff in their absence.

11.4 Military Leave.

11.4.1 Without pay. Any non-probationary nurse (regardless of length of service) who is required to report for active duty or to training sessions for any branch of the Armed Services or a reserve component thereof shall be granted such leave as necessary to complete his/her obligation, up to a maximum of five (5) years.

11.4.2 With pay. A nurse who has successfully completed the probationary period and who is a member of the National Guard or a reserve component of the Armed Forces shall be entitled, upon application, to a leave of absence from service for a period not exceeding fifteen (15) calendar days in any one (1) calendar year. Such leave shall be granted without loss of time, pay or other leave, and without impairment of other rights or benefits to which he/she is entitled; however, the nurse shall be required to transfer to the Employer any compensation he/she receives for the performance of such duty. Military leave with pay shall be granted only when a nurse receives bona fide orders to temporary active training duty, and shall not be paid if the nurse does not return to his/her position immediately following the expiration of the period for which he/she was ordered to duty.

11.4.3 Employer policy. In addition to the benefits granted in this Section 11.4, nurses shall be eligible for the same military leave benefits that are made available to all other employees in accordance with Employer policy.

11.5 Bereavement Leave. Bereavement leave may be granted to any non-probationary nurse. A nurse who has experienced a death of a significant person in the family life of the nurse will be granted up to thirty-six (36) scheduled hours with pay within fourteen (14) consecutive calendar days from notice of death. For
purposes of this provision, “significant person” includes spouse or domiciled partner; child (including foster child and stepchild); parent, brother, sister, grandparent or grandchild; step equivalent of parent, brother, sister, grandparent or grandchild; in-law equivalent of parent, child, brother or sister; and a person who was an integral part of the nurse’s household. If additional time for the leave is necessary, the nurse must request PTO for such additional time and obtain the supervisor’s approval in advance. All bereavement leave requests must be approved by the nurse’s department manager prior to the leave. The Employer reserves the right to require proof of death prior to payment of such leave.

11.6 **Jury Duty.** A regularly scheduled full or part-time nurse required to serve on a jury will be excused with pay at the straight time rate of pay from any regularly scheduled Employer duty whose hours conflict with the hours he/she must actually spend in connection with the jury service. Relief employees may receive such compensation only when scheduled to work in advance, in writing. For purposes of this provision, a nurse on jury duty will be treated as if the nurse were assigned to the day shift. If jury duty ends prior to the end of the day shift on the nurse’s scheduled day, the nurse must contact his or her supervisor to discuss whether time remaining on the shift is sufficient to require a return to work that day.

11.7 **Court/Witness Leave.** A regularly scheduled full or part-time nurse required by the Employer or subpoenaed to serve as a witness as related to Employer employment will be excused with pay from any regularly scheduled duty whose hours conflict with the hours he or she must actually spend in connection with the witness service, provided the nurse deposits any witness fees received with Human Resources. Relief nurses may receive such compensation only when scheduled to work in advance, in writing. The nurse must report to work if the witness service ends prior to the conclusion of the nurse’s scheduled shift. This provision shall not apply to Association-originated subpoenas, Association-related cases, arbitrations, or similar proceedings. When a nurse is called as a witness in a private case unrelated to Employer employment, he or she is not paid for hours excused from scheduled duty and may retain all witness fees received.
ARTICLE 12 – SENIORITY

12.1 **Definition.** Seniority shall mean continuous service with the Employer, computed on the basis of hours compensated (including an estimate of compensated hours at the predecessor Western Lane District Hospital), from the last date of hire by the Employer as a nurse, subject to the completion of the probationary period. Seniority will apply only where it is expressly referred to in this Agreement.

12.2 **Break in Seniority.** Seniority shall be broken by:
   
a. Termination, unless the nurse is rehired by the Employer within 90 days after termination, in which event the nurse’s seniority shall not include the time between the termination and the rehiring.

b. Layoff exceeding twelve (12) months.

c. Failure to respond to layoff recall given in accordance with this Agreement.

d. Failure to return to work from a leave of absence.

12.3 **Nurses Rehired Within 12 Months.** Any non-probationary nurse who terminates and is rehired by the Employer to a position covered by this Agreement within twelve (12) months from the date of termination (a) will be returned at the commencement of the same wage step at which the nurse had been paid prior to termination, (b) will not be required to complete a new probationary period, (c) will be credited with his or her previously accrued seniority, and (d) will have prior service credit count for PTO.

12.4 **Bargaining Unit List.** The Employer shall prepare and furnish to the Association a seniority list within thirty (30) days of the close of the last pay periods in the months of November, February, May and August. Seniority shall be fixed upon issuance of each such list until the next seniority list.

12.5 **Service Outside Bargaining Unit.** A bargaining unit nurse who has accepted a position outside the scope of the bargaining unit, without a break in Employer
service, and who later accepts a bargaining unit position will be credited with his or her previously accrued seniority as a nurse in the bargaining unit.

ARTICLE 13 – POSTING OF VACANCIES

13.1 Vacancy Notices. The Employer shall post vacancy notices for seven (7) days. Postings shall identify the unit, shift and regularly scheduled number of hours per week in which the vacancy exists. Designation of a posted position as a house float position satisfies the unit identification requirement. Charge nurse positions shall be posted and bid upon in accordance with this article.

13.2 Selection Process. Qualified nurses who apply for a vacancy during the posting period set forth in Section 13.1 above will be offered the vacancy in order of seniority, subject to the following exceptions: a junior nurse has greater skill, education or experience related to the vacancy; a nurse who has received a written corrective action within the previous six (6) months may be denied a transfer to a position on a different nursing unit, unless the nurse has made satisfactory progress, as determined by the Employer, on an existing action plan. Nurses shall not be eligible to transfer to another unit or position until they have successfully completed a minimum of six (6) months in the current position, excluding status changes (e.g., per diem to benefited).

a. Once a nurse has been offered a posted position, he/she shall be transferred to the new position no later than the end of the four (4) week schedule period following the schedule period in which the acceptance occurs. Upon filling the vacancy, nurses who have submitted a written application will be entitled, upon request, to a written reason (i.e., seniority or qualifications) for the Employer’s denial of the vacancy to said nurse.

b. During the posting period, during orientation, and during an emergency, the Employer may temporarily fill a vacancy without reference to the foregoing process.

13.3 Posting of New Benefited Positions. If a relief nurse works an average of twenty (20) or more hours per week in a unit during a calendar quarter, and such hours worked are not in replacement of other nurses’ use of PTO or leaves of
absence, then the Employer shall post a new benefited position of at least twenty (20) hours per week in that unit.

13.4 Qualified relief and regular nurses wishing to fill a temporary bargaining unit position while retaining their current status and position may do so only with the approval of the Employer based on the availability of replacements.

ARTICLE 14 – LAYOFF/RECALL

14.1 Reductions in Force. In the event of a reduction in force (which does not include “low census time” reductions covered in Section 14.2 below), the Employer shall adhere to the following procedure.

a. The Employer shall provide at least fourteen (14) calendar days’ notice to the Association and to nurses in the affected nursing unit, as defined below, who potentially will be impacted as a result of the reduction in force, unless such advance notice is not possible due to circumstances beyond the Employer’s control.

b. Before implementing the layoff procedure set forth below, the Employer shall first solicit volunteers for layoff within the affected nursing unit.

c. The least senior nurse in the affected nursing unit (surgical services, acute care, home health, other if instituted) shall be the first laid off, provided that nurses remaining in the unit have the ability to immediately perform the necessary work.

d. Any nurse who has been laid off in accordance with the preceding provisions may exercise seniority and displace the least senior nurse in another nursing unit if he/she possesses the ability to immediately perform the necessary work. The ability to immediately perform the necessary work shall not include the period of time customarily afforded a nurse for general orientation to a new nursing unit. Nurses receiving a 14-day notice shall have no less than five (5) days to exercise such right of seniority following receipt of the 14-day notice of position elimination. Any subsequently displaced nurse may then exercise seniority, if any, in the
same manner set forth above. Such nurse shall be given not less than five (5) days after notification of displacement to exercise such right unless agreed otherwise between the Employer and the Association. The nurse(s) so displaced shall be placed on layoff status. Nurses regularly scheduled for less than 20 hours per week may not bump nurses scheduled for 20 hours per week or more.

e. Nurses shall be recalled to work in inverse order of layoff, provided they are qualified to perform the duties of the position available. A nurse who is passed over retains his/her position on the recall list. Laid off nurses shall retain recall rights for twelve (12) months. Failure to report from layoff upon recall shall constitute voluntary surrender of layoff and recall rights.

f. Notices of layoff and recall shall be in writing. Notice of recall shall be sent to the former nurse’s last given home address.

14.2 Low Census. In lieu of the above provisions, low census time reductions will be in accordance with this section.

a. The low census time will be offered and assigned in the area and shift where the low census time occurs. Acute care, surgical services and home health are three separate areas for purposes of this provision.

b. In the event of low census, nurses will be placed on low census in the following order: (1) agency/traveler nurses and temporary nurses (unless a bargaining unit nurse volunteers to be placed on low census ahead of such a nurse), (2) nurses working at a premium or overtime rate of pay, (3) volunteers, (4) per diem nurses, and (5) by a system of rotation among all remaining regular nurses, provided they are qualified to perform the available work. If low census is assigned before the beginning of the affected shift, the Employer shall not be required to offer low census time to more than one (1) nurse, whose name shall be determined by an equitable rotation system from a volunteer list.

c. Nurses who have been placed on low census may be placed on call by
the Employer for the first four (4) hours of their shift. Nurses will not be required to remain on-call for the remainder of the shift unless they volunteer.

d. Charge nurses shall be included in the low census rotation. However, they shall not be placed on low census more than one (1) shift per pay period. Nurses qualified to be assigned relief charge in a particular area shall be considered to be qualified to replace a charge nurse in that area for purposes of low census rotation.

e. Nurses in a preceptor role shall not be included in the low census rotation during the first three weeks of a mentee’s preceptorship, but they thereafter shall be included in the rotation.

ARTICLE 15 – HEALTH AND WELFARE

15.1 Health Insurance Benefit Program. All nurses who are regularly scheduled to work at least twenty (20) hours per week are eligible to participate in the health insurance benefit program offered by the Employer. Nurses shall be offered benefit options, in accordance with the terms of the Employer’s program, with regard to medical, dental, vision, life, AD&D, long-term disability and short-term disability plans, and healthcare and dependent care spending accounts. The Employer will maintain its current non-standard health insurance benefits for this bargaining unit until December 31, 2014. Thereafter, the Employer will provide for this bargaining unit its standard health insurance benefits in accordance with the Professional Agreement between Sacred Heart Medical Center and the Association.

15.2 Benefit Maintenance and Changes. The rights and obligations of the parties with respect to benefit maintenance and changes under the health insurance benefit program shall be identical to and concurrent with the corresponding rights and obligations of the Association and Sacred Heart Medical Center pursuant to the terms of their Professional Agreement, including but not limited to the suspension of Article 18. In the event that the language of Section 15.2 of said Professional Agreement materially changes, then the current notification and
bargaining provisions of said section shall apply to this article.

15.3 **Employer Retiree Pharmacy Benefit Program.** At the time of ratification this plan will no longer be offered to new participants; however, nurses currently enrolled on the plan will be given the opportunity to remain on the plan.

15.4 **Retirement Plans.** The Employer shall continue to offer all eligible nurses a retirement plan which offers a level of benefits substantially equivalent to the current plan and consists of a noncontributory Base Plan, matching contributions from the Employer, and a tax-sheltered annuity plan.

15.5 **Information Requests.** The Employer will respond to all reasonable information requests from the Association regarding insurance plan premiums and plan design in a timely manner, and will regularly provide plan utilization and actuarial data upon request. Requested information related to insurance changes will be shared with the Association as soon as it is available and prior to open enrollment for the next insurance year.

15.6 **Employer Discount.** Continuing until December 31, 2014, an Employer discount policy shall be provided all eligible employees who have worked on the average twenty (20) or more hours weekly over the last six (6) months. Eligible employees who are not covered by insurance shall be entitled to a twenty-five percent (25%) discount on all Employer incurred charges based upon the Employer’s original charges. Eligible employees who are covered by insurance shall be entitled to a fifty percent (50%) discount on the remaining balance of all Employer incurred charges once any and all applicable employee insurance’s have met their obligation of payment. This provision will no longer be in effect as of January 1, 2015.

15.7 **Home Health and Hospice Safe Working Environment.** The Employer shall provide a safe working environment for home health and hospice on-call nurses to access after normal business hours and on weekends by either maintaining a secure, safe, and suitable space in Peace Harbor Medical Center for them or providing an escort to meet the nurse at the Kingwood office.
ARTICLE 16 – PROFESSIONAL DEVELOPMENT

16.1 Professional Development Leave. The Employer agrees to provide each nurse who has completed the initial probationary period with twenty-four (24) hours (thirty-two (32) hours for nurses receiving certification pay pursuant to Section 9.10) of paid professional development leave during each July 1-June 30 period. Nurses completing probation during this period shall receive a pro-rated leave to the nearest hour.

16.2 Professional Development Fund. The Employer shall establish an annual fund of $20,000 to assist participating nurses in meeting registration and related expenses, including travel fees.

16.3 Rate of Pay. Nurses on professional development leave shall receive their normally scheduled shift regular rate of pay.

16.4 Leave Requests. Requests for leaves should be forwarded in writing to the nurse’s manager at least two (2) weeks prior to the posting of the schedule covering the period in which the leave is sought.

16.5 Leave and Fund Guidelines. The nurse’s manager, or designee, shall grant requests for professional development leave for bona fide voluntary educational programs, including home study for continuing education units (CEUs) and up to eight (8) hours of preparatory study for ACLS, NRP, PALS and certifications in accordance with Section 9.10, subject only to staffing needs and the $20,000 maximum amount in the fund. Bona fide educational programs are those related to the nurse’s current position or other nursing opportunities within the Employer. The amount of money available for each nurse shall be allocated on a “first come first serve” basis. No nurse shall be entitled to more than $750 in expense reimbursements. Nurses completing probation during the July 1-June 30 period shall receive prorated reimbursement. The Employer will provide the designated bargaining unit representative with professional development leave use and disbursements under this Article, upon written request.

16.6 Training and Inservice Presentations. Professional development is a shared
responsibility. Nurses are required to complete 100% of their mandatory training requirements by the established training deadline, including on-line training on an annual basis. Mandatory training shall include, but not be limited to, life safety certifications required for nurses to work in designated patient care areas. The Employer shall provide to nurses sufficient opportunity to timely complete their mandatory trainings. Nurses are responsible for scheduling their training so that they do not incur overtime or premium pay as a result of the training. If it is not possible for the nurse to avoid incurring overtime or premium pay, then the nurse must receive prior approval from his or her manager. Nurses shall be compensated at their straight time hourly rate for voluntary attendance at approved inservices when individually approved by the Employer. The Employer shall note any nursing unit restrictions on expected attendants or recipients of an inservice on the inservice announcement.

16.7 Performance Evaluations. Each nurse shall receive a written evaluation of his/her performance upon the completion of probation and annually thereafter. This assessment is a collaborative process which may include self-assessment, goal setting and/or peer review. A copy of such evaluation shall be given to the nurse at the time of the evaluation.

a. The performance assessment is not intended to be a mechanism for disciplinary action. Employees who are rated as needing development in one or more core competencies will be expected to develop an action plan to bring their competencies up to standard.

b. Goals and core competencies must be sufficiently specific, measurable and outcome-focused so that the employee and manager can clearly understand whether they are met or not met.

c. The nurse’s supervisor shall, during the evaluation process, support the nurse’s assessment ratings and comments with sufficient detail of the nurse’s performance, including specific incident examples of actions and/or practices, to provide the nurse with an opportunity to fully discuss and learn from this feedback.
d. A nurse shall not be rated as needing development if the failure to meet a core competency is not within the nurse’s control.

16.8 Orientation. Nurses shall be provided appropriate orientation to procedures and responsibilities to which they are assigned. The Employer shall provide nurses with orientation that is individualized to fit the employee’s needs and experience level. Consistent with staffing schedules, it is desirable that the orientee be consistently scheduled with the same preceptor(s). Total orientation time for the newly employed nurse shall not be less than four (4) days, excluding general orientation. An orienting nurse shall not be utilized to augment established staffing patterns. Nurses expected to routinely work in a specialty unit will be provided the opportunity for at least two (2) days’ orientation on the unit prior to routine assignment.

16.9 Additional Paid Educational Functions. Required in-services, workshops and training classes, including but not limited to ACLS, NRP, Critical Care and IV Therapy courses when required by the Employer, shall be paid by the Employer separate from the professional development funds and leave specified above, except for the related home preparatory study referenced above.

16.10 Extended Education Programs. The Employer has the right to require that each nurse attending each education program of five (5) or more working days at Employer expense during which $1,200 or more is covered for registration and travel (exclusive of professional development days and funds specified in this Article) sign a contract guaranteeing his or her continuing employment with the Employer for at least one (1) year following attendance, or the nurse must reimburse the Employer, including authorization for payroll deduction, for registration and travel on a prorated basis if a voluntary termination should occur within that time period.

ARTICLE 17 – PROFESSIONAL NURSING CARE COMMITTEE

17.1 Composition. The Professional Nursing Care Committee shall be composed of up to three (3) bargaining unit nurses. The Committee members shall be selected by the Association.
17.2 **Responsibilities.** The Committee shall be responsible for promoting communicative and collaborative approaches to professional nursing issues at the medical center and for making written recommendations to the Regional Vice President of Acute Care Services and/or Regional CEO on the following:

a. Nursing practice issues;
b. Patient care considerations;
c. Education and training of nurses.

The Employer will give due consideration to all recommendations and input received from the Committee. The Vice President will review written recommendations received from the Committee and will respond in writing to each concern within thirty (30) days. The Vice President, other management representatives, or other guests may attend meetings at the Committee’s request.

17.3 **Meetings.** The Committee shall meet at least quarterly. Each Committee member, or substitute, shall be entitled to two (2) paid hours per meeting not to exceed twelve (12) paid hours per year at the nurse’s regular straight time rate of pay for the purpose of performing Committee work, provided that the Committee provides written notice to the Director of Nursing/Patient Care Services of such meeting and its attendees no less than seven (7) days in advance.

17.4 **Grievances.** The Committee shall not consider matters that are subject to the grievance procedure.

17.5 **Minutes.** The Committee will keep minutes and schedule meetings so as not to conflict with routine duty requirements. Copies of the minutes will be delivered to the Vice President within two (2) weeks after the meeting.

**ARTICLE 18 – STRIKES AND LOCKOUTS**

During the term of this Agreement both parties agree not to use economic weapons such as lockouts, strikes, slowdowns, picketing, or boycotts. Upon receiving notice that any employee is using economic weapons against the Employer, the Association will take all reasonable steps to terminate the activity.
ARTICLE 19 – GENERAL PROVISIONS

19.1 **Entire Agreement.** The parties acknowledge that during the negotiations which resulted in this Agreement each had the unlimited right and opportunity to make demands and proposals with respect to any subject or matter not removed by law from the area of employment relations, and that the understandings and agreements arrived at by the parties after the exercise of that right and opportunity are set forth in this Agreement. This Agreement constitutes the sole and entire existing Agreement between the parties and completely and correctly expresses all of the rights and obligations of the parties.

19.2 **Non-Reduction of Benefits; Past Practices.** The signing of this Agreement shall not result in a reduction of benefits or privileges of employment that are currently in effect and are not expressly covered herein, provided that such benefit or privilege is well established at the Employer. In addition, past customs or practices shall not be binding on the parties unless they are well established. Well established practices which affect the terms and conditions of employment of the bargaining unit shall not be unilaterally reduced or discontinued by the Employer without first notifying and bargaining upon demand with the Association. For purposes of this paragraph, “well established” shall mean that the benefit or privilege is unequivocal and readily ascertainable as an established practice accepted by both the Association and the Employer over a reasonable period of time.

19.3 **Supervisors’ Performance of Bargaining Unit Work.** The Association and the Employer recognize that non-registered nurse and supervisory classifications have traditionally done work which overlaps with registered nurse work. The parties agree that such practices will not be in violation of this Agreement. Supervisors, however, shall not be assigned bargaining unit work on the posted work schedule, or scheduled bargaining unit work following this posting, unless the Employer has undertaken reasonable efforts to contact qualified bargaining unit nurses and no such nurses are available.

19.4 **Staffing Committee.** The Employer and registered nurses will act in compliance with the Oregon Hospital Nurse Staffing Law, ORS 441.151 to 444.177 and ORS
The Nurse Staffing Committee shall be responsible for the development and implementation of a written Employer-wide staffing plan for nursing services. The staffing plan shall be developed, monitored, evaluated, and modified by the Staffing Committee, consistent with ORS 441.155.

**ARTICLE 20 – SAVINGS CLAUSE**

Should any article or section of this Agreement be held unlawful and unenforceable by any court of competent jurisdiction, such decision of the court shall apply only to the specific article or section directly specified in the decision. The remainder of this Agreement shall remain in effect pursuant to the terms of Article 21. Upon receipt of such court order, the parties agree to enter into negotiations within twenty (20) days to attempt to bargain a replacement provision for the specific provision affected by the order.

**ARTICLE 21 – DURATION**

21.1 **Length of Contract.** This Agreement shall be effective as of the first full pay period following its ratification by the nurses, except as otherwise specifically provided for herein, up to and including March 31, 2020.

21.2 **Notice of Reopener.** This Agreement shall be automatically renewed from year to year and shall be binding for additional periods of one year unless either the Employer or the Association gives written notice to the other of its desire to open negotiations for a new agreement not less than ninety (90) days nor more than one hundred twenty (120) days prior to the aforesaid expiration date. Whenever such written notice is given as provided herein, this Agreement shall remain in full force and effect during the period of negotiations, and may be terminated upon written notice by either party, subsequent to the expiration date, declaring that impasse has been reached.

21.3 **Reopener by Mutual Agreement.** This Agreement may be opened by mutual agreement of the parties at any time.

**ARTICLE 22 – COMMITTEES**

**Labor Management Committee.** The Employer and the Association agree to maintain
a Labor Management Committee. The purpose of the Committee is to foster improved communication between the Employer and Association, and to evaluate and lead to improvement of internal processes for the benefit, health, and safety of employees covered by this agreement. This Committee shall also evaluate and review recommendations to improve patient safety and overall patient and employee satisfaction.

The Committee may act as a forum for sharing information to the Association on organizational changes and initiatives. The Committee may be empowered to identify solutions and make decisions as directed by the Employer; otherwise, the Committee will function in an advisory rather than a decision-making role, and will recommend solutions to identified issues.

The Committee will not have bargaining authority nor will it address issues that are more appropriate for the grievance process.

The Committee will consist of up to six (6) members. Three (3) voting members will be appointed by the Employer and three (3) voting members will be appointed by the Association. The Committee will operate under the guidance of co-chairs, one to be selected by the Employer and one to be selected by the Association. The co-chairs will determine the agenda for the meetings.

The Committee will meet on a quarterly basis and will be for a maximum of two (2) hours. Association members will be compensated at their straight rate of pay for time spent at these meetings and such time shall not be counted in the calculation of overtime.

**ARTICLE 23 – UNIFORMED SECURITY OFFICERS**

The Employer will notify the Association of any substantial changes in services of uniformed security officers ninety (90) days in advance. Further, the Labor-Management Committee will discuss such changes thirty (30) days before they are implemented.
IN WITNESS WHEREOF the Employer and the Association have executed this Agreement this 7th day of October, 2017.

Oregon Nurses Association

PeaceHealth Peace Harbor Medical Center
APPENDIX A – WAGE RATES

A. **Steps and Step Advancements.** The column headings in this appendix denote the various steps in the pay range. The entrance step as provided in Section 9.3 shall be established by the Employer. Thereafter, advancement to the next step shall be made following the completion of a year of service in the lower step of the range, except that:

The time period for advancement to Step 7 shall be two (2) years of service at Step 6.
The time period for advancement to Step 8 shall be two (2) years of service at Step 7.
The time period for advancement to Step 9 shall be two (2) years of service at Step 8.
The time period for advancement to Step 10 shall be two (2) years of service at Step 9.
The time period for advancement to Step 11 shall be two (2) years of service at Step 10.
The time period for advancement to Step 12 shall be two (2) years of service at Step 11.
The time period for advancement to Step 13 shall be two (2) years of service at Step 12.
The time period for advancement to Step 14 shall be two (2) years of service at Step 13.

All step increases shall be effective the first full pay period following the date in which the nurse becomes eligible for step advancement. Upon ratification, nurses will advance to the next step based on their years of service at the current step (e.g., a nurse with two [2] years of service at step 11 will now move to step 12 the first pay period). Their anniversary date for future advancement will remain unchanged from their current anniversary date. As a result of this provision no nurse will be subject to a reduction in pay or step placement.

B. **Wage Increases.** Nurses shall be paid at the following hourly rates effective the first full pay period beginning on or after the following dates:
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APPENDIX B – SURGICAL SERVICES

The Employer and the Association agree that the following rules and practices shall apply in the Surgical Services Department:

1. **Performance of work at end of scheduled shift.** If continued utilization of staff is required following the end of the scheduled day shift, the Employer will first ask for volunteers to conclude unfinished cases. If there is not a sufficient number of volunteers, the Employer will utilize nurses on scheduled call.

2. **Low census.** A change of start time due to low census may be assigned to a nurse at the beginning of a scheduled shift, limited to Surgical Services and in accordance with Article 14.2. Such a reduction of scheduled hours will result in PTO accrual for all low census hours in accordance with Article 10.2.

3. **Delayed start time.** If a nurse is notified of a delayed start time without being placed on-call, the nurse will have no obligation to be available until the adjusted shift start time.

4. **Surgical Services Committee.** The Surgical Services nurses shall be provided the opportunity to draft and present recommendations to the Peace Harbor Medical Center Surgical Services Committee with regard to scheduling of surgery cases. The Employer agrees to meet with the Surgical Services nurses in advance to provide information needed by the nurses to formulate their recommendations.

5. **On-call scheduling exemption.** All nurses who have at least eighteen (18) years of service in Surgical Services at the Employer may elect to be exempt from on-call scheduling, provided that such exemption does not result in an increased call burden for other Surgical Services nurses.
MEMORANDUM OF UNDERSTANDING
OB On-Call Position

The Oregon Nurses Association ("Association") and PeaceHealth Peace Harbor Medical Center ("Employer") hereby mutually agree that the Employer in its discretion may create and maintain one or more benefited OB positions consisting exclusively of on-call hours. The Employer also has the right to discontinue such on-call positions. Existing on-call positions shall have the following parameters unless agreed otherwise between the parties:

1. Regularly scheduled on-call hours shall consist of no more than seven (7) shifts totaling no more than 84 hours per week, with every other week off. The positions consist of no regularly scheduled hours of work.

2. The position shall be defined and in all respects treated as a regular benefited position, including benefit eligibility under Articles 10 and 15 of the parties’ Agreement.

3. The position will have a guaranteed pay and PTO accrual of thirty-six (36) hours per week. The nurse will be paid at the regular straight-time hourly rate, and shall not be eligible for time and one-half pay except as provided in Paragraph 4 of this Memorandum. On-call nurses shall not be eligible for on-call compensation under Section 9.6 or for minimum call-in compensation under Section 9.15.4.

4. After working twelve (12) consecutive hours on a shift or forty (40) hours in a week, the nurse will be paid at the rate of time and one-half the regular rate of pay.

5. Work assignment from an on-call status shall be limited to direct patient care on the OB nursing unit. A nurse in an on-call only position may not be scheduled to work on another nursing unit without the nurse’s consent during regularly scheduled position call hours. The nurse may, however, volunteer for work in addition to the nurse’s regularly scheduled on-call hours on a regularly scheduled day off on any unit for which he or she is qualified. In addition, the nurse may be scheduled at a mutually agreeable time for work up to 8 hours per month for skill maintenance or inservice during any work day.
6. Holiday call pay rates specified in 9.6 shall not apply. Work from an on call status on a holiday shall be compensated at the premium rate as specified in 9.15.4, and shall count toward the first forty (40) hours worked in the pay period if part of the nurse’s regular call schedule or required holiday rotation.

7. The rate and applicable hours of the shift differentials specified in 9.5, Shift Differential, and weekend differential specified in 9.9 shall apply to all hours worked from an on-call status.

8. This position shall be posted and awarded in compliance with Article 13, Posting of Vacancies.

9. The Employer agrees to relieve, upon request, OB on-call nurses of duty after they have worked twelve (12) continuous hours.

10. The Employer has the right to compensate nurses in excess of the terms and amounts set forth in this Memorandum of Understanding as long as (1) the Association is notified prior to implementation, (2) all nurses in OB on-call positions are treated in an equivalent manner, and (3) such excess compensation is not reduced without providing notice to and offering to bargain with the Association.

11. The parties acknowledge that either party may request to bargain new or modified terms of this MOU based on changed staffing needs or an opportunity for providing better staffing coverage in the OB. Upon such request, the requested party shall agree to meet and bargain regarding any such new or modified terms. Neither party shall be obligated to reach agreement on new or modified terms, but both parties shall bargain in good faith to reach an agreement. The parties acknowledge and understand that failure to reach agreement on modified terms could result in discontinuance of the OB on-call position.
OREGON NURSES ASSOCIATION

By: [Signature]

Date: 1/30/14

PEACEHEALTH PEACE HARBOR MEDICAL CENTER

By: [Signature]

Date: 1/30/2014
MEMORANDUM OF UNDERSTANDING

Staff Meetings and Mandatory Meetings

PeaceHealth Peace Harbor Medical Center and the Oregon Nurses Association (“Association”) hereby agree as follows:

1. **Staff meetings.** A nurse will be required to attend 50% of all staff meetings for his or her department each fiscal year. Nurses will have the opportunity to participate by telephone. Nurses who do not attend will be required to review minutes of the meeting. In nursing units that operate on a 24/7 basis, staff meetings will be conducted at least two (2) separate times to allow for attendance by nurses working on different shifts. Attendance for an individual nurse will be excused if the nurse has no opportunity to attend because the nurse is on duty at the only time he or she could attend the meeting. Staff meetings will be posted on or before the beginning of each fiscal year.

2. **Mandatory meetings.** In addition to staff meetings, nurses will be required to attend up to three (3) mandatory meetings per fiscal year. In nursing units that operate on a 24/7 basis, staff meetings will be conducted at least three (3) separate times to allow for attendance by nurses working on different shifts. Attendance for an individual nurse will be excused in the event of illness, emergency or pre-approved PTO. Nurses are expected to avoid such an exceptional circumstance whenever possible.

3. **Compensation.** Nurses required to make an extra trip to the Medical Center to attend a staff meeting or mandatory meeting shall receive two (2) hours of pay at the appropriate rate for attending the meeting. Nurses who participate by telephone will receive pay for actual time spent in attendance by phone.

OREGON NURSES ASSOCIATION          PEACEHEALTH PEACE HARBOR
                                    MEDICAL CENTER

By: [Signature]                     By: [Signature]

Date  1/30/14                      Date:  1/28/13014
MEMORANDUM OF UNDERSTANDING
Career Pathways and RN Recruitment

PeaceHealth Peace Harbor Medical Center (“Employer”) and the Oregon Nurses Association (“Association”) acknowledge that expected turnover over the next several years among health care professionals at the Employer, including registered nurses in the bargaining unit, will present a significant staffing challenge. The Employer has invested considerable energy and funds under its Career Pathways program to address the future need for sufficiently qualified health care professionals, including registered nurses. It is imperative that the Employer be successful in meeting these expected turnover needs. A critical factor in meeting these needs will be the availability of learning and training opportunities and the opportunity for employment at the Employer among recent RN graduates.

Accordingly, the parties agree that, during the life of the Agreement, the Employer may, notwithstanding the provisions of Article 13, employ recent RN graduates to work in specified areas of the Medical Center for training and education in the medical/surgical area and in specialty skills areas. The goal is to provide such nurses with the opportunity to acquire skills that will qualify them for positions that thereafter become available and posted in accordance with Article 13. While employed in a training capacity, such nurses will be members of the bargaining unit and covered by the provisions of the parties’ Agreement.

The training opportunities provided to recent RN graduates in specialty skills areas shall not preempt the opportunity of other bargaining unit nurses to acquire such training, provided that any nurse desiring such training (1) has requested the training in writing, and (2) is willing to commit to filling a vacancy on any shift in the specialty skills area in which the nurse receives training.

OREGON NURSES ASSOCIATION  PEACEHEALTH PEACE HARBOR MEDICAL CENTER

By: [Signature] By: [Signature]

Date 1/30/14 Date 1/30/14
MEMORANDUM OF UNDERSTANDING
Low Census Maximum Pilot Program

The Oregon Nurses Association ("Association") and PeaceHealth Peace Harbor Medical Center ("Employer") hereby mutually agree that the following pilot program shall be implemented for nurses in the bargaining unit:

1. Effective the first full pay period following January 1, 2014 and continuing through December 31, 2014, the Employer will limit assignment of mandatory low census to regular nurses to a maximum of fifteen percent (15%) of a nurse’s regular scheduled hours per six (6) month period of January – June or July – December. Hours count toward the low census maximum only when low census is assigned pursuant to clause (5) of Section 14.2.b of the parties’ Agreement. In the event that one or more nurses on a unit end shift approach the maximum, the Employer may, notwithstanding this clause, assign low census to assure equitable distribution among all nurses on the unit and shift.

2. As part of this pilot program, nurses who have been placed on low census at the beginning of their shift may be assigned a later start time that is up to two (2) hours later than the shift’s normal start time. Time worked on the shift following the late start time will be paid at the regular rate of pay.

3. This pilot program will terminate effective January 1, 2015 unless the parties agree to extend the program in its current or modified form.

OREGON NURSES ASSOCIATION PEACEHEALTH PEACE HARBOR MEDICAL CENTER

By: _____________________________  By: _____________________________

Date 1/30/14  Date 1/30/2014
COMPLAINTS

(1) Any person may make a complaint verbally or in writing to the Division regarding an allegation against a hospital of a violation of any health care facility licensing law or condition of participation.

(2) The identity of a person making a complaint will be kept confidential.

An investigation will be carried out as soon as practicable after the receipt of a complaint in accordance with OAR 333-501-0010.

(4) If the complaint involves an allegation of criminal conduct or an allegation that is within the jurisdiction of another local, state, or federal agency, the Division will refer the matter to that agency.

Investigations

(1) As soon as practicable after receiving a complaint, taking into consideration the nature of the complaint, Division staff will begin an investigation.

(2) A hospital shall permit Division staff access to the facility during an investigation.

(3) An investigation may include but is not limited to:

(a) Interviews of the complainant, patients of the hospital, patient family members, witnesses, hospital management and staff;

(b) On-site observations of patients, staff performance, and the physical environment of the hospital; and

(c) Review of documents and records.

(4) In determining whether a violation has occurred under OAR 333-501-0020(6), the Division will consider the facility name, advertising used, and related content.
(5) Except as otherwise specified in 42 CFR § 401, Subpart B, information obtained by the Division during an investigation of a complaint or reported violation under this section is confidential and not subject to public disclosure under ORS 192.410 to 192.505. Upon the conclusion of the investigation, the Division may publicly release a report of its findings but may not include information in the report that could be used to identify the complainant or any patient at the health care facility. The Division may use any information obtained during an investigation in an administrative or judicial proceeding concerning the licensing of a health care facility, and may report information obtained during an investigation to a health professional regulatory board as defined in ORS 676.160 as that information pertains to a licensee of the board.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.057
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 31-2016, f. 11-14-16, cert. ef. 11-15-16

333-501-0015

Surveys

(1) The Division shall, in addition to any investigations conducted under OAR 333-501-0010, conduct at least one on-site licensing survey of each hospital every three years to determine compliance with health care facility licensing laws and at such other times as the Division deems necessary.

(2) In lieu of an onsite inspection required under section (1) of this rule, the Division may accept:

(a) CMS certification by a federal agency or an approved accrediting organization; or

(b) A survey conducted within the previous three years by an accrediting organization approved by the Division, if:

(A) The certification or accreditation is recognized by the Division as addressing the standards and condition of participation requirements of the CMS and other standards set by the Division. Health care facilities must provide the Division with the letter from CMS indicating its deemed status;

(B) The health care facility notifies the Division to participate in any exit interview conducted by the federal agency or accrediting body; and

(C) The health care facility provides copies of all documentation concerning the certification or accreditation requested by the Division.

(3) A hospital shall permit Division staff access to the facility during a survey.

(4) A survey may include but is not limited to:

(a) Interviews of patients, patient family members, hospital management and staff;

(b) On-site observations of patients, staff performance, and the physical environment of the hospital facility;

(c) Review of documents and records; and

(d) Patient audits.
(5) A hospital shall make all requested documents and records available to the surveyor for review and copying.

(6) Following a survey Division staff may conduct an exit conference with the hospital administrator or his or her designee. During the exit conference Division staff shall:

(a) Inform the hospital representative of the preliminary findings of the inspection; and

(b) Give the person a reasonable opportunity to submit additional facts or other information to the surveyor in response to those findings.

(7) Following the survey, Division staff shall prepare and provide the hospital administrator or his or her designee specific and timely written notice of the findings.

(8) If the findings result in a referral to another regulatory agency, Division staff shall submit the applicable information to that referral agency for its review and determination of appropriate action.

(9) If no deficiencies are found during a survey, the Division shall issue written findings to the hospital administrator indicating that fact.

(10) If deficiencies are found, the Division shall take informal or formal enforcement action in compliance with OAR 333-501-0025 or 333-501-0030.

Stat. Auth.: ORS 441.025 & 441.062
Stats. Implemented: ORS 441.060 & 441.062
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10

333-501-0020

Violations

In addition to non-compliance with any health care facility licensing law or condition of participation, it is a violation to:

(1) Refuse to cooperate with an investigation or survey, including but not limited to failure to permit Division staff access to the hospital, its documents or records;

(2) Fail to implement an approved plan of correction;

(3) Fail to comply with all applicable laws, lawful ordinances and rules relating to safety from fire;

(4) Refuse or fail to comply with an order issued by the Division;

(5) Refuse or fail to pay a civil penalty;

(6) Fail to comply with rules governing the storage of medical records following the closure of a hospital;

(7) Establish, conduct, maintain, manage or operate a health care facility or health maintenance organization, without a license; or
(6) Use the terms "emergency," "emergency department (ED)," "emergency room (ER)," "emergency-," "emergent-," or "emergi-care center" or any derivative term in a posted name or advertising that would give the impression that emergency medical services as that is defined in OAR 333-500-0010 is provided by the person at a particular facility unless that facility is a hospital licensed under ORS 441.025 with an emergency department. Use of the words "urgent" or "immediate" shall not be considered derivative terms.

(9) A person not licensed as a hospital under ORS 441.025 with an emergency department using the terms prescribed in section (6) of this rule has 90 days from November 15, 2016 to come into compliance.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.015, 441.025, 441.030 & 441.055
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 31-2016, f. 11-14-16, cert. ef. 11-15-16

333-501-0025

Informal Enforcement

(1) If, during an investigation or survey Division staff document violations of health care facility licensing laws or conditions of participation, the Division may issue a statement of deficiencies that cites the law alleged to have been violated and the facts supporting the allegation.

(2) A signed plan of correction must be received by the Division within 10 business days from the date the statement of deficiencies was mailed to the hospital. A signed plan of correction will not be used by the Division as an admission of the violations alleged in the statement of deficiencies.

(3) A hospital shall correct all deficiencies within 60 days from the date of the exit conference, unless an extension of time is requested from the Division. A request for such an extension shall be submitted in writing and must accompany the plan of correction.

(4) The Division shall determine if a written plan of correction is acceptable. If the plan of correction is not acceptable to the Division, the Division shall notify the hospital administrator in writing and request that the plan of correction be modified and resubmitted no later than 10 working days from the date the letter of non-acceptance was mailed to the administrator.

(5) If the hospital does not come into compliance by the date of correction reflected on the plan of correction or 60 days from date of the exit conference, whichever is sooner, the Division may propose to deny, suspend, or revoke the hospital license, or impose civil penalties.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.015 & 441.025
Hist.: PH 11-2009, f. & cert. ef. 10-1-09

333-501-0030

Formal Enforcement

(1) If, during an investigation or survey Division staff document substantial failure to comply with health care facility licensing laws, conditions of participation or if a hospital fails to pay a civil penalty imposed under ORS 441.170, the Division may issue a Notice of Proposed Suspension or Notice of Proposed Revocation in accordance with ORS 183.411 through 183.470.
(2) The Division may issue a Notice of Imposition of Civil Penalty for violations of health care facility licensing laws.

(3) At any time the Division may issue a Notice of Emergency License Suspension under ORS 183.430(2).

(4) If the Division revokes a hospital license, the order shall specify when, if ever, the hospital may reapply for a license.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.015 & 441.025
Hist.: PH 11-2009, f. & cert. ef. 10-1-09

333-501-0035

Nurse Staffing Audit Procedure

(1) The Authority shall conduct an on-site audit of each hospital once every three years to determine compliance with the requirements of ORS 441.152 to 441.177 and 441.192. The Authority shall notify the hospital and both co-chairs of the hospital nurse staffing committee three business days in advance of the audit.

(2) During an audit, the Authority shall review any hospital record and conduct any interview or site visit that is necessary to determine that the hospital is in compliance with the requirements of ORS 441.152 to 441.177 and 441.192.

(3) In conducting an audit, the Authority shall interview:

(a) Both co-chairs of the hospital nurse staffing committee; and

(b) Any additional hospital staff members deemed necessary to determine compliance with applicable nurse staffing laws. Interviews may address, but are not limited to, the following topics:

(A) Implementation and effectiveness of the hospital-wide staffing plan for nursing services;

(B) Input, if any, provided to the hospital nurse staffing committee; or

(C) Any other fact relating to hospital nursing services subject to the Authority’s review.

(4) In conducting an audit, the Authority may also interview:

(a) Hospital staff that does not voluntarily come forward for an interview during an audit; and

(b) Hospital patients or family members. Interviews may address, but are not limited to, any concerns or complaints related to nurse staffing in the hospital.

(5) Following an audit, the Authority shall issue a written survey report that communicates the results of the audit no more than 30 business days after the survey closes. This survey report:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and

(b) May include a notice of civil penalties that complies with ORS 441.175 and OAR 333-501-0045.
(6) If the survey report identifies any area of noncompliance, the hospital shall submit a written plan to correct each identified deficiency. This plan:

(a) Shall be called the plan of correction;

(b) Shall be submitted no more than 30 business days after receiving the Authority's survey report; and

(c) Shall be evaluated by the Authority for sufficiency.

(7) No more than 30 business days after receipt of the hospital's plan of correction, the Authority shall issue a written determination that communicates whether the plan of correction is sufficient. This determination:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and

(b) Shall require the hospital to either:

(A) Revise and resubmit the rejected plan of correction no more than 30 business days after receiving the Authority's determination that the plan is insufficient; or

(B) Implement the approved plan of correction no more than 45 business days after receiving the Authority's determination that the plan is sufficient.

(8) Following the approval of the plan of correction, the Authority shall conduct a second audit of the hospital to verify that the hospital has implemented the approved plan of correction. This audit shall be conducted within 60 business days of the plan of correction approval date.

(9) The identity of an individual providing evidence during an audit will be kept confidential to the extent permitted by law.

Stat. Auth.: ORS 413.042, 441.157 & 441.175
Stats. Implemented: ORS 441.157
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 22-2016, f. & cert. ef. 7-1-16

333-501-0040

Nurse Staffing Complaint Investigation Procedures

(1) The Authority shall conduct an unannounced on-site investigation of a hospital within 60 calendar days after receiving a valid complaint against the hospital for violating a provision of ORS 441.152 to 441.177. A complaint is valid when an allegation, if assumed to be true, would violate a requirement of ORS 441.152 to 441.177.

(2) During an investigation, the Authority shall review any hospital record and conduct any interview or site visit that is necessary to determine whether the hospital has violated a provision of ORS 441.152 to 441.177.

(3) In conducting an investigation, the Authority may:

(a) Review any documentation that may be relevant to the complaint, including patient records; and
(b) Interview any person who may have information relevant to the complaint, including patients and family members.

(4) In reviewing information collected during an investigation, the Authority shall consider:

(a) The amount and strength of objective evidence, if any, that substantiates or refutes the complaint; and
(b) The number and credibility of witnesses, if any, who attest to or refute an alleged violation.

(5) Following an investigation, the Authority shall issue a written investigation report that communicates the results of the investigation no more than 30 business days after the investigation closes. This investigation report:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and
(b) May include a notice of civil penalties that complies with ORS 441.175 and OAR 333-501-0045.

(6) If the investigation report identifies any area of noncompliance, the hospital shall submit a written plan to correct each identified deficiency. This plan:

(a) Shall be called the plan of correction;
(b) Shall be submitted no more than 30 business days after receiving the Authority's investigation report; and
(c) Shall be evaluated by the Authority for sufficiency.

(7) No more than 30 business days after receipt of the hospital's plan of correction, the Authority shall issue a written determination that communicates whether the plan of correction is sufficient. This determination:

(a) Shall be issued to the hospital and both co-chairs of the hospital nurse staffing committee; and
(b) Shall require the hospital to either:

(A) Revise and resubmit the rejected plan of correction no more than 30 business days after receiving the Authority's determination that the plan is insufficient; or
(B) Implement the approved plan of correction no more than 45 business days after receiving the Authority's determination that the plan is sufficient.

(8) Following the approval of the plan of correction, the Authority shall conduct a second investigation of the hospital to verify that the hospital has implemented the approved plan of correction. This investigation shall be conducted within 60 business days of the plan of correction approval date.

(9) The identity of an individual providing evidence during an investigation will be kept confidential to the extent permitted by law.

Stat. Auth.: ORS 413.042, 441.025, 441.057, 441.171 & 441.175
Stats. Implemented: ORS 441.057 & 441.171
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 22-2016, f. & cert. ef. 7-1-16
333-501-0045

Civil Penalties for Violations of Nurse Staffing Laws

(1) For the purposes of this rule, "safe patient care" has the meaning given to the term in OAR 333-510-0002.

(2) The Authority may impose civil penalties for a violation of any provision of ORS 441.152 to 441.177 and 441.185 if there is a reasonable belief that safe patient care has been or may be negatively impacted.

(3) Each violation of the written hospital-wide staffing plan shall be considered a separate violation.

(4) If imposed, the Authority will issue civil penalties in accordance with Table 1 of this rule.

(5) In determining whether to issue a civil penalty, the Authority will consider all relevant evidence including, but not limited to, witness testimony, written documents and observations.

(6) A civil penalty imposed under this rule shall comply with ORS 183.745.

(7) The Authority shall maintain for public inspection records of any civil penalties imposed on hospitals penalized under this rule.

[ED. NOTE: Table referenced is not included in rule text. Click here for PDF copy of table.]

Stat. Auth.: ORS 413.042, 441.175 & 441.185
Stats. Implemented: ORS 441.175 & 441.185
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 22-2016, f. & cert. ef. 7-1-16

333-501-0050

Civil Penalties for Violation of Smoking Prohibition

(1) If the Division determines that an administrator or person in charge of a hospital permits a person to smoke tobacco in a hospital or within 10 feet of a doorway, open window or ventilation intake of a hospital, the Division may assess a civil penalty of not more than $500 per day against the administrator or the person in charge of a hospital.

(2) In determining whether an administrator or person in charge of a hospital has permitted a person to smoke tobacco in violation of ORS 441.815, the Division shall consider whether:

(a) A hospital administrator or person in charge of a hospital has taken steps to enforce the smoking prohibitions, including calling law enforcement to report a violation;

(b) The hospital administrator or person in charge of a hospital took affirmative action to address any complaints about smoking in a hospital or within 10 feet of a doorway, open window or ventilation intake of a hospital; and

(c) A hospital administrator or person in charge of a hospital has taken steps to educate the public and staff about the smoking ban.

(3) A civil penalty issued under this rule shall not exceed $2,000 in any 30-day period.
(4) A civil penalty imposed under this rule shall comply with ORS 183.745.

Stat. Auth.: ORS 441.815
Stats. Implemented: ORS 441.815
Hist.: PH 11-2009, f. & cert. ef. 10-1-09

333-501-0055

Civil Penalties, Generally

(1) This rule does not apply to civil penalties for violations of ORS 441.155, 441.166, 441.815, or 435.254 or rules adopted to implement these statutes.

(2) A person that violates a health care facility licensing law, including OAR 333-501-0020 (violations), is subject to the imposition of a civil penalty not to exceed $500 per day per violation.

(3) In addition to the penalties under section (2) of this rule, civil penalties may be imposed for violations of ORS 441.030 or 441.015(1).

(4) In determining the amount of a civil penalty the Division shall consider whether:

(a) The Division made repeated attempts to obtain compliance;

(b) The licensee has a history of noncompliance with health care facility licensing laws;

(c) The violation poses a serious risk to the public’s health;

(d) The licensee gained financially from the noncompliance; and

(e) There are mitigating factors, such as a licensee’s cooperation with an investigation or actions to come into compliance.

(5) The Division shall document its consideration of the factors in section (4) of this rule.

(6) Each day a violation continues is an additional violation.

(7) A civil penalty imposed under this rule shall comply with ORS 183.745.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.990
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 31-2016, f. 11-14-16, cert. ef. 11-15-16

333-501-0060

Approval of Accrediting Organizations

(1) An accrediting organization may request approval by the Division to ensure that hospitals meet state licensing standards.

(2) An accrediting organization shall request approval in writing and shall provide, at a minimum:
(a) Evidence that it is recognized as a deemed organization by CMS, or

(b) If the accrediting organization is not a deemed organization under CMS, provide:

(A) Documentation of program policies and procedures that its accreditation process meets state licensing standards;

(B) Accreditation history; and

(C) References from a minimum of two facilities currently receiving services from the organization.

(3) If the Division finds that an accrediting organization has the necessary qualifications to certify that state licensing standards have been met, the Division will enter into an agreement with the accrediting organization.

Stat. Auth.: ORS 441.062
Stats. Implemented: ORS 441.062
Hist.: PH 25-2010, f. 12-14-10, cert. ef. 12-15-10

Source: Oregon Administrative Rules, Oregon Health Authority, Public Health Division. 
DIVISION 510

PATIENT CARE AND NURSING SERVICES IN HOSPITALS

333-510-0001

Applicability

These rules apply to all hospitals, regardless of classification.

Stat. Auth.: ORS 413.042 & 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HD 21-1993, f. & cert. ef. 10-28-93; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0002

Definitions

As used in OAR chapter 333, division 510, the following definitions apply:

(1) "Direct Care Registered Nurse" means a nurse who is routinely assigned to a patient care unit, who is replaced for scheduled and unscheduled absences and includes charge nurses if the charge nurse is not management services.

(2) "Direct Care Staff" means registered nurses, licensed practical nurses and certified nursing assistants that are routinely assigned to patient care units and are replaced for scheduled or unscheduled absences.

(3) "Direct Care Staff Member" means an individual who is a direct care registered nurse, licensed practical nurse or certified nursing assistant who is routinely assigned to a patient care unit and is replaced for a scheduled or unscheduled absences.

(4) "Epidemic" means the occurrence of a group of similar conditions of public health importance in a community or region that are in excess of normal expectancy and that are from a common or propagated source.

(5) "Evidence Based Standards" means standards that have been scientifically developed, are based on current literature, and are driven by consensus.

(6) "Hospital" means a hospital as described in ORS 442.015 and an acute inpatient care facility as defined in ORS 442.470.

(7) "Mandatory Overtime" is any time that exceeds those time limits specified in ORS 441.166 unless the nursing staff member voluntarily chooses to work overtime.

(8) "Nurse Manager" means a registered nurse who has administrative responsibility 24 hours a day, 7 days a week for a patient care unit, units or hospital and who is not replaced for short-term scheduled or unscheduled absences.
(9) "Nursing care intensity" means the level of patient need for nursing care as determined by the nursing assessment.

(10) "Nursing staff" means registered nurses, licensed practical nurses and certified nursing assistants.

(11) "Nursing staff member" means an individual who is a registered nurse, licensed practical nurse or a certified nursing assistant.

(12) "On Call" means a scheduled state of availability to return to duty, work-ready, within a specified period of time.

(13) "On Call Nursing Staff" means individual nursing staff members or nursing service agencies maintained by a hospital that are available and willing to cover nursing staff shortages due to unexpected nursing staff absences or unanticipated increased nursing service needs.

(14) "Patient acuity" means the complexity of patient care needs requiring the skill and care of nursing staff.

(15) "Potential Harm" or "At Risk of Harm" means that an unstable patient will be left without adequate care for an unacceptable period of time if the assigned nursing staff member leaves the assignment or transfers care to another nursing staff member.

(16) "Quorum" means that a majority, or one-half plus one, of the staffing committee members are present during a staffing committee meeting.

(17) "Safe Patient Care" means nursing care that is provided appropriately, in a timely manner, and meets the patient's health care needs. The following factors may be, but are not in all circumstances, evidence of unsafe patient care:

(a) A failure to implement the written nurse staffing plan;

(b) A failure to comply with the patient care plan;

(c) An error that has a negative impact on the patient;

(d) A patient report that his or her nursing care needs have not been met;

(e) A medication not given as scheduled;

(f) The nursing preparation for a procedure that was not accomplished on time;

(g) A nursing staff member who was practicing outside his or her authorized scope of practice;

(h) Daily unit-level staffing that does not include coverage for all known patients, taking into account the turnover of patients;

(i) The skill mix of employees and the relationship of the skill mix to patient acuity and nursing care intensity of the workload is insufficient to meet patient needs; or
(j) An unreasonable delay in responding to a request for nursing care made by a patient or made on behalf of a patient by his or her family member.

(18) "Staffing Committee" means the hospital nurse staffing committee.

(19) "Staffing Plan" means the written hospital-wide staffing plan for nursing services developed by the hospital nurse staffing committee.

(20) "Standby" means a scheduled state of availability to return to duty, work-ready within a specified period of time.

(21) "Waiver" means a variance to the hospital-wide staffing plan requirements as described in ORS 441.164.

Stat. Auth.: ORS 413.042 & 441.151 – 441.177
Stats. Implemented: ORS 441.165, 441.166 & 441.179
Hist.: PH 21-2006, f. & cert. ef. 10-6-06; PH 11-2009, f. & cert. ef. 10-1-09; PH 22-2016, f. & cert. ef. 7-1-16

333-510-0010

Patient Admission and Treatment Orders

(1) No patient, including patients admitted for observation status, shall be admitted to a hospital except on the order of an individual who has admitting privileges. The admitting physician or nurse practitioner shall provide sufficient information at the time of admission to establish that care can be provided to meet the needs of the patient. Admission medical information shall include a statement concerning the admitting diagnosis and general condition of the patient. Other pertinent medical information, orders for medication, diet, and treatments shall also be provided, as well as a medical history and physical.

(2) Within 24 hours of a patient’s admission, a hospital shall ensure that:

(a) The patient’s medical history is taken and a physical examination performed, unless:

(A) A medical history and physical examination has been completed within 30 days prior to admission, as provided in the medical staff rules and regulations; or

(B) The patient is readmitted within a month’s time for the same or related condition, as long as an interval note is completed.

(b) The patient is given a provisional diagnosis.

(3) Even if a medical history or physical examination at the time of admission is not required under section (2) of this rule, a hospital shall ensure that any changes crucial to patient care are noted in an admission note.
(4) Visits from licensed health care providers shall be according to patient's needs. Initial and ongoing assessments shall be performed for each patient and the results and observations recorded in the medical record.

(5) A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) or nurse practitioner with admitting privileges shall be responsible, as permitted by the individual's scope of practice for the care of any medical problem that may be present on admission or that may arise during an inpatient stay.

(6) No medication or treatment shall be given except on the order of a licensed healthcare professional authorized to give such orders within the State of Oregon.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015

333-510-0020

Nursing Care Management

(1) The nursing care of each patient, including patients admitted for observation status, in a hospital shall be the responsibility of a registered nurse (RN).

(2) The RN will only provide services to the patients for which the RN is educationally and experientially prepared and for which competency has been maintained.

(3) The RN shall be responsible and accountable for managing the nursing care of the RN's assigned patients. The RN shall only assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. The responsible RN shall ensure that the following activities are completed:

(a) Document the admission assessment of the patient within four hours following admission and initiate a written plan of care. This shall be reviewed and updated whenever the patient's status changes.

(b) Develop and document within eight hours following admission a plan of care for nursing services for the patient, based on the patient assessment and realistic, understandable, achievable patient goals consistent with the applicable rules in OAR chapter 851, division 045.

(c) Observe and report to the nurse manager and the patient's physician or other responsible health care provider authorized by law, when appropriate, any significant changes in the patient's condition that warrant interventions that have not been previously prescribed or planned for:
(A) When the RN questions the efficacy, need or safety of continuation of medications being administered to a patient, the RN shall report that question to the physician or other responsible health care provider authorized by law authorizing the medication and shall seek further instructions concerning the continuation of the medication.

(4)(a) A hospital shall maintain documentation of certification of certified nursing assistants (CNAs), which shall be available on request to Division personnel.

(b) A nursing assistant who works in a hospital must be certified prior to assuming nursing assistant duties in accordance with OAR chapter 851, division 062.

(c) A hospital shall maintain documentation that CNAs whose functions include administration of non-injectable medications, are qualified. This documentation shall be available on request to Division personnel.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015

333-510-0030

Nursing Services

(1) The hospital shall provide a nursing service department, which provides 24-hour onsite registered nursing care, 7 days per week.

(2) The nursing services department shall be under the direction of a nurse executive who is a registered nurse, licensed to practice in Oregon.

(3) All nursing personnel shall maintain current certification in cardiopulmonary resuscitation.

Stat. Auth.: ORS 413.042, 441.055
Stats. Implemented: ORS 441.160 - 441.192

333-510-0040

Nurse Executive

(1) The nurse executive position shall be full-time (40 hours per week). Time spent in professional association workshops, seminars and continuing education may be counted as
duties in considering whether or not the nurse executive is full-time. If the nurse executive has responsibility for direct patient care activities, sufficient time must be available to devote to administrative duties. For hospitals with attached long-term care facilities, the nurse executive may function as the nurse executive for both the hospital and the long-term care facility.

(2) The nurse executive shall have had progressive responsibility in managing in a health care setting. The nurse executive shall be a registered nurse licensed in Oregon. In addition, the nurse executive must have a baccalaureate degree, other advanced degree, or appropriate equivalent experience, with emphasis in management preferred.

(3) The nurse executive shall have written administrative authority, responsibility, and accountability for assuring functions and activities of the nursing services department and shall participate in the development of any policies that affect the nursing services department. This includes budget formation, implementation and evaluation. The nurse executive shall ensure the:

(a) Development and maintenance of a nursing service philosophy, objective, standards of practice, policy and procedure manuals, and job descriptions for each level of nursing service personnel;

(b) Development and maintenance of personnel policies of recruitment, orientation, in-service education, supervision, evaluation, and termination of nursing service staff or ensure it is done by another department;

(c) Development and maintenance of policies and procedures for determination of nursing staff’s capacity for providing nursing care for any patient seeking admission to the facility;

(d) Development and maintenance of a quality assessment and performance improvement program for nursing service;

(e) Coordination of nursing service departmental function and activities with the function and activities of other departments; and

(f) Ensure participation with the administrator and other department directors in development and maintenance of practices and procedures that promote infection control, fire safety, and hazard reduction.

(4) Whenever the nurse executive is not available in person or by phone, the nurse executive shall designate in writing a specific registered nurse or nurses, licensed to practice in Oregon, to be available in person or by phone to direct the functions and activities of the nursing services department.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015

333-510-0045
Nurse Staffing Posting and Record Requirements

(1) On each hospital unit, a hospital shall post a complaint notice that:

(a) Summarizes the provisions of ORS 441.152 to 441.177;

(b) Is clearly visible to the public; and

(c) Includes the Authority’s complaint reporting phone number, electronic mail address and website address.

(2) A hospital shall also post an anti-retaliation notice on the premises that:

(a) Summarizes the provisions of ORS 441.181, 441.183, 441.184 and 441.192;

(b) Is clearly visible; and

(c) Is posted where notices to employees and applicants for employment are customarily displayed.

(3) A hospital shall keep and maintain all records necessary to demonstrate compliance with ORS 441.152 to 441.177. These records shall:

(a) Be maintained for no fewer than three years;

(b) Be promptly provided to the Authority upon request; and

(c) Include, at minimum:

(A) The staffing plan;

(B) The hospital nurse staffing committee charter;

(C) Staffing committee meeting minutes;

(D) Documentation showing how all members of the staffing committee were selected;

(E) All complaints filed with the staffing committee;

(F) Personnel files for all nursing staff positions that include, at minimum, job descriptions, required licensure and specialized qualifications and competencies required for the individual’s assigned nurse specialty or unit;

(G) Documentation showing work schedules for nursing staff in each hospital nurse specialty or unit;

(H) Documentation showing actual hours worked by all nursing staff;

(I) Documentation showing all work schedule variances that resulted in the use of replacement nursing staff;
(J) Documentation showing how many on-call hours, if any, required nursing staff to be on the hospital premises;

(K) Documentation showing how many required meeting, education and training hours, if any, were required of nursing staff;

(L) The hospital's mandatory overtime policy and procedure;

(M) Documentation showing how many, if any, overtime hours were worked by nursing staff;

(N) Documentation of all waiver requests, if any, submitted to the Authority;

(O) Documentation showing how many, if any, additional hours were worked due to emergency circumstances and the nature of those circumstances;

(P) The list of on-call nursing staff used to obtain replacement nursing staff;

(Q) Documentation showing how and when the hospital updates its list of on-call staff used to obtain replacement nursing staff and how the hospital determines eligibility to remain on the list;

(R) Documentation showing the hospital's procedures for obtaining replacement nursing staff, including efforts made to obtain replacement staff;

(S) Documentation showing the hospital's actual efforts to seek replacement staff when needed;

(T) Documentation showing each actual instance in which the hospital implemented the policy described in OAR 333-510-0110(2)(g) to initiate limitations on admission or diversion of patients to another hospital; and

(U) All staffing committee reports filed with the hospital administration following a review of the staffing plan.

Stat. Auth.: ORS 413.042, 441.155, 441.169, 441.173 & 441.185
Stats. Implemented: ORS 441.155, 441.169, 441.173 & 441.185
Hist.: OHD 2-2000, f. & cert. ef. 2-15-00; OHD 3-2001, f. & cert. ef. 3-16-01; OHD 20-2002, f. & cert. ef. 12-10-02; PH 22-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-29-06; PH 21-2006, f. & cert. ef. 10-6-06; PH 11-2009, f. & cert. ef. 10-1-09; PH 11-2009, f. & cert. ef. 10-1-09; PH 22-2016, f. & cert. ef. 7-1-16

333-510-0050

Inservice Training Requirements for Nursing

(1) The nurse executive or her or his designee shall coordinate all inservice training for nursing. Each year the inservice training agenda shall include at least the following:

(a) Infection control measures;

(b) Emergency procedures including, but not limited to, procedures for fire and other disaster;
(c) Application of physical restraints (if the facility population includes any patient with orders for
restraints); and

(d) Other special needs of the facility population.

(2) Training for procedures for life-threatening situations, including cardiopulmonary
resuscitation shall be provided every two years.

(3) The facility, through the nurse executive, shall assure that each licensed or certified
employee is knowledgeable of the laws and rules governing his or her performance and that
employees function within those performance standards.

(4) Documentation of such training shall include the date, content and names of attendees.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HD 29-1988, f. 12-29-88, cert. ef. 1-1-89; HD 21-1993, f. & cert. ef. 10-28-93; OHD 2-
2000, f. & cert. ef. 2-15-00; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0060

Patient Environment

(1) A hospital shall provide for each patient:

(a) A good bed, mattress, pillow with protective coverage, and necessary bed coverings;

(b) Items needed for personal care; and

(c) Separate storage space for clothing, toilet articles, and other personal belongings.

(2) In multiple-bed rooms, opportunity for patient privacy shall be provided by flame retardant
curtains or screens. In hospitals caring for pediatric patients, cubicle curtains or screens are not
required for beds assigned these patients.

(3) No patient shall be admitted to a bed in any room, other than one regularly designated as a
bedroom or ward. The placing of a patient’s bed in a diagnostic room, treatment room, operating
room or delivery room is expressly prohibited, except under emergency circumstances.

(4) No towels, wash cloths, bath blankets, or other linen which comes directly in contact with the
patient shall be interchangeable from one patient to another unless it is first laundered.

(5) Temperature-controlled pads shall be so covered that the patient cannot be harmed by
excessive heat or cold and carefully checked as to temperature and leakage. Electrical heating
pads, blankets, or sheets shall be used only on the written order of the physician or other health
care practitioner authorized by law.

(6) The use of torn or unclean bed linen is prohibited.
(7) In facilities caring for pediatric patients, an emergency signaling system for use by
attendants summoning assistance and a two-way voice intercommunication system between
the nurses' station and rooms or wards housing pediatric patients shall be provided.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HB 183, f. & ef. 5-26-66; HB 209, f. 12-18-68; HD 11-1980, f. & ef. 9-10-80; Renumbered
from 333-023-0170; HD 5-1981, f. & ef. 3-30-81; Renumbered from 333-023-0172; HD 29-1988,
f. 12-29-88, cert. ef. 1-1-89, Renumbered from 333-072-0010 & 333-072-0015(3) thru (6); HD
21-1993, f. & cert. ef. 10-28-93; HD 2-2000, f. & cert. ef. 2-15-00; PH 11-2009, f. & cert. ef. 10-
1-09

333-510-0105

Nurse Staffing Committee Requirement

(1) Each hospital shall establish and maintain a hospital nurse staffing committee. The staffing
committee shall develop a written hospital-wide staffing plan for nursing services in accordance
with ORS 441.155 and OAR chapter 333, division 510 rules. In developing the staffing plan, the
staffing committee’s primary goal shall be to ensure that the hospital is adequately staffed to
meet the health care needs of its patients.

(2) The staffing committee shall meet:

(a) At least once every three months; and

(b) At any time and place specified by either co-chair of the staffing committee.

(3) The hospital shall release a member of the staffing committee from his or her assignment to
attend committee meetings and provide paid time for this purpose.

(4) The staffing committee shall be comprised of an equal number of hospital nurse managers
and direct care staff. Direct care staff members shall be selected as follows:

(a) The staffing committee shall include at least one direct care registered nurse from each
hospital nurse specialty or unit as the specialty or unit is defined by the hospital to represent that
specialty or unit;

(b) In addition to the direct care registered nurses described in subsection (a) of this section
there must be one position on the staffing committee that is filled by a direct care staff member
who is not a registered nurse and whose services are covered by the staffing plan;

(c) If the direct care registered nurses working at the hospital are represented under a collective
bargaining agreement, the bargaining unit shall coordinate voting to allow the direct care
registered nurses who work at the hospital to select each direct care registered nurse on the
staffing committee;
(d) If the direct care registered nurses working at the hospital are not represented under a collective bargaining agreement, the direct care registered nurses belonging to each hospital nurse specialty or unit shall select the direct care registered nurse to represent it on the staffing committee; and

(e) If the position that must be filled by a direct care staff member who is not a registered nurse and whose services are covered by the staffing plan is represented under a collective bargaining agreement, the bargaining unit shall coordinate voting to allow the direct care staff members who are not registered nurses to select the direct care staff member who is not a registered nurse to represent them on the staffing committee.

(f) If the position that must be filled by a direct care staff member who is not a registered nurse and whose services are covered by the staffing plan is not represented under a collective bargaining agreement, the direct care staff members who are not registered nurses shall select the direct care staff member who is not a registered nurse to represent them on the staffing committee.

(5) The staffing committee shall have two co-chairs. One co-chair must be a hospital nurse manager elected by a majority of the staffing committee members who are hospital nurse managers. The other co-chair must be a direct care registered nurse elected by a majority of the staffing committee members who are direct care staff.

(6) The staffing committee must develop a written charter that documents the policies and procedures of the staffing committee. At minimum, the charter must include:

(a) How meetings are scheduled;

(b) How members are notified of meetings;

(c) How agendas are determined;

(d) How input from hospital nurse specialty or unit staff is submitted;

(e) Who may participate in decision-making;

(f) How decisions are made; and

(g) How the staffing committee shall monitor, evaluate and modify the staffing plan over time.

(7) Staffing committee meetings must be conducted as follows:

(a) A meeting may not be conducted unless a quorum of staffing committee members is present;

(b) Except as set forth in subsection (c) of this section, a meeting must be open to all hospital nursing staff as observers and to any other individual as either observer or presenter by invitation of either co-chair of the staffing committee;
(c) Either co-chair of the staffing committee may temporarily exclude all non-members from a meeting during staffing committee deliberations and voting; and

(d) Each staffing committee decision must be made by majority vote; however, if a quorum consists of an unequal number of hospital nurse managers and direct care staff, only an equal number of hospital nurse managers and direct care staff may vote.

(8) The staffing committee must document meeting proceedings by keeping written meeting minutes that include, but are not limited to, the following information:

(a) The name and position of each staffing committee member in attendance;

(b) The name and position of each observer or presenter in attendance;

(c) Motions made;

(d) Outcomes of votes taken;

(e) A summary of staffing committee discussions; and

(f) Instances in which non-members have been excluded from staffing committee meetings.

(9) The staffing committee shall approve meeting minutes prior to or during the next staffing committee meeting.

(10) The staffing committee shall provide meeting minutes to hospital nursing staff and other hospital staff upon request no more than 30 calendar days after the meeting minutes are approved by the staffing committee.

Stat. Auth.: ORS 413.042, 441.151 & 441.154
Stats. Implemented: ORS 441.154
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0110

Nurse Staffing Plan Requirements

(1) Each hospital shall implement a written hospital-wide staffing plan for nursing services that is developed and approved by the hospital nurse staffing committee established in accordance with ORS 441.154 and OAR chapter 333 division 510 rules.

(2) The staffing plan:

(a) Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients;

(b) Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct
care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit;

(c) Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses;

(d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations such as, but not limited to: The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPN);

(e) Must recognize differences in patient acuity and nursing care intensity;

(f) Must establish minimum numbers of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts, provided that no fewer than one registered nurse and one other nursing staff member is on duty in a unit when a patient is present;

(g) Must include a formal process for evaluating and initiating limitations on admission or diversion of patients to another hospital when, in the judgment of a direct care registered nurse or a nurse manager, there is an inability to meet patient care needs or a risk of harm to patients;

(h) Must consider tasks not related to providing direct care, including meal breaks and rest breaks;

(i) May not base nursing staff requirements solely on external benchmarking data;

(j) May not be used by a hospital to impose upon unionized nursing staff any changes in wages, hours or other terms and conditions of employment unless the hospital first provides notice to and, upon request, bargains with the union; and

(k) May not create, preempt or modify a collective bargaining agreement or require parties to an agreement to bargain over the staffing plan while a collective bargaining agreement is in effect.

Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0115

Nurse Staffing Plan Review Requirement

(1) The staffing committee shall:

(a) Review the staffing plan at least once per year; and

(b) At any other time specified by either co-chair of the staffing committee.

(2) In reviewing the staffing plan, the staffing committee shall consider:
(a) Patient outcomes;

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

(c) The number of hours of nursing care provided through a hospital unit compared with the number of patients served by the hospital unit during a 24-hour period;

(d) The aggregate hours of mandatory overtime worked by nursing staff;

(e) The aggregate hours of voluntary overtime worked by nursing staff;

(f) The percentage of shifts for each hospital unit for which staffing differed from what is required by the staffing plan;

(g) Any other matter determined by the committee to be necessary to ensure that the hospital is staffed to meet the health care needs of patients; and

(h) Any report filed by a nursing staff member stating the nursing staff member's belief that the hospital unit engaged in a pattern of requiring direct care nursing staff to work overtime for nonemergency care.

(3) Following its review of the staffing plan, the staffing committee shall issue a written report to the hospital that indicates whether the staffing plan ensures that the hospital is adequately staffed and meets the health care needs of patients. If the report indicates that it does not, the staffing committee shall modify the staffing plan as necessary to accomplish this goal.

Stat. Auth.: ORS 413.042 & 441.156
Stats. Implemented: ORS 441.156
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0120

Nurse Staffing Plan Mediation

(1) If the staffing committee is unable to reach an agreement on the staffing plan, either co-chair of the staffing committee may invoke a waiting period of 30 business days.

(a) During the 30-day waiting period, the staffing committee shall continue to develop the staffing plan; and

(b) The hospital shall promptly respond to any reasonable requests for data that is related to the impasse and is submitted by either co-chair of the staffing committee.

(2) If at the end of the 30-day waiting period, the staffing committee remains unable to reach an agreement on the staffing plan, one of the staffing committee co-chairs shall notify the Authority of the impasse. This notification shall include:
(a) Documentation that the staffing committee voted on the provision or provisions in question and a deadlock resulted;

(b) Documentation that either co-chair of the staffing committee formally invoked a 30-day waiting period;

(c) Documentation that during the 30-day waiting period, the staffing committee continued to develop the staffing plan including documentation of options the staffing committee considered after invoking the 30-day waiting period;

(d) Documentation of any reasonable requests for data submitted to the hospital by either staffing committee co-chair and the hospital’s response, if any; and

(e) Documentation that the staffing committee voted on the provision or provisions in question again after the 30-day waiting period formally ended and another deadlock resulted.

(3) No more than 15 business days after receiving notice of an impasse, the Authority shall assign the staffing committee a mediator to assist the staffing committee in reaching an agreement on the staffing plan.

(a) Mediation shall be consistent with requirements for implementing and reviewing staffing plans set forth in ORS 441.155 and 441.156 and OAR chapter 333 division 510 rules; and

(b) Mediation shall be provided for no more than 90 calendar days.

(4) The Authority may impose civil monetary penalties against a hospital, if the staffing committee is unable to reach an agreement on the staffing plan after 90 days of mediation.

Stat. Auth.: ORS 413.042, 441.154 & 441.175
Stats. Implemented: ORS 441.154
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0125

Replacement Nurse Staffing Requirements

(1) A hospital must maintain and post or publish a list of on-call nursing staff that may be contacted to provide qualified replacement or additional nursing staff in the event of a vacancy or unexpected shortage. This list must:

(a) Provide for sufficient replacement nursing staff on a regular basis; and

(b) Be available to the individual who is responsible for obtaining replacement staff during each shift.

(2) When developing and maintaining the on-call list, the hospital must explore all reasonable options for identifying local replacement staff and these efforts must be documented.
(3) When a hospital learns about the need for replacement nursing staff, the hospital must make every reasonable effort to obtain adequate voluntary replacement nursing staff for unfilled hours or shifts before requiring a nursing staff member to work overtime and these efforts must be documented. Reasonable efforts include, but are not limited to:

(a) The hospital seeking replacement nursing staff at the time the vacancy is known; and

(b) The hospital contacting all available resources on its list of on-call nursing staff as described in this rule.

Stat. Auth.: ORS 413.042, 441.155 & 441.166
Stats. Implemented: ORS 441.155 & 441.166
Hist.: PH 22-2016, f. & cert. ef. 7-1-16

333-510-0130

Nursing Staff Member Overtime

(1) For purposes of this rule "require" means to make compulsory as a condition of employment whether as a result of a previously scheduled shift or hours actually worked during time spent on call or on standby.

(2) A hospital may not require a nursing staff member to work:

(a) Beyond the agreed-upon and prearranged shift, regardless of the length of the shift;

(b) More than 48 hours in any hospital-defined work week;

(c) More than 12 hours in a 24-hour period;

(d) During the 10-hour period immediately following the 12th hour worked during a 24-hour period. This work period begins when the nursing staff member begins a shift; or

(e) During the 10-hour period immediately following any agreed-upon and prearranged shift in which the nurse worked more than 12 hours in a 24-hour period.

(3) Time spent by the nursing staff member in required meetings or receiving education or training shall be included as hours worked for the purpose of section (2) of this rule.

(4) Time spent on call or on standby when the nursing staff member is required to be at the hospital shall be included as hours worked for the purpose of section (2) of this rule.

(5) Time spent on call or on standby when the nursing staff member is not required to be at the hospital may not be included as hours worked for the purpose of section (2) of this rule.

(6) Nothing in this rule precludes a nursing staff member from volunteering to work overtime.

(7) A hospital may require an additional hour of work beyond the hours authorized in section (2) of this rule if:
(a) A staff vacancy for the next shift becomes known at the end of the current shift; or

(b) There is a potential harm to an assigned patient if the nursing staff member leaves the assignment or transfers care to another nursing staff member.

(8) Each hospital must have a policy and procedure in place to ensure, at minimum, that:

(a) Mandatory overtime, when required, is documented in writing; and

(b) Mandatory overtime policies and procedures are clearly written, provided to all new nursing staff and readily available to all nursing staff.

(9) If a nursing staff member believes that a hospital unit is engaging in a pattern of requiring direct care nursing staff to work overtime for nonemergency care, the nursing staff member may report that information to the staffing committee. The staffing committee shall consider the information when reviewing the staffing plan as described in OAR 333-510-0115.

(10) The provisions of sections (2) through (8) of this rule do not apply to nursing staff needs:

(a) In the event of a national or state emergency or circumstances requiring the implementation of a facility disaster plan; or

(b) In emergency circumstances that include:

(A) Sudden and unforeseen adverse weather conditions;

(B) An infectious disease epidemic suffered by hospital staff;

(C) Any unforeseen event preventing replacement staff from approaching or entering the premises; or

(D) Unplanned direct care staff vacancies of 20 percent or more of the nursing staff for the next shift hospital-wide at the Oregon State Hospital if, based on the patient census, the Oregon State Hospital determines the number of direct care staff available hospital-wide cannot ensure patient safety.

(11) Nothing in section (10) of this rule relieves the Oregon State Hospital from contacting voluntary replacement staff as described in OAR 333-510-0125 and documenting these contacts.

(12) A registered nurse at a hospital may not place a patient at risk of harm by leaving a patient care assignment during an agreed upon scheduled shift or an agreed-upon extended shift without authorization from the appropriate supervisory personnel as required by the Oregon State Board of Nursing OAR, chapter 851.

(13) Until the Authority defines "other nursing staff" as that term is described in ORS 441.166(1), this rule applies only to "nursing staff member" as that term is defined in these rules.
Nurse Staffing Plan Waiver

(1) At a hospital’s request, the Authority may waive any staffing plan requirement set forth in ORS 441.155 provided that a waiver is necessary to ensure that the hospital is staffed to meet the health care needs of its patients.

(2) All requests for a waiver must:

(a) Be submitted to the Authority in writing;

(b) State the reason or reasons for which the hospital is seeking the waiver;

(c) Explain how the waiver is necessary for the hospital to meet patient health care needs; and

(d) Include verification that the hospital notified the staffing committee of the request for a waiver prior to its submission.

Source: Oregon Administrative Rules, Oregon Health Authority, Public Health Division. Division 510. Patient Care and Nursing Services in Hospitals.

Welcome to the State of Oregon!
This booklet will assist you in the lawful practice of nursing in our state. It also explains why the Oregon State Board of Nursing exists, how it functions, and its importance to each nurse in the state.

Each state regulates its own practice of nursing; therefore, the scope of nursing practice varies from state to state. It is your legal and professional responsibility to understand your scope of practice. It also is your responsibility to be familiar with the Oregon Nurse Practice Act.

Again, we welcome you to the nursing profession in Oregon and invite you to attend OSBN board meetings. Please visit our website at www.oregon.gov/OSBN, or call or write the OSBN office if we can be of assistance to you.
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About The Board of Nursing

The mission of the Oregon State Board of Nursing (OSBN) is to safeguard the public’s health and wellbeing by providing guidance for, and regulation of, entry into the profession, nursing education and continuing safe practice.

The nine OSBN members are appointed by the Governor and include: four Registered Nurses, two Licensed Practical Nurses, one nurse practitioner and two public members. They represent a variety of geographic locations and areas of nursing practice, and may serve a maximum of two three-year terms. The OSBN is an agency within Oregon state government that licenses and regulates Licensed Practical Nurses, Registered Nurses, Nurse Practitioners, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, Certified Nursing Assistants and Certified Medication Aides.

The law that regulates nurses and nursing assistants is known as the Oregon Nurse Practice Act (Oregon Revised Statutes, Chapter 678.010-678.445). Any changes in the law must be made by the legislature. This law grants the OSBN authority to write administrative rules that further define the law (Oregon Administrative Rules, Chapter 851). These rules have the effect of law and help define safe and competent practice. There is an opportunity for public comment and input during the rulemaking process, in accordance with the Oregon Administrative Procedures Act.

The OSBN meets five times a year and may hold special meetings if necessary. Board meetings are open to the public. A schedule of meetings is available from the OSBN office or on its website at www.oregon.gov/OSBN. The OSBN employs a staff of more than 40 who assist Board members and provide customer service.

The OSBN, with the help of its staff:
- determines licensure and certification requirements;
- interprets the Oregon Nurse Practice Act, including scope-of-practice;
- evaluates and approves nursing education programs and nursing assistant training programs;
- issues licenses and renewals;
- investigates complaints and takes disciplinary action against licensees who violate the Oregon Nurse Practice Act;
- maintains the nursing assistant registry, administers competency evaluations and imposes disciplinary sanctions for nursing assistants;
- provides testimony to the legislature and other organizations as needed.
You become subject to the authority of the Oregon State Board of Nursing upon application for licensure. You remain subject to that authority while you are licensed in this state.

**Responsibilities of a Licensed Nurse**

Holding a professional license gives you the right to engage in your profession lawfully. However, with that right comes a responsibility to the public. These basic tips will help you comply with the Oregon Nurse Practice Act:

**Obtain an Oregon License Before Practicing Nursing**

According to Oregon’s mandatory licensure law, all nurses are required to have a current Oregon license before employment as a nurse. It is unlawful for a person to use any sign, card or device indicating they are a nurse, or to use the letters “LPN,” “RN,” “CNS,” “CRNA,” or “NP” unless they hold a current license issued by the OSBN. The OSBN does not issue temporary licenses.

**Notify the OSBN When You Change Your Name or Address**

According to Oregon Administrative Rule, licensees must keep their current name and home address on file with the OSBN at all times. When a change of name occurs, you must complete a duplicate license application and send that, along with legal proof of your name change and appropriate fees, to the OSBN office. For address changes, send your old and new addresses to the OSBN office via fax, e-mail, US mail or telephone (you must speak directly with a representative—no voicemail messages are accepted for address changes). Or, you can change your address through our internet renewal system (www.oregon.gov/OSBN and click on “License Renewal”). By keeping us informed, we can ensure you receive license renewal notifications, newsletters and information about new nursing-related laws and regulations in a timely manner.

**Remember to Renew your License on Time**

Your nursing license must be renewed every two years according to your birthdate. For instance, if you were born in an even-numbered year, you will need to renew your license in even-numbered years.

Approximately six to eight weeks before your license expires, you should receive a renewal notice from the OSBN. Failure to receive this courtesy notice in the mail, however, does not relieve you of your responsibility to maintain a current license.
To renew your license, you may use the OSBN internet renewal system. Navigate your web browser to: www.oregon.gov/OSBN and click on “License Renewal.” Simply follow the on-screen directions that will lead you through the secure renewal application process. If you do not want to use the internet renewal system, you can print an application from our website (click on “Forms”) or call the OSBN office and request that a paper application form be mailed to you.

If you allow your license to expire, you may have it reinstated by submitting a renewal form to the OSBN office with the appropriate fees. If you practice nursing without a current license, you could be subject to a civil penalty of up to $5,000. If you do not renew your license within 60 days of its expiration date it will need to be reactivated (with additional fees).

Report Lost or Stolen Licenses
If your license is stolen or lost, report it to the OSBN office at 971-673-0685 immediately. We can help you obtain a duplicate license.

Nursing Practice Requirements
To receive your initial RN or LPN license or to renew, you must meet the practice requirements in one of these ways:
• practice nursing for a minimum of 960 hours (at the level of license you are seeking) during the five years preceding your application; or,
• graduate from an approved nursing program within the five years preceding your application; or,
• successfully complete an approved re-entry program within the two years preceding your application.

If you are unable to meet the practice requirement, you will be required to complete an approved re-entry program before licensure. Contact the OSBN office at 971-673-0685 for more information on eligibility and a list of re-entry programs.

Although the OSBN encourages nurses to participate in continuing education programs as a professional responsibility, it does not require continuing education credits/hours for RN or LPN licensure. However, the state of Oregon does require that all healthcare practitioners, including nurses, receive seven hours of pain management-related continuing education. This is a one-time only requirement and does not affect future renewal cycles.

Visit the OSBN website (www.oregon.gov/OSBN) for more information.
Moving To or From Another State?
If you are moving and want to be licensed in another state, request an Endorsement Application from your new state and follow its procedures. Usually, that packet includes a NURSYS Verification Form to be sent to the National Council of State Boards of Nursing for completion.

If you recently moved to Oregon and hold a current license in your previous state, request an endorsement package from the OSBN office. You can receive an Oregon license without retaking the National Council Licensing Examination. Remember, you cannot work as a nurse in this state without a current Oregon license.

Call the OSBN office at 971-673-0685 for details. If you need information on another state's board of nursing, check the National Council of State Boards of Nursing website at www.ncsbn.org.

Know the Oregon Nurse Practice Act, Administrative Rules and Standards of Practice

As a licensed nurse, you are responsible for knowing the Oregon Revised Statutes and Oregon Administrative Rules that comprise the Nurse Practice Act (ORS 678,010–678.445 and OAR Chapter 851). Ignorance of the law cannot be used as an excuse for violations of the Oregon Nurse Practice Act. You should have working knowledge of these documents to practice nursing within the legal scope and provide the public with safe nursing care. Each division in the Nurse Practice Act undergoes periodic review and is subject to the public rulemaking process. If you have any questions, please contact the OSBN office at 971-673-0685.

The Oregon Nurse Practice Act is available on the OSBN website (www.oregon.gov/OSBN). Hard copies are available for a fee and can be obtained by calling the OSBN office at 971-673-0685. Several of the rules that may apply to your practice are:

- Standards and scope of practice for the Registered Nurse and Licensed Practical Nurse (see pages 14–21);
- Delegation of nursing care tasks to unlicensed persons;
- Nurse practitioner, CNS or CRNA rules and scope of practice;
- Nursing assistants;
- Licensure requirements;
- Standards for nursing education programs; and,
- Conduct derogatory to the standards of nursing defined (see page 21).
Understand the Complaint Investigation Process & Disciplinary Options

According to Oregon state law, all information obtained during a specific investigation is confidential, including who makes a complaint. This encourages consumers and licensees to make valid complaints because they need not fear reprisal or other negative acts based on their complaint.

Approximately 70 percent of all complaints received by the Board are closed without disciplinary action. Upon investigation, the Board may determine that no violations of statute or administrative rule occurred. Complainants may request a written explanation for cases that are closed without disciplinary action. Any disciplinary action taken by the Board during a Board Meeting is public information, however details of the investigations leading up to such actions are not.

1. Complaints: Complaints may be filed in writing, over the phone or in person. Anonymous complaints are accepted. Approximately 50–60 percent of complaints come from nursing employers. The remainder come from state agencies, other professionals, coworkers or patients/families.

2. Investigations: Investigations into complaints are performed by OSBN staff investigators. Investigators first validate whether there is concern about the nurse’s practice or conduct. The investigation may include:
   - a review of pertinent documents, such as a summary of the incident;
   - interviews with the complainant(s), coworkers or employer; and,
   - a review of patient records, the nurse’s personnel record, police reports or court records.

If there is evidence of a practice or conduct problem, an investigator will meet with the licensee or applicant in person or by phone. If there are grounds for disciplinary action, the investigator makes a recommendation to the Board based on the OSBN discipline theory model, OSBN disciplinary policies and past Board decisions.

3. Resolution: Disciplinary cases may be resolved by:
   - Stipulated agreement—The nurse signs a document acknowledging the facts of the incident, violations of law and OSBN rules, the proposed disciplinary action and any terms and conditions to be imposed. The agreement goes to the Board for consideration and potential adoption and a Final Order is issued. Most disciplinary cases (98 percent) are resolved by stipulated agreement.
• **Notice**—If agreement is not reached, a “Notice” document is sent to the nurse. The Notice is a public document and may be requested by the complainant. It is essentially a statement of charges against the nurse. The Notice contains a timeframe within which a hearing can be requested, and specifies the level of sanction that has been proposed. The nurse is entitled to a hearing and is granted every opportunity to exercise that right. If the nurse does not request a hearing within the allotted timeframe, the case goes to the Board for a decision by default. If the nurse has a hearing and does not agree with the Board’s final decision, she/he can appeal to the Oregon Court of Appeals. If there is disagreement with the Court’s decision, the nurse can appeal further to the Oregon Supreme Court.

4. **Disciplinary Sanctions**: The Board can impose a range of disciplinary sanctions:

• **Reprimand**—A formal notice to the nurse that OSBN standards have been violated. The nursing license is not “encumbered.”

• **Civil Penalty**—A fine of up to $5,000.

• **Probation**—An imposition of restrictions or conditions under which a nurse must practice, including the type of employment setting or job role.

• **Suspension**—A period of time during which a nurse may not practice nursing.

• **Revocation**—A removal of a license or certification for an unspecified period of time, perhaps permanently.

• **Voluntary Surrender**—An action on the part of the nurse to give up her/his license or certificate instead of facing potential suspension or revocation.

• **Denial of Licensure**—An action by the Board not to issue a license or certificate.

If you have any questions, please call the OSBN office at 971-673-0685.

**The Oregon Mandatory Reporting Law**

Oregon law mandates that licensed nurses report suspected violations of the Oregon Nurse Practice Act to the OSBN. You may report violations in writing or by phone. The rules governing reporting are on page 12 of this booklet, and reportable violations are listed on pages 21–26.
Provide Accurate Information

Providing complete and accurate information helps us expedite your licensure process. Please be aware that all licensure and renewal requests are run through the Oregon Law Enforcement Data System (LEDs) and may be run through the National Council of State Boards of Nursing Information Systems and Disciplinary Data Bank. Including false or misleading information on your application may result in denial of licensure, disciplinary action, and/or a civil penalty up to $5,000.

Stay Informed

As stated before, you are ultimately accountable for providing safe, competent nursing care. There are several ways to keep informed of changes in the Oregon Nurse Practice Act:

- Attend OSBN board meetings and committee meetings. These meetings are open to the public and their locations, dates and times are available on the OSBN website, or by calling the OSBN office at 971-673-0685.
- Attend public hearings when proposed changes in the rules are presented for discussion. Notice of these hearings is published on the OSBN website at www.oregon.gov/OSBN and in the Oregon Bulletin, which is available from the Oregon Secretary of State’s office.
- Read the OSBN Sentinel, mailed to every currently licensed nurse twice a year. Please contact the OSBN Public Information Officer with suggestions for or questions concerning newsletter articles.
- Consider seeking appointment to the Oregon State Board of Nursing. Refer to the Oregon Nurse Practice Act, ORS 678.140, for information on Board member qualifications and the appointment process. Contact the Governor’s office or the OSBN for more information.
- Receive notices of upcoming rule changes at home. Call the OSBN office to be added to the interested parties’ mailing list.
- Review the Oregon Nurse Practice Act and Board policies on the OSBN website or purchase a personal copy by calling the OSBN office.

Get to Know Your Board of Nursing

Do you have questions about whether a certain nursing task falls within your scope of practice? Do you need assistance with license renewal? Or perhaps you simply need to update your address? Contact the OSBN staff at 971-673-0685—we are an important resource for you and are available if you have any questions.
OSBN Programs

Licensing and Customer Service

The Licensing Program approves applications for licensure and issues licenses or certifications to: Registered Nurses; Licensed Practical Nurses; Nurse Practitioners; Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Certified Nursing Assistants and Certified Medication Aides. The program also approves applications by new graduates or others to take the National Council Licensing Examination (NCLEX), and all applications for the CNA competency exam. They also maintain a registry of all CNAs and CMAs in Oregon.

In addition, the program compiles statistical data on Oregon nurses, such as practice area, specialty, and the location of practice, to help provide workforce and demographic data on nurses to public and private entities.

Nursing Investigations & Compliance

The Nursing Investigation and Compliance Program helps nurses, their employers and the public to understand the legal scope of nursing practice according to state law. Program advisors help nurses and nursing assistants determine if violations of the Nurse Practice Act have occurred, and explain when and how problems should be reported. They also investigate violations of the act, recommend appropriate disciplinary actions to the OSBN
and monitor licensees or certificate-holders who have had disciplinary action taken against their license.

*The Nurse Monitoring Program* is a nondisciplinary program that monitors the practice of nurses with chemical dependency, psychiatric disorders or physical disabilities that prevent them from safely practicing nursing.

The program gives nurses the chance to seek treatment and continue, or return to, the practice of nursing in a way that protects the public’s health, safety and welfare, while supporting the nurse’s recovery.

**Education & Practice Consultant Team**

*The Education Program Consultant* approves nursing education and re-entry programs, ensuring they meet OSBN standards, and visits schools of nursing to discuss licensing requirements, the Nurse Practice Act, and NCLEX with students. In addition, the program consultant is available to confer with nurse educators on a variety of issues.

*The RN/LPN Practice Consultant* helps RNs and LPNs, their employers and the public to understand the scope of nursing practice in Oregon. The consultant also develops practice policies and is available to provide in-service presentations to nursing employers and other interested groups.

*The Advanced Practice Consultant* helps Nurse Practitioners, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists understand their scopes of practice, and answers questions concerning prescriptive and dispensing privileges. The consultant is available to discuss advanced practice issues with employers, educators and other interested groups.

*The CNA Program Consultant* approves all nursing assistant and medication aide training programs and examination sites. In addition, the program consultant is available to confer with instructors and CNA/CMA programs on a variety of educational and examination issues.

**Nursing Education Programs Accredited by the OSBN**

Oregon has six baccalaureate degree programs, and 15 associate degree programs. Seven of the 15 associate degree programs have a Practical Nurse (PN) curriculum during the first year, which allows students to take the NCLEX-PN exam upon completion. Plus, there are six stand-alone PN programs. Oregon also has two masters programs and one doctoral program. Four universities offer RN to BSN completion programs.
Baccalaureate Degree Programs

1. Concordia University
   2811 NE Holman Street
   Portland, OR 97211-6099
   503-288-9371

2. George Fox University
   414 N. Meridian St., #6238
   Newberg, OR 97132-2697
   503-554-8383

3. Linfield Good Samaritan School of Nursing*
   2255 NW Northrup, Rm. 304
   Portland, OR 97210
   503-413-7161

4. University of Portland School of Nursing*
   5000 N. Willamette Blvd.
   Portland, OR 97203
   503-943-7211

5a. Oregon Health Sciences University School of Nursing*+
    3181 SW Sam Jackson Pk. Rd.
    Portland, OR 97201
    503-494-7100

5b. OHSU School of Nursing at Eastern Oregon University
    1 University Blvd.
    La Grande, OR 97850
    541-962-3646

5c. OHSU School of Nursing at Oregon Institute of Technology
    3201 Campus Dr.
    Klamath Falls, OR 97601
    541-885-1370 or 800-422-2017

5d. OHSU School of Nursing at Southern Oregon University*+
    1250 Siskiyou Blvd.
    Ashland, OR 97520
    541-552-6226

6. Walla Walla College School of Nursing*
   10345 SE Market St.
   Portland, OR 97216
   503-251-6115

+ Offers a master's level nurse practitioner program.
* Offers a RN-to-BSN program.

Stand-Alone Practical Nurse Programs

1. Apollo College
   2004 Lloyd Center, 3rd Floor
   Portland, OR 97232
   503-761-6100

2. Concorde Career Institute
   1425 NE Irving St., Building 300
   Portland, OR 97232
   503-281-6141

3. Mt. Hood Community College
   26000 SE Stark St.
   Gresham, OR 97128
   503-491-6727

4. Pioneer Pacific College
   27375 SW Parkway Ave.
   Wilsonville, OR 97070
   503-682-1862

5. Rogue Community College
   202 S. Riverside
   Medford, OR 97501
   541-245-7504

6. Valley Medical College
   4707 Silverton Rd. NE
   Salem, OR 97305
   503-393-9001
Associate Degree Programs

1. Blue Mountain Community College**
   2411 NE Cardin
   PO Box 100
   Pendleton, OR 97801
   541-278-5879

2. Central Oregon Community College**
   2600 NW College Way
   Bend, OR 97701
   541-383-7540

3. Chemeketa Community College**
   4000 Lancaster Dr. NE
   Salem, OR 97309
   503-399-5058

4. Clackamas Community College***
   19600 S. Molalla Ave.
   Oregon City, OR 97045
   503-657-6958

5. Clatsop Community College**
   1653 Jerome
   Astoria, OR 97103
   503-338-2496

6. Columbia Gorge Community College**
   400 East Scenic Drive
   The Dalles, OR 97058
   541-298-3112

7. Lane Community College***
   4000 E. 30th Avenue
   Eugene, OR 97405
   541-747-4501

8. Linn-Benton Community College
   6500 SW Pacific Blvd.
   Albany, OR 97321
   541-917-4511

9. Mt. Hood Community College***
   26000 SE Stark
   Gresham, OR 97030
   503-491-7113

10. Oregon Coast Community College**
    332 SW Coast Highway
    Newport, OR 97365-4928
    (541) 574-7106

11. Portland Community College
    12000 SW 49th
    PO Box 19000
    Portland, OR 97280
    (503) 977-4205

12. Rogue Community College***
    3345 Redwood Highway
    Grants Pass, OR 97527
    541-956-7308

13. Southwestern Oregon Community College***
    1988 Newmark Ave.
    Coos Bay, OR 97420
    1-800-962-2838 or 541-888-7340

14. Treasure Valley Community College**
    650 College Blvd.
    Ontario, OR 97914
    (541) 889-6493 Ext. 345

15. Umpqua Community College***
    1140 College Rd.
    PO Box 967
    Roseburg, OR 97470
    541-440-4613

** Has PN curriculum the first year.
*** Adopted Oregon Consortium for Nursing Education (OCNE) curriculum.
Excerpts from the Oregon Nurse Practice Act

As mentioned earlier, the Oregon Nurse Practice Act is comprised of Oregon Revised Statutes (ORS), which can only be altered by the state legislature, and Oregon Administrative Rules (OAR). Administrative rules are created by the OSBN and further define the statutes. For each change in administrative rules, there is an opportunity for public comment.

Mandatory Reporting Defined (OAR 851-045-0090)

Note: Oregon Revised Statutes (ORS), contained within the Oregon Nurse Practice Act, provide protection for those who find themselves in the position of having to report a licensee.

1. It is not the intent of the Board of Nursing that each and every nursing error be reported.

2. It is not the intent of the Board of Nursing that mandatory reporting take away the disciplinary ability and responsibility from the employer of the nurse.

3. Anyone knowing of a licensed nurse whose behavior or nursing practice fails to meet accepted standards for the level at which the nurse is licensed, shall report the nurse to the person in the work setting who has authority to institute corrective action. Anyone who has knowledge or concern that the nurse’s behavior or practice presents a potential for, or actual danger to the public health, safety and welfare, shall report or cause a report to be made to the Board of Nursing. Failure of any licensed nurse to comply with this reporting requirement may in itself constitute a violation of nursing standards.

4. Any organization representing licensed nurses shall report a suspected violation of ORS Chapter 678, or the rules adopted within, in the manner prescribed by sections (5) and (6) of this rule.

5. The decision to report a suspected violation of ORS Chapter 678, or the rules adopted within, shall be based on, but not limited to, the following:
   a. The past history of the licensee’s performance;
   b. A demonstrated pattern of substandard practice, errors in practice or conduct derogatory to the standards of nursing, despite efforts to assist the licensee to improve practice or conduct through a plan of correction; and

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c. The magnitude of any single occurrence for actual or potential harm to the public health, safety and welfare.

6. The following shall always be reported to the Board of Nursing:
   a. A nurse imposter. As used here “nurse imposter” means an individual who has not attended or completed a nursing education program or who is ineligible for nursing licensure as a LPN or RN and who practices or offers to practice nursing or uses any title, abbreviation, card, or device to indicate that the individual is licensed to practice nursing in Oregon;
   b. Practicing nursing when the license has become void due to nonpayment of fees;
   c. Practicing nursing as defined in ORS 678.010 unless licensed as a Registered Nurse or Licensed Practical Nurse or certified as a Nurse Practitioner;
   d. Arrest for or conviction of a crime which relates adversely to the practice of nursing or the ability to safely practice nursing;
   e. Dismissal from employment due to unsafe practice or conduct derogatory to the standards of nursing;
   f. Client abuse;
   g. A pattern of conduct derogatory to the standards of nursing as defined by the rules of the Board or a single serious occurrence;
   h. Any violation of a disciplinary sanction imposed on the licensee by the Board of Nursing;
   i. Failure of a nurse not licensed in Oregon and hired to meet a temporary staffing shortage to apply for Oregon licensure by the day the nurse is placed on staff;
   j. Substance abuse as defined in ORS 678.111(e); and
   k. Any other cause for discipline as defined in ORS 678.111.

Confidentiality of Information Supplied to the OSBN (ORS 678.126)

1. Any information provided to the OSBN pursuant to ORS 678.021, 678.111, 678.113 or 678.135 is confidential and shall not be subject to public disclosure.

2. Any person, facility, licensee or association that reports or provides information to the OSBN under ORS 678.021, 678.111, 678.113 or 678.135 in good faith shall not be subject to an action for civil damages as a result thereof.
Scope of Practice Standards for **All** Licensed Nurses  
(OAR 851-045-0040)

1. Standards related to the licensed nurse’s responsibilities for client advocacy. The licensed nurse:
   a. Advocates for the client’s right to receive appropriate care, including person-centered care and end-of-life care, considerate of the client’s needs, choices and dignity;
   b. Intervenes on behalf of the client to identify changes in health status, to protect, promote and optimize health, and to alleviate suffering;
   c. Advocates for the client’s right to receive appropriate and accurate information;
   d. Communicates client’s choices, concerns and special needs to other members of the healthcare team; and
   e. Protects clients’ rights to engage in or refuse to engage in research.

2. Standards related to the licensed nurse’s responsibilities for the environment of care. The licensed nurse:
   a. Promotes an environment conducive to safety and comfort for all levels of care, including self-care and end-of-life care; and
   b. Identifies client safety and environment concerns; takes action to correct those concerns and report as needed.

3. Standards related to the licensed nurse’s responsibilities for ethics, including professional accountability and competence. The licensed nurse:
a. Has knowledge of the statutes and regulations governing nursing, and practices within the legal boundaries of licensed nursing practice;
b. Accepts responsibility for individual nursing actions and maintains competence in one's area of practice;
c. Obtains instruction and supervision as necessary when implementing nursing practices;
d. Accepts only nursing assignments for which one is educationally prepared and has the current knowledge, skills and ability to safely perform;
e. Accepts responsibility for notifying the employer of an ethical objection to the provision of specific nursing care or treatment;
f. Maintains documentation of the method by which competency was gained, and evidence that it has been maintained;
g. Ensures unsafe nursing practices are reported to the Board of Nursing and unsafe practice conditions to the appropriate regulatory agency(s);
h. Retains professional accountability when accepting, assigning, or supervising nursing care and interventions;
i. Demonstrates honesty and integrity in nursing practice;
j. Promotes and preserves clients' autonomy, dignity and rights in a nonjudgmental, nondiscriminatory manner that recognizes client diversity;
k. Maintains appropriate professional boundaries; and
l. Protects confidential client information, and uses judgment in sharing this information in a manner that is consistent with current law.

4. Standards related to the licensed nurse’s responsibilities toward nursing technology. The licensed nurse:
a. Acquires and maintains knowledge, skills and abilities for informatics and technologies used in nursing practice settings; and
b. Promotes the selection and use of informatics and technologies that are compatible with the safety, dignity, and rights of the client.

5. Standards related to the licensed nurse’s responsibility to assign and supervise care. The licensed nurse:
a. Assigns to another person, tasks of nursing that fall within the nursing scope of practice and/or the work that each staff member is already authorized to perform;
b. Supervises others to whom nursing activities are assigned by monitoring performance, progress, and outcomes;
c. Ensures documentation of the activity;
d. Matches client needs with available, qualified personnel, resources and supervision;
e. Provides follow-up on problems and intervenes when needed;
f. Evaluates the effectiveness of the assignment and the outcomes of the interventions; and
g. Revises or recommends changes to the plan of care as needed.

6. Standards related to the licensed nurse's responsibility to accept and implement orders for client care and treatment. The licensed nurse:
   a. May accept and implement orders for client care from licensed health care professionals who are authorized by Oregon statute to independently diagnose and treat;
   b. May accept and implement recommendations for care in collaboration with other health care professionals;
   c. May accept and implement orders for client care and treatment from Certified Registered Nurse Anesthetists licensed under ORS 678. These orders may be accepted in ambulatory surgical centers, and in hospital settings, as long as independent Certified Registered Nurse Anesthetists practice is consistent with hospital bylaws;
   d. May accept and implement orders for client care and treatment from Physician Assistants licensed under ORS 677, provided that the name of the supervising or agent physician is recorded with the order, in the narrative notes, or by a method specified by the health care facility. At all times the supervising or agent physician must be available to the licensed nurse for direct communication;
   e. Prior to implementation of the order or recommendation, must have knowledge that the order or recommendation is within the health care professional's scope of practice and determine that the order or recommendation is consistent with the overall plan for the client's care; and
   f. Has the authority and responsibility to question any order or recommendation which is not clear, perceived as unsafe, contraindicated for the client or inconsistent with the plan of care.
Scope of Practice Standards for Licensed Practical Nurses
(OAR 851-045-0050)

1. The Board recognizes that the scope of practice for the licensed practical nurse encompasses a variety of roles, including but not limited to:
   a. Provision of client care;
   b. Supervision of others in the provision of care;
   c. Participation in the development and implementation of health care policy;
   d. Participation in nursing research; and
   e. Teaching health care providers and prospective health care providers.

2. Standards related to the Licensed Practical Nurse’s responsibility for nursing practice implementation. Under the clinical direction of the RN or other licensed provider who has the authority to make changes in the plan of care, and applying practical nursing knowledge drawn from the biological, psychological, social, sexual, economic, cultural and spiritual aspects of the client’s condition or needs, the Licensed Practical Nurse shall:
   a. Conduct and document initial and ongoing focused nursing assessments of the health status of clients by:
      A. Collecting objective and subjective data from observations, examinations, interviews, and written records in an accurate and timely manner as appropriate to the client’s health care needs and context of care;
      B. Distinguishing abnormal from normal data, sorting, selecting, recording, and reporting the data;
C. Detecting potentially inaccurate, incomplete or missing client information and reporting as needed;
D. Anticipating and recognizing changes or potential changes in client status; identifying signs and symptoms of deviation from current health status; and
E. Validating data by utilizing available resources, including interactions with the client and health team members.
b. Select nursing diagnostic statements and/or reasoned conclusions, from available resources, which serve as the basis for the plan or program of care.
c. Contributes to the development of a comprehensive plan of nursing care, and develops focused plans of nursing care. This includes:
   A. Identifying priorities in the plan of care;
   B. Setting realistic and measurable goals to implement the plan of care in collaboration with the client and the healthcare team; and
   C. Selecting appropriate nursing interventions and strategies.
d. Implement the plan of care by:
   A. Implementing treatments and therapy, appropriate to the context of care, including but not limited to, medication administration, nursing activities, nursing, medical and interdisciplinary orders; health teaching and health counseling; and
   B. Documenting nursing interventions and responses to care in an accurate, timely, thorough, and clear manner.
e. Evaluating client responses to nursing interventions and progress toward desired outcomes.
   A. Outcome data shall be used as a basis for reassessing the plan of care and modifying nursing interventions; and
   B. Outcome data shall be collected, documented and communicated to appropriate members of the healthcare team.

3. Standards related to the Licensed Practical Nurse’s responsibility for collaboration with an interdisciplinary team. The Licensed Practical Nurse:
a. Functions as a member of the healthcare team to collaborate in the development, implementation and evaluation of integrated client-centered plans of care;
b. Demonstrates knowledge of roles of members of the interdisciplinary team;
c. Communicates with the registered nurse and/or other relevant personnel regarding integrated client-centered plans of care; and
d. Makes referrals as necessary.

4. Standards related to the Licensed Practical Nurse’s responsibility for leadership. The Licensed Practical Nurse:
   a. Contributes to the formulation, interpretation, implementation and evaluation of the policies, protocols and operating guidelines related to nursing practice, and to the needs of the clients served;
   b. Assists with the development and mentoring of other members of the healthcare team; and
   c. Identifies changes in clients and changes in the practice environment that require change in policy and/or protocol.

5. Standards related to the Licensed Practical Nurse’s responsibility for quality of care. The Licensed Practical Nurse:
   a. Identifies factors that affect the quality of client care and contributes to the development of quality improvement standards and processes.
   b. Contributes to the collection of data related to the quality of nursing care; and
   c. Participates in the measurement of outcomes of nursing care and overall care at the individual and aggregate level.

6. Standards related to the Licensed Practical Nurse’s responsibility for health promotion. The Licensed Practical Nurse:
   a. Selects or implements evidence-based health education plans that address the client’s context of care, culture, learning needs, readiness and ability to learn, in order to achieve optimal health; and
   b. Evaluates the outcome of health education to determine effectiveness, adjusts teaching strategies, and refers client to another licensed healthcare professional as needed.

7. Standard related to the Licensed Practical Nurse’s responsibility for cultural sensitivity. The Licensed Practical Nurse applies a basic knowledge of cultural differences to collaborate with clients to provide healthcare that recognizes cultural values, beliefs, and customs.
Scope of Practice Standards for Registered Nurses (OAR 851-045-0060)

1. The Board recognizes that the scope of practice for the registered nurse encompasses a variety of roles, including but not limited to:
   a. Provision of client care;
   b. Supervision of others in the provision of care;
   c. Development and implementation of health care policy;
   d. Consultation in the practice of nursing;
   e. Nursing administration;
   f. Nursing education;
   g. Case management;
   h. Nursing research;
   i. Teaching health care providers and prospective health care providers;
   j. Specialization in advanced practice; and
   k. Nursing Informatics.

2. Standards related to the Registered Nurse's responsibility for nursing practice implementation. Applying nursing knowledge, critical thinking and clinical judgment effectively in the synthesis of biological, psychological, social, sexual, economic, cultural and spiritual aspects of the client's condition or needs, the Registered Nurse shall:
   a. Conduct and document initial and ongoing comprehensive and focused nursing assessments of the health status of clients by:
      A. Collecting objective and subjective data from observations, examinations, interviews, and written records in an accurate and timely manner as appropriate to the client's health care needs and context of care;
      B. Distinguishing abnormal from normal data, sorting, selecting, recording, analyzing, synthesizing and reporting the data;
      C. Detecting potentially inaccurate, incomplete or missing client information and reporting as needed;
      D. Anticipating and recognizing changes or potential changes in client status; identifying signs and symptoms of deviation from current health status; and
      E. Validating data by utilizing available resources, including interactions with the client and health team members.
   b. Establish and document nursing diagnostic statements and/or reasoned conclusions which serve as the basis for the plan or program of care.
c. Develop and coordinate a comprehensive and/or focused plan of nursing care. This includes:
   A. Identifying priorities in the plan of care;
   B. Setting realistic and measurable goals to implement the plan of care in collaboration with the client and the healthcare team; and
   C. Developing nursing orders and identifying nursing strategies, interventions and actions.

d. Implement the plan of care by:
   A. Implementing treatments and therapy, appropriate to the context of care, including emergency measures, interpretation of medical orders, medication administration, independent nursing activities, nursing, medical and interdisciplinary orders, health teaching and health counseling; and
   B. Documenting nursing interventions and responses to care in an accurate, timely, thorough, and clear manner.

e. Evaluating client responses to nursing interventions and progress toward desired outcomes.
   A. Outcome data shall be used as a basis for reassessing the plan of care and modifying nursing interventions; and
   B. Outcome data shall be collected, documented and communicated to appropriate members of the healthcare team.
3. Standards related to the Registered Nurse’s responsibility for collaboration with an interdisciplinary team. The Registered Nurse:
   a. Functions as a member of the healthcare team to collaborate in the development, implementation and evaluation of integrated client-centered plans of care;
   b. Demonstrates knowledge of roles of members of the interdisciplinary team;
   c. Communicates with other relevant personnel regarding integrated client-centered plans of care; and
   d. Makes referrals as necessary and ensures follow-up on those referrals.

4. Standards related to the Registered Nurse’s responsibility for leadership. The Registered Nurse:
   a. Formulates, interprets, implements and evaluates the policies, protocols and operating guidelines related to nursing practice, and the needs of the clients served;
   b. Assumes responsibility for the development and mentoring of other members of the healthcare team; and
   c. When available, uses evidence to identify needed changes in practice, standards for policy development, and clinical decision-making.

5. Standards related to the Registered Nurse’s responsibility for quality of care. The Registered Nurse:
   a. Identifies factors that affect the quality of client care and develops quality improvement standards and processes;
   b. Applies the knowledge and tools of continuous improvement in practice to improve the delivery of healthcare; and
   c. Measures outcomes of nursing care and overall care at the individual and aggregate level.

6. Standards related to the Registered Nurse’s responsibility for health promotion. The Registered Nurse:
   a. Develops and implements evidence-based health education plans that address the client’s context of care, learning needs, readiness, ability to learn, and culture, to achieve optimal health; and
   b. Evaluates the outcome of health education to determine effectiveness, adjusts teaching strategies, and refers client to another licensed healthcare professional as needed.
7. Standard related to the Registered Nurse’s responsibility for cultural sensitivity: The Registered Nurse applies a broad knowledge of cultural differences to collaborate with clients to provide healthcare that recognizes cultural values, beliefs, and customs.

8. Standards Related to Registered Nurse’s responsibility to delegate and supervise the practice of nursing. The Registered Nurse:
   a. Delegates to other Oregon licensed nurses and Certified Nursing Assistants or Medication Aides tasks of nursing that may not be within the licensee’s or certificate-holder’s normal duties but always fall within the licensee’s scope of practice or certificate-holder’s authorized duties;
   b. Delegates to Unlicensed Assistive Personnel;
   c. Delegates only within the scope of Registered Nursing practice;
   d. May delegate tasks of nursing, but may not delegate the nursing process. The core nursing functions of assessment, planning, evaluation, and nursing judgment cannot be delegated;
   e. Maintains responsibility, accountability and authority for teaching and delegation of tasks of nursing;
   f. Maintains sole responsibility, based on professional judgment, whether or not to delegate a task of nursing or to rescind that delegation;
   g. Maintains the right to refuse to delegate tasks of nursing if the Registered Nurse believes it would be unsafe to delegate or is unable to provide adequate supervision;
   h. Considers the training, experience and cultural competence of the delegated individual, as well as facility and agency policies and procedures before delegating;
   i. Delegates tasks of nursing to another individual only if that individual has the necessary skills and competence to accomplish those tasks of nursing safely;
   j. Matches client needs with available, qualified personnel, resources and supervision;
   k. Communicates directions and expectations for completion of the delegated tasks of nursing;
   l. Supervises others to whom nursing activities are delegated and monitors performance, progress, and outcomes. Ensures documentation of the activity;
m. Evaluates the effectiveness of the delegation and the outcomes of the interventions;

n. Revises the plan of care as needed;

o. Follows OAR 851-047-0000 through 851-047-0040 when delegating tasks of nursing in practice settings identified in those rules;

p. May not delegate the insertion or removal of devices intended for intravenous infusion; and

q. May not delegate administration of medications by the intravenous route, except as provided in OAR 851-047-0030.

Conduct Derogatory to the Standards of Nursing (OAR 851-045-0070)

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

1. Conduct related to the client’s safety and integrity:
   a. Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.
   b. Failing to take action to preserve or promote the client’s safety based on nursing assessment and judgment.
   c. Failing to develop, implement and/or follow through with the plan of care.
   d. Failing to modify, or failing to attempt to modify the plan of care as needed based on nursing assessment and judgment, either directly or through proper channels.
   e. Assigning persons to perform functions for which they are not prepared or which are beyond their scope of practice/scope of duties.
f. Improperly delegating tasks of nursing care to unlicensed persons in settings where a registered nurse is not regularly scheduled.

g. Failing to supervise persons to whom nursing tasks have been assigned.

h. Failing to teach and supervise unlicensed persons to whom nursing tasks have been delegated.

i. Leaving a client care assignment during the previously agreed upon work time period without notifying the appropriate supervisory personnel and confirming that nursing care for the client(s) will be continued.

j. Leaving or failing to complete any nursing assignment, including a supervisory assignment, without notifying the appropriate personnel and confirming that nursing assignment responsibilities will be met.

k. Failing to report through proper channels facts known regarding the incompetent, unethical, unsafe or illegal practice of any health care provider.

l. Failing to respect the dignity and rights of clients, regardless of social or economic status, age, race, religion, sex, sexual orientation, national origin, nature of health needs, or disability.

m. Engaging in or attempting to engage in sexual contact with a client; and

n. Failing to maintain professional boundaries with a client.

2. Conduct related to other federal or state statute/rule violations:

a. Abusing a client. The definition of abuse includes, but is not limited to, intentionally causing physical or emotional harm or discomfort, striking a client, intimidating, threatening or harassing a client, wrongfully taking or appropriating money or property, or knowinglysubjecting a client to distress by conveying a threat to wrongfully take or appropriate money or property in a manner that causes the client to believe the threat will be carried out.

b. Neglecting a client. The definition of neglect includes, but is not limited to, carelessly allowing a client to be in physical discomfort or be injured.

c. Engaging in other unacceptable behavior towards or in the presence of a client such as using derogatory names or gestures or profane language.
d. Failing to report actual or suspected incidents of client abuse through the proper channels in the work place and to the appropriate state agencies.

e. Failing to report actual or suspected incidents of child abuse or elder abuse to the appropriate state agencies.

f. Unauthorized removal or attempted removal of narcotics, other drugs, supplies, property, or money from clients, the work place, or any person.

g. Soliciting or borrowing money, materials, or property from clients.

h. Using the nurse client relationship to exploit the client by gaining property or other items of value from the client either for personal gain or sale, beyond the compensation for nursing services.

i. Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs.

j. Aiding, abetting, or assisting an individual to violate or circumvent any law, rule or regulation intended to guide the conduct of nurses or other health care providers.

k. Failing to conduct practice without discrimination on the basis of age, race, religion, sex, sexual orientation, national origin, nature of health needs, or disability.

l. Violating the rights of privacy, confidentiality of information, or knowledge concerning the client, unless required by law to disclose such information or unless there is a “need to know.”

m. Violating the rights of privacy, confidentiality of information, or knowledge concerning the client by obtaining the information without proper authorization or when there is no “need to know.”

n. Unauthorized removal of client records, client information, facility property, policies or written standards from the work place; and

o. Failing to dispense or administer medications, including Methadone, in a manner consistent with state and federal law.

3. Conduct related to communication:

a. Inaccurate recordkeeping in client or agency records.

b. Incomplete recordkeeping regarding client care; including, but not limited, to failure to document care given or other information important to the client’s care or documentation which is inconsistent with the care given.
c. Falsifying a client or agency record or records prepared for an accrediting or credentialing entity; including, but not limited to, filling in someone else's omissions, signing someone else's name, record care not given, and fabricating data/values.

d. Altering a client or agency record or records prepared for an accrediting or credentialing entity; including, but not limited to, changing words/letters/numbers from the original document to mislead the reader of the record, adding to the record after the original time/date without indicating a late entry.

c. Destroying a client or agency record or records prepared for an accrediting or credentialing entity.

f. Directing another person to falsify, alter or destroy client or agency records or records prepared for an accrediting or credentialing entity.

g. Failing to maintain client records in a timely manner which accurately reflects management of client care, including failure to make a late entry within a reasonable time period.

h. Failing to communicate information regarding the client's status to members of the health care team (physician, nurse practitioner, nursing supervisor, nurse co-worker) in an ongoing and timely manner; and

i. Failing to communicate information regarding the client's status to other individuals who need to know; for example, family, and facility administrator.

4. Conduct related to achieving and maintaining clinical competency:
   a. Performing acts beyond the authorized scope or the level of nursing for which the individual is licensed.
   b. Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.
   c. Assuming duties and responsibilities within the practice of nursing for direct client care, supervisory, managerial or consulting roles without documented preparation for the duties and responsibilities and when competency has not been established and maintained; and
   d. Performing new nursing techniques or procedures without documented education specific to the technique or procedure and clinical preceptored experience to establish competency.
5. Conduct related to impaired function:
   a. Practicing nursing when unable/unfit to perform procedures and/or make decisions due to physical impairment as evidenced by documented deterioration of functioning in the practice setting and/or by the assessment of a health care provider qualified to diagnose physical condition/status.
   b. Practicing nursing when unable/unfit to perform procedures and/or make decisions due to psychological or mental impairment as evidenced by documented deterioration of functioning in the practice setting and/or by the assessment of a health care provider qualified to diagnose mental condition/status; and
   c. Practicing nursing when physical or mental ability to practice is impaired by use of drugs, alcohol or mind-altering substances.

6. Conduct related to licensure or certification violations:
   a. Practicing nursing without a current Oregon license or certificate.
   b. Practicing as a nurse practitioner or clinical nurse specialist without a current Oregon certificate.
   c. Allowing another person to use one's nursing license or certificate for any purpose.
   d. Using another's nursing license or certificate for any purpose.
   e. Resorting to fraud, misrepresentation, or deceit during the application process for licensure or certification, while taking the examination for licensure or certification, while obtaining initial licensure or certification or renewal of licensure or certification.
   f. Impersonating any applicant or acting as a proxy for the applicant in any nurse licensure or certification examination; and
   g. Disclosing the contents of the examination or soliciting, accepting or compiling information regarding the contents of the examination before, during or after its administration.

7. Conduct related to the licensee's relationship with the Board:
   a. Failing to provide the Board with any documents requested by the Board.
   b. Failing to answer truthfully and completely any question asked by the Board on an application for licensure or during the course of an investigation or any other question asked by the Board.
c. Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except client-attorney privilege.

d. Violating the terms and conditions of a Board order; and

e. Failing to comply with the terms and conditions of Nurse Monitoring Program agreements.

8. Conduct related to the client’s family:

a. Failing to respect the rights of the client’s family regardless of social or economic status, race, religion or national origin.

b. Using the nurse client relationship to exploit the family for the nurse’s personal gain or for any other reason.

c. Theft of money, property, services or supplies from the family; and

d. Soliciting or borrowing money, materials or property from the family.

9. Conduct related to co-workers: Violent, abusive or threatening behavior towards a co-worker which either occurs in the presence of clients or otherwise relates to the delivery of safe care to clients.

10. Conduct related to advanced practice nursing:

a. Ordering laboratory or other diagnostic tests or treatments or therapies for one’s self.

b. Prescribing for or dispensing medications to one’s self.

c. Using self-assessment and diagnosis as the basis for the provision of care which would otherwise be provided by a client’s professional caregiver.

d. Billing fraudulently.

e. Failing to release patient records upon receipt of request or release of information, including after closure of practice, and within a reasonable time, not to exceed 60 days from receipt of written notification from patient.

f. Ordering unnecessary laboratory or other diagnostic test or treatments for the purpose of personal gain; and

g. Failing to properly maintain patient records after closure of practice or practice setting.
For More Information

Please call us at 971-673-0685 between 8 a.m.—4:30 p.m.,
Monday–Friday, or write us at:

Oregon State Board of Nursing
17938 SW Upper Boones Ferry Rd.
Portland, OR 97224-7012

FAX: 971-673-0684
Automated License Verification Line: 971-673-0679
E-Mail: oregon.bn.info@state.or.us
OREGON NURSES ASSOCIATION
PROFESSIONAL NURSING CARE COMMITTEE (PNCC) RESOURCE MANUAL’S
AMERICAN NURSES ASSOCIATION (ANA) RESOURCES

The following ANA resources can be found on pages 153-157 of the 2015 Oregon Nurses Association (ONA) Professional Nursing Care Committee (PNCC) Resource Manual, which is available to ONA members on the ONA website (www.OregonRN.org). You may also request a copy of the PNCC Resource Manual by emailing ONA’s Professional Services at Practice@OregonRN.org.
Code of Ethics for Nurses

Provision 1
The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

Provision 2
The nurse’s primary commitment is to the patient, whether an individual, family, group, or community.

Provision 3
The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

Provision 4
The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care.

Provision 5
The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

Provision 6
The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.

Provision 7
The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

Provision 8
The nurse collaborates with other health professionals and the public in promoting community, national and international efforts to meet health needs.

Provision 9
The profession of nursing value, for maintaining the integrity of the profession and its practice, and for shaping social policy.

American Nurses Association
Center for Ethics and Human Rights
http://www.nursingworld.org
DEFINITION OF PROFESSIONAL NURSING

_Nursing_ is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

_Essential Features_ OF PROFESSIONAL NURSING:

- Provision of a caring relationship that facilitates health and healing.

- Attention to the range of human experiences and responses to health and illness within the physical and social environments.

- Integration of objective data with knowledge gained from an appreciation of the patient’s or group’s subjective experience.

- Application of scientific knowledge to the processes of diagnosis and treatment through the use of judgment and critical thinking.

- Advancement of professional nursing knowledge through scholarly inquiry.

- Influence on social and public policy to promote social justice.

_ANA’s Nursing’s Social Policy Statement, Second Edition_  
[www.nursesbooks.org](http://www.nursesbooks.org)
Nursing Scope and Standards of Practice

Standard of Practice for the Registered Nurse:

The six Standards of Practice describe a competent level of nursing care as demonstrated by the nursing process.

1. Assessment – Collects comprehensive data pertinent to the patient's health or the situation.

2. Diagnosis – Analyzes the assessment data to determine the diagnoses or issues.

3. Outcomes Identification – Identifies expected outcomes for a plan individualized to the patient or the situation.

4. Planning – Develops a plan that prescribes strategies and alternatives to attain expected outcomes.

5. Implementation – Implements the identified plan. Elaborating this standard are five others: 5A. Coordination of Care, 5B. Health Teaching and Health Promotion, 5C. Consultation, 5D. Prescriptive Authority, and 5E. Treatment and Evaluation.


Standards of Professional Performance for the Registered Nurse:

The nine Standards of Professional Performance describe a competent level of behavior in the professional role.

7. Quality of Practice – Systematically enhances the quality and effectiveness of nursing practice.

8. Education – Attains knowledge and competency that reflects current nursing practice.

10. **Collegiality** – Interacts with and contributes to the professional development of peers and colleagues. **Collaboration** – Collaborates with patient, family, and others in the conduct of nursing practice.

11. **Collaboration** – Collaborates with patient, family, and others in the conduct of nursing practice.

12. **Ethics** – Integrates ethical provision in all areas of practice.

13. **Research** – Integrates research findings into practice.

14. **Resource Utilization** – Considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

15. **Leadership** – Provides leadership in the professional practice setting and the profession.
CONTRACT RECEIPT FORM

Please fill out neatly and completely, and return to
Oregon Nurses Association
18765 SW Boones Ferry Road, Suite 200
Tualatin, OR 97062-8498
Or, fax to ONA at 503-293-0013. Thank you.

Your name ________________________________________________

I certify that I have received a copy of the ONA Collective Bargaining Agreement with

Signature ___________________________ Today’s date ________________

Your mailing address __________________________________________

________________________________________________________________

________________________________________________________________

Cell phone __________________ Home phone _________________________

Personal email _____________________________________________

Unit _______________________________________________________

Shift ______________________________________________________