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UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

CROFT METALS, INC,

Employer,

- and -

INTERNATIONAL BROTHERHOOD OF
BOILERMAKERS, IRON SHIP BUILDERS,
BLACKSMITHS, FORGERS AND HELPERS, AFL-
CIO,

Petitioner.

Case 15-RC-8393

OAKWOOD HEALTHCARE, INC.,

Employer,

- and -

INTERNATIONAL UNION, UNITED AUTOMOBILE,
AEROSPACE AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA (UAW), AFL-CIO,

Petitioner.

Case 7-RC-22141

BEVERLY ENTERPRISES-MINNESOTA, INC., d/b/a
GOLDEN CREST HEALTHCARE CENTER,

Employer,

- and -

UNITED STEELWORKERS OF AMERICA, AFL-
CIO, CLC,

Petitioner.

Cases 18-RC-16415
18-RC-16416

**BRIEF OF AMICI CURIAE AMERICAN NURSES ASSOCIATION AND
UNITED AMERICAN NURSES, AFL-CIO**

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TABLE OF CONTENTS

TABLE OF AUTHORITIES	ii
I. INTEREST OF <i>AMICI</i>	1
II. PRELIMINARY STATEMENT	2
III. COLLECTIVE BARGAINING HAS PLAYED A KEY ROLE IN ALLEVIATING THE CRISIS FACING THE NURSING PROFESSION	4
A. The Nursing Profession	4
B. Collective Bargaining and Nursing	10
IV. IN DETERMINING WHAT CONSTITUTES INDEPENDENT JUDGMENT UNDER THE ACT, THE BOARD SHOULD CONSIDER FACTORS SUCH AS HOSPITAL POLICIES AND PROCEDURES, THE NURSES' <i>CODE OF ETHICS</i> , THE ANA'S <i>NURSING: SCOPE AND STANDARDS OF PRACTICE</i> AND STATE NURSE PRACTICE ACTS, ALL OF WHICH STRICTLY CIRCUMSCRIBE RNS' DECISION MAKING AND PRACTICE	14
A. Hospital Policies and Procedures	16
B. The <i>Code of Ethics</i>	18
C. <i>Nursing: Scope and Standards of Practice</i>	20
D. Nurse Practice Acts	21
V. RNS' DELEGATION OF TASKS TO OTHERS DOES NOT RISE TO THE LEVEL OF ASSIGNMENT OR DIRECTION UNDER THE ACT	24
VI. CONCLUSION	29

TABLE OF AUTHORITIES

CASES

	<u>Page</u>
<i>Beverly Enterprises-Pennsylvania, Inc. v. NLRB</i> , 129 F.3d 1269 (D.C. Cir. 1997)	27
<i>Beverly Enterprises v. NLRB</i> , 148 F.3d 1042 (8th Cir. 1998)	16
<i>Crittenton Hosp.</i> , 328 N.L.R.B. 879 (1999)	22
<i>Ferguson Electric Co.</i> , 335 N.L.R.B. No. 15 (2001)	16
<i>General Dynamics Corp.</i> , 213 N.L.R.B. 851, 859 (1974)	26
<i>NLRB v. Bell Aerospace Co.</i> , 416 U.S. 267 (1974)	15
<i>NLRB v. Kentucky River Community Care, Inc.</i> , 532 U.S. 706 (2001)	4, 24
<i>NLRB v. Security Guard Service</i> , 384 F.2d 143 (5th Cir. 1967)	15
<i>NLRB v. Southern Bleachery & Print Works, Inc.</i> , 257 F.2d 235 (4th Cir. 1958)	15, 26
<i>Providence Hospital</i> , 320 N.L.R.B. 717 (1996)	15, 16, 24, 25
<i>Southern Bleachery & Print Works</i> , 111 N.L.R.B. 787 (1956)	26
<i>Ten Broeck Commons</i> , 320 N.L.R.B. 806 (1996)	15
<i>Westinghouse Elec. Corp. v. NLRB</i> , 424 F.2d 1151 (7th Cir. 1970)	15

STATUTES

29 C.F.R. §103.30(a)(1) (2003) 2

29 U.S.C. §152(11) (1947) 3

29 U.S.C. §2(11) 15

Ala. Code §§ 34-21-1(3) (2003) 21

Ala. Code §34-8A-3 (1994) 18

Alaska Stat. §§ 08.68.100(a)(9) (2003) 21

Colo. Rev. Stat. §§ 12-38-103(9)-(10) (2002) 21

Colo. Rev. Stat. §§ 12-38-132 (2002) 22

D.C. Code §2-3306.8 (1995) 18

Del. Code Ann. tit. 24 §§ 1902(b)(7) (2003) 22

Fla. Admin Code Ann. r.59 - 3.208 §§ 5(5) (f) (2003) 23

Fla. Stat. Ann. §§400.23(2003) 23

Haw. Rev. Stat. Ann. §§ 457-2 22

Ind. Code Ann. §§ 25-23-1-1.1(b)(7)(2003) 22

Kan. Admin. Regs. 28-34-7(2002) 23

Ky. Rev. Stat. Ann. §§314.011(6)(d)(2002) 22, 28

La. Rev. Stat. Ann. §§ 37:913(14)(f) (2003) 28

Mass. Ann. Laws ch. 112, §§ 80B (2003) 28

Me. Rev. Stat. Ann. tit. 32, §§ 2102(2)(C)-(D) (2003) 22

Me. Rev. Stat. Ann. tit. 32, §§2102(2)(C)-(D) (2003) 28

Mich. Comp. Laws §§333.17201(c)(2003) 22

Mich. Comp. Laws §§ 333.16104(1) (2003)	27
Minn.R. 4640.00900 (2002)	23
Minn. Stat. §§ 148.171(14)-(15) (2002)	21
Minn. Stat. §148.271 (2003)	23
Miss. Code Ann. §§ 73-15-5(2)-(3) (2003)	21
Mont. Code Ann. §§ 37-8-102(5)(a)-(b) (2002)	21
N.C. Gen. Stat. §§ 90-171.20(8)(c) (2003)	28
N.H. Rev. Stat. Ann. §§ 326-B:2(XVI), (XVII), (XVIII)(2002)	21
N.J. Stat. Ann. §§ 45:11-23(1)(b) (2003)	21
Neb. Rev. Stat. §§ 71-1, 132.05(8)-(9) (2003)	21
Nurse Reinvestment Act, PL 107-205 (2002)	6
Ohio Rev. Code Ann. §§ 4723.02(B)(6) (2003)	22
Okla. Stat. tit. 59, §§ 567.3a(2002)	28
S.C. Code Ann. §§ 40-33-10(g)-(h) (2002)	21
22 Tex. Admin. Code §§48.6040(2003)	28
Wash. Rev. Code §§ 18.135.060 (2003)	28

LEGISLATIVE HISTORY

<i>Collective Bargaining Units in the Health Care Industry</i> , 53 Fed. Reg. 33,900, (Sept. 1, 1988)	passim
<i>Collective Bargaining Units in the Health Care Industry</i> , 54 Fed. Reg. 16,336 (1989)	3
<i>Legislative History of the Labor-Management Relations Act</i> , 1947 at 410 (GPO 1974)	3
S. Rep. No. 105, at 4, 19 (1947)	3

BOOKS AND PERIODICALS

Linda Aiken, et al., <i>Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction</i> , J. Am. Med. Ass'n 1987 (2002)	6, 7, 8
Am. Hosp. Ass'n Comm'n on Workforce for Hospitals and Health Systems <i>In Our Hands: How Hospital Leaders Can Build a Thriving Workforce</i> (2002)	8
Am. Nurses Ass'n <i>ANA & You: Ensuring Nursing's Future, 2002 Annual Stakeholders Report</i> (2002)	9
Am. Nurses Ass'n, <i>Code of Ethics for Nurses With Interpretative Statements</i> (2001)	passim
Am. Nurses Ass'n, <i>Nursing's Social Policy Statement</i> (2003)	4
Am. Nurses Ass'n, <i>Nursing: Scope and Standards of Prac.</i> (2003)	passim
C.C. Bandovinac, et al., <i>The Use of Unlicensed Assistive Personnel and Selected Outcome Indications</i> 4 Nursing Econ. 17 (1999)	17
Howard Berliner & Eli Ginzberg, <i>Why This Hospital Nursing Shortage is Different</i> , J. Am. Med. Ass'n 2742 (2002)	7, 8
Bureau of Lab. Statistics 2002 National Occupational Employment and Wage Estimates, Classification 29-1111 (Registered Nurses) (2002)	10
Leah L. Curtin, <i>An Integrated Anal. of Nurse Staffing and Related Variables: Effects on Patient Outcomes</i> , Online J. of Nursing (Sept. 30, 2003)	9
<i>DOL Official Calls Health Workers Shortage a Major Focus of New Job Training Initiative</i> , Daily Lab. Rep. Aug. 29, 2003	6, 7
Patrick Hardin, <i>The Developing Labor Law</i> (3d ed. 1992)	3
Daniel Hecker, <i>Occupational Employment Predictions to 2010</i> , 124 Monthly Lab. Rev. (2001)	6
Inst. of Med., <i>To Err Is Human</i> (1999)	17
Joint Commission on Accreditation of Healthcare Organizations, <i>Health Care at the Crossroads: Strategies for Addressing the Evolving Nurse Crisis</i>	passim

National Center for Health Workforce Anal., Bureau of Health Professions, Health Resources and Services Admin., Dept. of Health and Hum. Serv., <i>Projected Supply, Demand and Shortages of Registered Nurses: 2000-2020 (2000)</i>	6
Nat'l Coun. of State Bds. of Nursing, <i>Model Nurse Prac. Act (2002)</i>	passim
Brenda Nevidjon and Jeanette Ives Erickson, <i>The Nursing Shortage: Solutions for the Short and Long Term</i> , Online J. of Issues in Nursing (Jan. 31, 2001)	8
<i>Nurses: Vital Signs</i> , Department for Professional Employees AFL-CIO Fact Sheet, 2003-4	10, 11
John Pekkanen, <i>Condition: Critical</i> , Reader's Dig., Sept. 2003.	6
<i>The Role of Collective Bargaining and Unions in Advancing the Profession of Nursing</i> , 3 Nursing World, Feb. 1998	11
J. Rosenthal, et al., <i>State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey (April 2000)</i>	17
Ernell Spratley, et al. <i>The Registered Nurse Population: Findings From the National Sample Survey of Registered Nurses (2000)</i>	10

I. **INTEREST OF AMICI**

For over a century, the **American Nurses Association** (“ANA”) has represented the interests of America’s registered nurses (“RNs”). Today, the ANA is comprised of 54 constituent member associations, including one from every state of the United States, the District of Columbia, Guam, and the Virgin Islands, as well as federal uniformed nurses. In addition, several hundred thousand registered nurses are members of ANA’s organizational affiliates – specialty nursing organizations formally affiliated with ANA. In the course of its representation of registered nurses, the ANA establishes professional standards of practice and promulgates the *Code of Ethics for Nurses* (“*Code of Ethics*”), which guides the work of registered nurses throughout the profession. In addition, the ANA sets standards for the practice of nursing and has a keen interest in addressing the nursing shortage that exists in the United States.

The **United American Nurses** (“UAN”) is a national labor organization affiliated with the ANA. It is the largest union of RNs in the country, representing approximately 100,000 RNs in the federal, private and state public sectors. State Nurse Associations (“SNAs”) in 25 states, the affiliated members of the UAN, are parties to more than 500 collective bargaining agreements with health care institutions covering the RNs who staff them. In 2000, the UAN affiliated with the AFL-CIO in order to strengthen its goal of improving RNs’ working conditions, as well as ensuring patient safety and safe staffing levels.

The ANA has long supported the rights of registered nurses to be represented for purposes of collective bargaining. Indeed, as set forth in the ANA’s *Code of Ethics*:

The professional association [*i.e.*, the SNA] also serves as an advocate for the nurse by seeking to secure just compensation and humane working conditions for nurses. To accomplish this, the professional association may engage in collective bargaining on behalf of nurses. While seeking to assure just economic and general welfare for nurses, collective bargaining, nonetheless, seeks to keep the interests of both nurses and patients in balance.¹

The UAN was formed in 2000, with the primary goal of organizing and representing RNs. Both the ANA and the UAN consider the Board's determination whether registered nurses continue to fall within the statutory framework of the National Labor Relations Act (the "Act") to be critical in ensuring not only the rights of the affected nurses, but also patient care and safety.

II. PRELIMINARY STATEMENT

Numerous challenges face the health care profession today, not least of which is the threat to patient care and safety caused by the profound shortage of registered nurses. Collective bargaining in the RN context has been instrumental in addressing these challenges, ensuring safe staffing levels and addressing other issues that directly affect patient care and safety.

Recognizing the key role played by collective bargaining in addressing issues facing the health care industry, the NLRB has repeatedly recognized the right of RNs to organize, and frequently rejected challenges to that right based on the purported supervisory status of RNs. Notably, the Board's 1988 rule making, which concluded that "a separate RN unit is appropriate for collective bargaining purposes," *Collective Bargaining Units in the Health Care Industry*, 53 Fed. Reg. at 33,912; *see also* 29 C.F.R. §103.30(a)(1) (2003); *Collective*

¹Am. Nurses Ass'n, *Code of Ethics for Nurses With Interpretative Statements*, Canon 6.3 (2001).

Bargaining Units in the Health Care Industry, 54 Fed Reg. 16,336 (1989) (to be codified at 29 C.F.R. pt. 103), evidences a firm commitment to protecting RNs' right to bargaining collectively. Indeed, in promulgating the rule establishing RN bargaining units, the Board emphasized that allowing RNs to bargain collectively would make the "nursing profession a more attractive employment opportunity." 53 Fed. Reg. at 33,917.

The Act has long excluded supervisors from its coverage, see 29 U.S.C. §152(11) (1947), in order to ensure that unions do not become dominated by employers and that employees are not forced to "divide their loyalties between management and the union."² The definition of "supervisor" added to the Act in 1947, however, was only intended to apply to those employees who have "genuine management prerogatives."³ As discussed below, the responsibilities of RNs, including those working as "charge nurses," are entirely distinct from those contemplated by Congress as falling within the statutory exclusion. See S. Rep. No. 105, at 4, 19 (1947) (employees excluded from the Act's coverage must be "truly supervisory").

This brief first discusses the problems plaguing the nursing profession, and the significant beneficial effect of collective bargaining on these problems. We then address a question posed by the Board in its July 25, 2003 Notice⁴ concerning the specific "factors" that the Board should consider in applying the term "independent judgment". These factors include hospital practices and procedure, the *Code of Ethics*, the ANA's *Scope and Standards of Nursing Practice*, and state Nurse Practice Acts.

²Patrick Hardin, *The Developing Labor Law* 1616 (3d ed. 1992).

³*Legislative History of the Labor-Management Relations Act*, 1947 at 410 (GPO 1974).

⁴See "Notice and Invitation to File Briefs," July 25, 2003.

Finally, with respect to the Board's inquiry concerning the meaning of the terms "assign" and "direct" under section 2(11) of the Act, we demonstrate that the delegation of tasks by RNs, including charge RNs, as defined and limited by the nursing profession, does not rise to the level of "assign" or "direct" under the Act. As set forth below, this is entirely consistent with the Supreme Court's suggestion in *NLRB v. Kentucky River Community Care, Inc.*, 532 U.S. 706, 720 (2001), that the Board offer a "limiting interpretation" of these terms.⁵

III. **COLLECTIVE BARGAINING HAS PLAYED A KEY ROLE IN ALLEVIATING THE CRISIS FACING THE NURSING PROFESSION**

A. **The Nursing Profession**

Nursing is defined as

"the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individuals, families, groups, communities and populations."⁶

These few words, of course, cannot capture the reality of day-to-day life for registered nurses. Indeed, the responsibilities of an RN, whether in the role of charge nurse or staff nurse, cover the entire spectrum of care. They include assessing the health status of patients, developing comprehensive nursing care plans, updating patient records, delivering wound care and medical treatments, monitoring intravenous procedures, providing patients with health counseling, providing a safe and therapeutic environment, and meeting patients' basic physical needs such as bathing, feeding and toileting.

⁵Briefs of *amici curiae* from the AFL-CIO and the several affiliated unions representing RNs have also been submitted to the Board. We fully endorse the arguments set forth therein.

⁶Am. Nurses Ass'n, *Nursing's Social Policy Statement 1* (2003), available at <http://www.nursingworld.org/> (last visited Sept. 9, 2003).

In the context of this wide array of responsibilities, nurses continually make patient care decisions. Regardless of practice settings, nurses must examine and interview patients, assess physiological and psychosocial factors related to care and, when appropriate, diagnose or make recommendations to primary care providers. The ability to assess and evaluate is the heart and soul of nursing practice. Nurses' roles and responsibilities, however, are completely constrained by hospital policies and procedures, professional standards, Nurse Practice Acts and regulations that guide the delivery of health care and the coordination of the health care team. Nurses make judgments within these set parameters.

Media and industry reports on the nursing profession and the hospital industry repeatedly recognize three critical issues facing the nursing profession and, by implication, the health care industry: the current and impending shortage of nurses, concerns of patient care and safety, and the question of how to improve the retention of nurses to eliminate the shortage of nurses and address patient care issues. Collective bargaining between RN unions and RNs' employers has played a key role in effectively addressing these issues.

Nursing Shortage. The shortage of registered nurses in the United States is widely reported and manifest, and this shortage only promises to worsen in the coming years. The reasons for the nursing shortage are numerous; a critical failure to attract a sufficient number of people to the profession and to retain existing RNs are probably the strongest contributing factors. The nursing work force is aging rapidly, and tens of thousands of RNs will be retiring in the next few years. It is anticipated that, by 2020, there will be a shortage of more

than 800,000 nurses.⁷ The shortage has serious, often dire side effects. A recent study in the Journal of the American Medical Association reported that “the odds of patient mortality increased by 7% for every additional patient in the average nurse’s workload in the hospital.”⁸

A recent news article gives a graphic illustration of the dangers:

When her husband underwent surgery, Karen Chase, an RN in Westwood, N.J., virtually moved into his hospital room. Chase knew exactly what patients are up against: She once worked in a hospital, but is now a private duty nurse.

At one point, as her husband moved from his bed to a chair, a spinal catheter that administered his pain medication slipped out. ‘This catheter should be sterile, and it was dangling on the floor,’ Chase says. She watched in disbelief as a nurse’s aide started to stick the catheter back in.

‘What are you doing?’ Chase screamed. ‘You can’t reattach that. It’s dirty!’ If Chase hadn’t been camped out in the room, she wouldn’t have caught the mistake. Most frustrating to her, she knows that any RN would have known what to do. But there were no nurses around.⁹

⁷National Center for Health Workforce Anal., Bureau of Health Professions, Health Resources and Services Admin., Dept. of Health and Hum. Serv., *Projected Supply, Demand and Shortages of Registered Nurses: 2000-2020*, (2000) (predicting shortage of 808,416 RNs). The Bureau of Labor Statistics makes the more dire prediction of a shortage of one million nurses as of 2010, see Daniel Hecker, *Occupational Employment Predictions to 2010*, 124 Monthly Lab. Rev. ¶11 at 57-84 (2001). See also Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Addressing the Evolving Nurse Crisis* (hereinafter “JCAHO Report”)17 available at <http://www.jcaho.org/> (last visited Sept. 9, 2003). In 2002, Congress passed the Nurse Reinvestment Act, which authorizes new programs to increase the number of qualified nurses and assist in the retention of nurses. See Nurse Reinvestment Act, PL 107-205 (2002). Indeed, the Department of Labor perceives the coming shortage as such a serious problem that it has created the “High Growth Job Training Initiative” to address the health care worker shortage. See *DOL Official Calls Health Workers Shortage a Major Focus of New Job Training Initiative*, Daily Lab. Rep., Aug. 29, 2003, at A-10.

⁸Linda Aiken, et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction*, J. Am. Med. Ass’n 1987, 1991 (2002).

⁹John Pekkanen, *Condition: Critical*, Reader’s Dig., Sept. 2003, at 90.

An additional side effect of the nursing shortage is the increasing delegation of patient care activities to nurses' aides and unlicensed assistive personnel. Although state laws and ethical codes governing the practice of nursing require that nurses delegate such activities only where appropriate, nurses "have neither the managerial support nor the control over their environments. . . to marshal and deploy scarce resources in order to manage the often challenging, and sometimes critical patient care situations which they may face."¹⁰

Retention. The causes of the crisis of retention include unrealistic work loads, including high ratios of patients to nurses,¹¹ resulting in high levels of job dissatisfaction,¹² and concerns about compensation.¹³ The Journal of the American Medical Association has admonished that "[a]s long as hospitals understaff their nursing units, require nurses to float from unit to unit, require mandatory overtime, and disrespect their nurses in general, the constant high turnover in the nursing profession will continue."¹⁴ The nursing and hospital industries recognize the problems posed by the retention crisis, and literature on the topic

¹⁰JCAHO Report *supra* note 7 at 10.

¹¹See Aiken, *supra* note 8 at 1987.

¹²Howard Berliner & Eli Ginzberg, *Why This Hospital Nursing Shortage is Different*, J. Am. Med. Ass'n, 2742, 2743 (2002).

¹³DOL Official Calls Health Workers Shortage A Major Focus of New Job Training Initiative, *supra* note 7 at A-10 (Assistant Secretary of Labor for Employment and Training Emily Stover DeRocco: "Compensation issues and the physically demanding nature of work in some health care jobs are among the working conditions that sometimes detract from recruitment and retention.")

¹⁴Berliner & Ginzberg, *supra* note 12 at 2744.

suggests that there are effective strategies for remedying this problem by preventing nurse burnout.¹⁵ Among these are

- Improving nurse staffing levels;¹⁶
- Ensuring that nurses are involved in providing direct care;¹⁷
- Addressing nurses' salaries;¹⁸
- Addressing scheduling issues concerning nurses;¹⁹ and
- Creating a culture where nurses feel valued and respected.²⁰

As recognized by the Board and as set forth more fully below, these strategies for improving retention are often effectuated through collective bargaining. *See Collective Bargaining Units in the Health Care Industry*, 53 Fed. Reg. 33,900, 33,914-15 (Sept. 1, 1988) (to be codified at 29 C.F.R. pt. 103).

Patient Care and Safety. An unfortunate side effect of the nursing shortage, the increasing inability of the profession to retain experienced and qualified nurses, as well as “cost

¹⁵In addition to addressing the issue of retention, the nursing and hospital industry are also seeking ways to increase the number of people going into the nursing field. A serious component of the nursing shortage is that the number of people going into nursing has not kept up with population growth. This problem is expected to be severely exacerbated when the baby boom generation begins to retire. *See* Berliner & Ginzberg, *supra* note 12, at 2742.

¹⁶*See* Aiken, *supra* note 8, at 1993.

¹⁷Brenda Nevidjon & Jeanette Ives Erickson, *The Nursing Shortage: Solutions for the Short and Long Term*, Online J. of Issues in Nursing (Jan. 31, 2001) at 10, available at http://nursingworld.org/ojin/topic14/tpc14_4.htm (last visited Aug. 19, 2003).

¹⁸*Id.* at 9.

¹⁹*See* JCAHO Report, *supra*, note 7, at 17; *see also* Nevidjon, *supra* note 17 at 9.

²⁰Am. Hosp. Ass'n Comm'n on Workforce for Hospitals and Health Systems *In Our Hands: How Hospital Leaders Can Build a Thriving Workforce* 30 (2002).

constraints driven by managed care, reduced Medicare reimbursement, and private sector purchase initiatives,”²¹ is that patient care and safety suffers. In addition to increased mortality as described above, high patient-to-nurse ratios also increase the average length of hospital stays by as much as 49 percent.²² The nursing profession and hospital industries both recognize the importance of decreasing patient-to-nurse ratios in the interest of patient safety:

[one] study found that, among other things, a higher proportion of hours of care per day and a greater absolute number of hours of care per day provided by RNs were associated with shorter lengths of stay; fewer urinary tract infections and incidences of upper gastrointestinal bleeding; and lower rates of pneumonia, shock and cardiac arrest.²³

Staffing levels are not the only issue affecting patient care. Mandatory overtime, apart from being a “major source” of nurses’ job dissatisfaction,²⁴ creates a dangerous environment for patients. The Board has long acknowledged that RNs are subject to “mandatory

²¹See JCAHO Report, *supra* note 7, at 8.

²²Leah L. Curtin, *An Integrated Anal. of Nurse Staffing and Related Variables: Effects on Patient Outcomes*, Online J. of Nursing (Sept. 30, 2003) available at http://nursingworld.org/ojin/topic22/tpc22_5.htm (last visited September 18, 2003).

²³Am. Nurses Ass’n *ANA & You: Ensuring Nursing’s Future, 2002 Annual Stakeholders Report*, 25 (2002) (referencing a May 2002 study published in the *New England Journal of Medicine*). See also JCAHO Report, *supra* note 7, at 13 (“spread too thinly or lacking the appropriate skill set, the nurse is at risk of missing early signs of a problem, or missing the problem altogether. One recent study found that higher nurse staffing levels, particularly with a greater number of R.N.s in the staffing mix, correlated with a 3-to-12 percent reduction in certain adverse outcomes. . .”). The JCAHO further notes that (1) the current nursing shortage has required hospitals to turn to temp agencies for nurses, but such temporary nurses “have increasingly been the focus of medical error investigations which turn out to be related to a lack of knowledge of hospital procedures or unfamiliarity with patient ailments,” *id.* at 19; and (2) labor unions have long advocated for mandated nurse-to-patient ratios, but that the hospital industry has opposed such ratios, *id.* at 20.

²⁴JCAHO Report *supra* note 7, at 17.

overtime and double or rotating shifts, or evening, night and weekend shifts, all of which are said to increase the likelihood of nurse error.” 53 Fed. Reg. at 33,915. Indeed, the Board cited just such concerns in determining that bargaining units consisting solely of RNs are appropriate. *See id.* As shown below, collective bargaining uniquely allows nurses, who have on-the-ground experience in hospitals and other health care institutions, to collectively formulate solutions to the problems facing the nursing profession with their health care industry employers.

B. Collective Bargaining and Nursing

Of the more than 2.1 million people working as registered nurses in the United States in the year 2002,²⁵ 15.6% were union members.²⁶ Registered nurses covered by a collective bargaining agreement earn approximately 11% more per week than non-unionized nurses: in 2002, nurses covered by collective bargaining agreements had average weekly earnings of \$924.00, compared with an average \$823.00 weekly for nurses not covered by a collective bargaining agreement.²⁷ The difference is significant, in part because the wages of registered nurses have not grown at the same rate as the wages of the labor force as a whole:

²⁵Bureau of Lab. Statistics 2002 National Occupational Employment and Wage Estimates, Classification 29-1111 (Registered Nurses) (2002). The number of registered nurses, *including* those not working in the profession is probably much higher: there were a total of 2.7 million registered nurses in 2000, 2.2 million of whom were employed as registered nurses. *See* Ernell Spratley, et al. *The Registered Nurse Population: Findings From the National Sample Survey of Registered Nurses* (2000).

²⁶*See Nurses: Vital Signs, Department for Professional Employees AFL-CIO Fact Sheet, 2003-4*, (citing Bureau of National Affairs, Union Membership and Earnings Data Book: Compilations of the Current Population Survey, 2002 & 2003), available at <http://www.aflcio.org/issuespolitics/healthpolicy/nurses/upload/vitalsigns.pdf>. (last visited Sept. 9, 2003).

²⁷*Id.*

RNs' wages rose by only 3.3% from 1992 to 2002, while wages for the total labor force rose 6.8%.²⁸ Statistics, however, tell only part of the story: numerous provisions in collective bargaining agreements provide far greater protection for unionized nurses than for those who are not.

The NLRB expressed its view in 1988 that collective bargaining gains accomplished through the creation of separate RN units have been an "important step toward making the nursing profession a more attractive employment opportunity." *Collective Bargaining Units in the Health Care Industry*, 53 Fed. Reg. at 33,917. As demonstrated in the various ANA and UAN publications, collective bargaining has provided for significant accomplishment in salaries, benefits, and the professional practice of nurses.²⁹ The following are illustrative provisions of collective bargaining agreements negotiated between employers and the state affiliates of the UAN, as well as other unions representing RNs:

Wages, Benefits and Working Conditions

- Nurses at New York City's Mt. Sinai Hospital have negotiated starting salaries of \$62,232.91 by July 4, 2004;³⁰

²⁸*Id.*, (citing U.S. Dep't of Lab., Bureau of Lab. Statistics, Current Population Survey, 1993, 1998, 2002, 2003).

²⁹*The Role of Collective Bargaining and Unions in Advancing the Profession of Nursing*, 3 Nursing World, Feb. 1998 at 8; see U. Am. Nurses, *About UAN*, available at <http://nursingworld.org/uan/about.htm> (last visited Sept. 18, 2003).

³⁰See U. Am. Nurses, *UAN Agenda: Wages and Benefits . . . the Best Base Salary, Pensions, Overtime and Differential Pay in the Industry*, available at <http://nursingworld.org/uan/wages.htm> (last visited Sept. 9, 2003).

- Nurses at St. Mary's in West Palm Beach, Florida, are guaranteed raises of 28 percent of four years,³¹
- Minnesota nurses who are required to work longer than the hours for which they are regularly scheduled are paid time-and-a-half, earn double time for more than 12 hours' work and, in some cases, receive the equivalent of triple time;³²

Mandatory Overtime

- Nurses in Youngstown, Ohio have negotiated contracts that completely eliminate the use of mandatory overtime;³³
- Nurses in Michigan have negotiated a provision allowing nurses to determine whether accepting an overtime assignment "would pose a direct threat to patients by working mandatory overtime. The employer and the association agree that mandatory overtime is not an appropriate tool to staff the hospital."³⁴

Safe staffing levels

- A collective bargaining agreement covering nurses at one Michigan hospital allows the hospital to be "fined" by nurses if staffing levels fall below those outlined in the contract;³⁵

³¹See SEIU, *The SEIU Nurse Alliance: Reaching for Higher Standards*, available at http://www.seiu.org/health/nurses/safe_staffing/bargaining_efforts/nv_and_fl.cfm (last visited Sept. 16, 2003).

³²See *UAN Agenda: Wages and Benefits*, *supra* note 30.

³³See U. Am. Nurses, *UAN Agenda: Mandatory Overtime . . . The Power To Say 'No' When Additional Work Hours Are Unsafe For You and Your Patients*, available at <http://nursingworld.org/uan/mandatory.htm> (last visited Aug. 29, 2003);

³⁴*Id.*

³⁵See U. Am. Nurses, *UAN Agenda: Staffing . . . Guaranteeing Safe Staffing Through Enforceable Levels, Ratios and Record-keeping*, available at <http://nursingworld.org/uan/staffing.htm> (last visited Aug. 29, 2003).

- Nurses in several New York hospitals have negotiated the right to determine nurse-to-patient staffing ratios on a unit-by-unit or clinical specialty basis;³⁶
- Las Vegas nurses have negotiated a provision that allows nurses concerned that staffing procedures are substandard to take such concerns to a staffing committee and, if the concerns are unresolved, to a review panel, both of which are comprised of an equal number of staff nurses and managers;³⁷
- Nurses in Pascack, New Jersey have negotiated a contract provision that grants the union input into staffing standards developed by the hospital, with recourse to arbitration if the matter is not resolved;³⁸
- Many state nurses associations affiliated with the UAN use “Assignment Despite Objection” forms, which allow nurses to document assignments that they believe are inappropriate or inadequate for providing patient care, for future use in formulating contractual limitations on staffing.³⁹

Professional Development

- Ohio nurses have negotiated a contract that allows for full tuition reimbursement for successful completion of specialty certification courses;⁴⁰

³⁶*Id.*

³⁷See *SEIU Nurse Alliance, Reaching for High Standards*, *supra* note 31.

³⁸See Am. Fed. Teachers, *AFT Healthcare: Pascack Valley Hospital HPAE, Local 5029, Contract Language Establishing Staffing Guidelines*, available at <http://aft.org/healthcare/contractlanguage/PVH.html> (last visited Sept. 16, 2003).

³⁹See *UAN Agenda: Staffing*, *supra* note 35.

⁴⁰See U. Am. Nurses, *UAN Agenda: Professional Development . . . Helping You Keep up with the Latest Advances Through Tuition Reimbursement and Paid Leave*, available at <http://nursingworld.org/uan/prodevelopment.htm> (last visited Aug. 29, 2003).

- Nurses at Howard University Hospital in Washington D.C. receive free tuition and administrative leave for continuing education.⁴¹

Restructuring and Mergers

To give nurses a voice in the structuring of the workplace:

- Missouri nurses collectively negotiated a contract that protects their employment if the hospital is merged, sold, or changes management;⁴²

These contractual provisions are merely illustrative of the beneficial effect of collective bargaining in addressing the crises faced by the health care industry and nursing profession. Continued collective bargaining is a uniquely appropriate mechanism for continuing to address these crises.

IV. **IN DETERMINING WHAT CONSTITUTES INDEPENDENT JUDGMENT UNDER THE ACT, THE BOARD SHOULD CONSIDER FACTORS SUCH AS HOSPITAL POLICIES AND PROCEDURES, THE NURSES' *CODE OF ETHICS*, THE ANA'S *NURSING: SCOPE AND STANDARDS OF PRACTICE* AND STATE NURSE PRACTICE ACTS, ALL OF WHICH STRICTLY CIRCUMSCRIBE RNS' DECISION-MAKING AND PRACTICE**

In response to the first question posed by the Board, the unique nature of the nursing profession requires that factors such as hospital policies and procedures, the *Code of Ethics*, the ANA's *Nursing: Scope and Standards of Practice*, and state Nurse Practice Acts be considered in determining what constitutes "independent judgment" under the Act. These instruments constrain and delineate nurses' decision-making as to all care decisions, even when nurses are acting in the capacity of charge nurses. On an individual level, each nurse's

⁴¹*Id.*

⁴²*Id.*

decisionmaking is, moreover, further constrained by orders given by doctors and by the specific care plans to be implemented for each patient.

The Act defines “supervisor” as “. . . any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees or responsibly to direct them, or to adjust their grievances, or effectively recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.” 29 U.S.C. §2(11). The inclusion of the phrase “independent judgment” arose in connection with the attempt of Congress to distinguish between true “supervisors” with “genuine management prerogatives” and those who are still eligible to organize under the Act, even if they perform “minor supervisory duties.” *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 280-281 (1974) (quoting Sen. Rep. No. 105, 80th Cong., 1st Sess. 4 (1947)); *see also Providence Hospital*, 320 N.L.R.B. 717, 725 (1996), *enf’d*, 121 F.3d 548 (9th Cir. 1997) at 725, quoting *NLRB v. Security Guard Service*, 384 F.2d 143, 151 (5th Cir. 1967) (“[e]very order-giver is not a supervisor”). The Board has interpreted the phrase “independent judgment” in a manner that recognizes that the application by an employee of professional, technical or craft knowledge in the direction of others is not necessarily supervisory if the direction is routine. *See, e.g., NLRB v. Southern Bleachery & Print Works, Inc.*, 257 F.2d 235, 239 (4th Cir. 1958); *Westinghouse Elec. Corp. v. NLRB*, 424 F.2d 1151, 1156 (7th Cir. 1970) (directives are not supervisory when they “are necessary incidents of the application of [field engineers’] technical know-how”); *Ten Broeck Commons*, 320 N.L.R.B. 806, 812 (1996).

In analyzing whether RNs exercise “independent judgment” sufficient to justify denying them the Act’s protection, the Board has found that the degree to which a nurse’s judgment is constrained by set policy or procedure, or is of a routine nature, is determinative of whether the judgment exercised is supervisory. For example, in *Beverly Enterprises v. NLRB*, 148 F.3d 1042, 1047 (8th Cir. 1998), the court approved the Board’s determination that nurses’ authority to adjust aides’ duties and priorities in response to changes in patient condition and in personnel availability “does not require the use of independent judgment but is instead narrowly circumscribed by an elaborate system of procedures, policies, and protocol regarding patient care.” See also *Ferguson Electric Co.*, 335 N.L.R.B. No. 15 (2001).

The work of registered nurses, when acting simply as nurses who delegate tasks to unlicensed assistive personnel such as nurses aides, or when acting as charge nurses assigning patients to peers, is constrained by a myriad of “procedures, policies and protocol” that make their judgments skilled and professional – but not “independent.” See, e.g., *Providence Hospital*, 320 N.L.R.B. at 727 (working assignments made to equalize work among employees’ skills, when the differences in skills are well known, are routine functions and do not require the exercise of independent judgment). In any event, such delegation – even if a result of “independent judgment” – does not rise to the level of assignment or direction, as shown in Section V, below.

A. Hospital Policies and Procedures

All hospitals and healthcare institutions have policies and procedures which dictate RNs’ practice. They include what is expected of nurses, what actions will lead to discipline or termination, and the relationship between nurses and other staff, including

unlicensed or assistive personnel.⁴³ Thus, for instance, the Alameda County Medical Center's *Scope of Service: Plan for the Provision of Nursing Care*⁴⁴ states that

A Nurse Manager for each unit with 24-hour accountability and a charge nurse for each shift oversee the delivery of patient care. Staffing mix and ratios are determined for each unit using budgetary parameters in association with acuity data and census. The shift supervisor adjusts staffing patterns using predetermined criteria for special circumstances.

The Regional Director in *Oakwood Healthcare* found substantial evidence that the RNs' work was strictly defined by hospital guidelines: "[F]or every task performed by a nurse, there is a very specific policy and procedure in writing." *Oakwood Healthcare, Inc. and UAW*, Case No. 7-RC-22141 10 (N.L.R.B. Div. of Judges, 2002). Although RNs are listed as being responsible for "guiding and supervising nursing personnel" under the RN level, they lack real authority to address a refusal to follow the RN's direction. *Id.* at 11. Similarly, although charge nurses, who tend to be the more experienced nurses, assess patient acuity and often determine the most appropriate staff to cover certain patients, *id.* at 11-14, the hospitals generally have a "very detailed written policy for the assignment of patients by charge nurses . . ." *id.* at 20, including guidance that a nurse or charge nurse "encountering any sort of patient, operational, or ethical problem is expected to notify a clinical manager or clinical nurse supervisor," *id.* at 7, thereby limiting the scope of their discretion or judgment.

Hospitals often incorporate professional standards of nursing practice (such as the

⁴³See Inst. of Med., *To Err Is Human*, (1999); J. Rosenthal, et al., *State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey* (April 2000); C.C. Bandovinac, et al., *The Use of Unlicensed Assistive Personnel and Selected Outcome Indications* 4 Nursing Econ. 17 at 194 (1999).

⁴⁴available at <http://www.acmedctr.org/nursingscope.htm> (last visited Sept. 19, 2003).

Code of Ethics and Nursing: Scope and Standards of Practice) into their policies and procedures as well. For instance, the University of Texas Medical Branch, in its *Nursing Practice Standards*,⁴⁵ sets forth the responsibilities of nursing staff to assess patient needs, make diagnoses, act under a specific plan of care, and coordinate and collaborate the provision of such care. The standards further incorporate the nurse practice standards of the ANA, as well as several other nursing associations.

B. The Code of Ethics

The *Code of Ethics* also rigorously directs nursing conduct.⁴⁶ Although not a handbook guiding day-to-day practice in the way that hospital policies are, the *Code of Ethics* establishes general ethical standards applicable to all registered nurses. In particular, the *Code of Ethics* highlights the primacy of the *patients'* interests, as distinct from the interests of the hospital, in all decisions made by RNs.⁴⁷ The *Code of Ethics* further provides that in the event of a conflict between the needs of patients and the needs of health care organizations, RNs should

⁴⁵available at <http://wahoo.utmb.edu/policy/toc.htm> (last visited Sept. 18, 2003).

⁴⁶The *Code of Ethics* has been incorporated in whole or in part, into various state nursing laws or regulations. See Ala. Code §34-8A-3 (1994) exemption for nurses . . . working as counselors whose activities and services are consistent with . . . any code of ethics of their profession (Alabama); Cal. Pen. Code §2653 (1995) (giving nurses the right to question, seek clarification of an order from a physician that in the professional judgement of the nurse endangers patient health or safety, or otherwise is contrary to the professional ethics of the registered nurse); Del. Code ch. 16 §1908 (1995) (exempts nurse from confidentiality privilege as covered by law or ethics and mandates testimony in cases of abuse, neglect, dependency, exploitation or abandonment); D.C. Code §2-3306.8 (1995) (requiring nurses who seek licensure as an advanced practice nurse to be in “good ethical standing with the profession”).

⁴⁷See *Code of Ethics*, *supra* note 1, at Canon 2.1: Primacy of the Patient’s Interests.

strive to resolve such conflicts in ways that ensure patient safety, guard the patient's best interests, and preserve the professional integrity of the nurse.⁴⁸

In connection with RNs' ethical obligations to assure the best possible patient care, Canon 2.3 calls for collaboration with other health care professionals:

Collaboration is not just cooperation, but it is the concerted effort of individuals and groups to attain a shared goal. In health care, that goal is to address the health needs of the patient and the public. . . . Within this context, nursing's unique contribution, scope of practice, and relationship with other health professionals needs to be clearly articulated, represented, and preserved.⁴⁹

As more fully set forth below, the *Code of Ethics* contains an extensive explanation of delegation and how registered nurses manage collaboration on the nursing team. Nurse managers, who are clearly outside the scope of the Act, are directed to provide guidelines that registered nurses, including charge nurses, must follow with respect to the transfer of tasks to others on the team: “[n]urses functioning in management or administrative roles have a particular responsibility to provide an environment that supports and facilitates appropriate assignment and delegation. This includes . . . establishing policies and procedures that protect both the patient and nurse from the inappropriate assignment or delegation of nursing responsibilities, activities, or tasks.”⁵⁰ Thus, while a charge nurse must make determinations as to the delegation of tasks, she exercises her judgment strictly pursuant to the direction of her supervisors. The *Code of Ethics* further admonishes all nurses, including charge nurses, to

⁴⁸*Id.* at Canon 2.2: Conflict of Interest for Nurses.

⁴⁹*Id.* at Canon 2.3: Collaboration.

⁵⁰*Id.* at Canon 4.4: Delegation of Nursing Duties.

address patient care under the rubrics set forth in the *Nursing Standards* and Model Practice Act, discussed below.

The *Code of Ethics* also calls upon all nurses to prevent inappropriate or questionable patient care practice by any caregiver, including fellow RNs.⁵¹ The requirements for nursing care set forth in the *Code of Ethics*, while requiring that *all* nurses oversee patient care, make determinations concerning delegation under the policies set by nurse managers, and prevent questionable care from occurring, further restricts how nurses, including charge nurses, exercise independent judgment.

C. *Nursing: Scope and Standards of Practice*

To guide nurses in organizing their work, the ANA publishes *Nursing: Scope and Standards of Practice* (“*Nursing Standards*”).⁵² These practice standards set forth in great detail the procedures to be used by nurses in providing care. The *Nursing Standards* require that the nurse first assess the data relevant to the patient’s needs; then determine the diagnosis or issues raised by the data; identify outcomes for a plan individualized to the patient or situation; develop a plan to obtain such outcomes; and implement such plan, including coordination of care delivery.⁵³ Such coordination requires that *all* nurses coordinate and document implementation of the designated care plan. Similarly, all nurses are expected to evaluate the progress toward the attainment of the desired outcome.⁵⁴ Such evaluation includes disseminating

⁵¹*See id.* at Canon 3.5: Acting on Questionable Practice.

⁵²Am. Nurses Ass’n, *Nursing: Scope and Standards of Prac.* (“*Nursing Standards*”) (2003).

⁵³*Id.* at Standards 1-5.

⁵⁴*Id.* at Standard 6.

the nurse's opinion to others involved in the patient's care in accordance with state and federal laws and regulations.

The step-by-step procedures for providing patient care laid out in the *Nursing Standards* focus and delimit the range of choices available to nurses in each step of their caregiving. Though required to make professional judgments as to necessary treatment, nurses' decisionmaking is very much subject to a standard script, even in the charge nurse capacity.

D. Nurse Practice Acts

Nursing practice is regulated and controlled by the states through their Nurse Practice Acts, which nurses "are required to follow." *Collective Bargaining Units in the Health Care Industry*, 53 Fed. Reg. at 33,912.⁵⁵ These acts recognize the RN's role in the health care delivery system and generally establish statutory nursing practice definitions consistent with current nursing practice. Nurse Practice Acts also generally differentiate the duties of registered professional nurses from those of less-skilled health care workers, such as licensed practical nurses, nursing aides or assistants. *See, e.g.*, Ala. Code §§ 34-21-1(3) (2003); Ariz. Rev. Stat. §§ 32-1601(10)-(11) (2003); Colo. Rev. Stat. §§ 12-38-103(9)-(10) (2002); Del. Code Ann. tit. 24, §§ 1902(b) (2003); Minn. Stat. §§ 148.171(14)-(15) (2002); Miss. Code Ann. §§ 73-15-5(2)-(3) (2003); Mont. Code Ann. §§ 37-8-102(5)(a)-(b) (2002); Neb. Rev. Stat. §§ 71-1, 132.05(8)-(9) (2003); N.H. Rev. Stat. Am. §§ 326-B:2(XVI), (XVII), (XVIII)(2002); N.J. Stat. Ann. §§ 45:11-23(1)(b) (2003); S.C. Code Ann. §§ 40-33-10(g)-(h) (2002). It is these statutes that confer on a registered nurse the authority to carry out her professional responsibilities in a

⁵⁵Authority to issue licenses, rules, regulations and advisory opinions under these acts typically rests with the state boards of nursing. *See, e.g.*, Alaska Stat. §§ 08.68.100(a)(9) (2003).

health care facility.

Not unlike the ANA's *Nursing Standards*, the Model Nursing Practice Act ("Model Practice Act"), developed by the National Council of State Boards of Nursing, sets forth a detailed set of protocols to be followed by RNs.⁵⁶ Specifically, the Model Practice Act provides that practice as a registered nurse includes, but is not limited to,

- Providing comprehensive assessment of the health status of clients, families, groups and communities;
- Developing a comprehensive nursing plan that establishes nursing dialogues; sets goals to meet identified health care needs; and prescribes nursing interventions;
- Implementing nursing care through the execution of independent nursing strategies and prescribed medical regimen;
- Managing nursing care through cohesive, coordinated care management within and across care settings;
- Delegating and assigning nursing interventions to implement the plan of care.

The Model Practice Act is the baseline for many state Nurse Practice Acts.

Numerous states' definitions of the nurse as a professional also provide that the nurse's scope of practice "includes the teaching, direction, and supervision of less skilled personnel in the performance of delegated nursing activities."⁵⁷ Mich. Comp. Laws §§

⁵⁶Nat'l Coun. of State Bds. of Nursing, *Model Nurse Prac. Act* (2002) available at http://ncbsn.org/public/regulation/nursing_practice_model_practice_act.htm (last accessed Sept. 17, 2003).

⁵⁷It should be noted that the Board has held that the use of the term "supervision" in nurse practice acts does not inform whether such nurses are "supervisors" under the Act: "[N]urse practice laws relate to RNs' professional obligations and have nothing to do with the purpose of the Section 2(11) supervisory exclusion, with its definitional language, or with the Board's application of the provision. Those laws do not purport to in any way track the NLRA's

333.17201(c)(2003); *see also* Model Practice Act, Section 2; Ky. Rev. Stat. Ann. §§ 314.011(6)(d)(2002) (“Registered nursing practice” is “the performance of acts requiring substantial specialized knowledge, judgment, and nursing skill,” including “[t]he supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care.”); Ohio Rev. Code Ann. §§ 4723.02(B)(6) (2003) (“Practice of nursing as a registered nurse” encompasses the provision of nursing care requiring “specialized knowledge, judgment, and skill,” and specifically, “[t]eaching, administering, supervising, delegating, and evaluating nursing practice.”); Colo. Rev. Stat. §§ 12-38-132 (2002); Del. Code Ann. tit. 24 §§ 1902(b)(7) (2003); Haw. Rev. Stat. Ann. §§ 457-2; Ind. Code Ann. §§ 25-23-1-1.1(b)(7)(2003); Me. Rev. Stat. Ann. tit. 32, §§ 2102(2)(C)-(D) (2003); Md. Code Ann., Health Occ. §§ 8-101(a)(iv) (2002); Minn. Stat. §148.271 (2003).

These statutory definitions of nursing practice explicitly recognize that all registered professional nurses, in order to perform their ordinary duties and fulfill the responsibilities that most state laws impose, must delegate the work of other registered professional nurses and less-skilled, non-professional health care employees. To this end, many states mandate that medical facilities provide that “[a] sufficient number of registered professional nurses shall be on duty at all times to give patients the nursing care that requires the judgment and specialized skills of a registered nurse, and . . . to facilitate appropriate intervention by nursing, medical or other hospital staff members.” Fla. Admin Code Ann. r.59 -

definition of a supervisor. We will not substitute the wording of the nurse practice acts for the Congressionally mandated requirements for supervisory status in the NLRA.” *Crittenton Hospital*, 329 N.L.R.B. 879 (1999).

3.208 §§ 5(5)(f) (2003). *See also* Fla. Stat. Ann. §§400.23(2003); Kan. Admin. Regs. 28-34-7(2002); Minn.R. 4640.00900 (2002); N.Y. Comp. Codes R. & Regs. tit. 10, §§ 405.5 (2003).

The foregoing demonstrates that the exercise of RNs' professional judgment is strictly circumscribed. Every action taken by an RN and, more particularly, a charge nurse, is subject to several layers of policies, guidelines and rules. First, RNs are constrained by hospital policies and procedures that clearly delineate the method by which each aspect of their duties must be accomplished. Next, nurses' duties are guided by a *Code of Ethics*, which requires them to ensure that all actions they take are within the rubric of the *Nursing Standards* and under the oversight of nurse managers. Finally, nurses are subject to state Nurse Practice Acts that clearly delineate the RNs' duties, including implementing care plans and delegating tasks to other care professionals, even when not in the charge nurse capacity.

This intricate web of policies, procedures, codes and standards defines and limits the practice of nursing. It is the background and foreground against which the "independent judgment" of RNs must be measured. In sharp contrast to typical supervisory personnel, RNs may not act independently of these statutory, regulatory and professional constraints. Rather, these constraints are the starting point, and the end point, of an analysis of whether the judgment exercise by RNs is truly "independent" within the meaning of the Act.

V. **RNS' DELEGATION OF TASKS TO OTHERS DOES NOT RISE TO THE LEVEL OF ASSIGNMENT OR DIRECTION UNDER THE ACT**

The Supreme Court, in *Kentucky River*, suggested that "[p]erhaps the Board could offer a limiting interpretation of the supervisory function of responsible direction by distinguishing employees who direct the manner of others' performance of discrete tasks from employees who direct other employees, as §152(11) requires." *Kentucky River*, 532 U.S. at 720,

(citing *Providence Hosp.*, 320 N.L.R.B. at 729, with approval). As discussed herein, the nursing profession dictates that RNs, including charge nurses, *delegate tasks* to other healthcare workers, including other RNs, rather than actually directing other RNs or assistive personnel.⁵⁸ Indeed, the various hospital practices and procedures, codes of conduct, industry standards, and state Nurse Practice Acts discussed earlier both explain and clarify the limits of RNs' authority to delegate work. Such delegation, while requiring careful attention to the details of patient care and the task to be delegated, does not rise to the level of assignment or direction necessary under the Act to a finding of supervisory authority.

The Board discussed the terms "assign" and "direct" in *Providence Hospital*, 320 N.L.R.B. at 727. As to assignment, the Board held that it

clearly differs from responsible direction in that it refers to the assignment of an employee's hours or shift, the assignment of an employee to a department or other division, or other overall job responsibilities. It would also include calling in an employee or reassigning the employee to a different unit. Whether assignment also includes ordering an employee to perform a specific task is, however, less clear.

Id. The Board further noted that "[a]s with every supervisory indicium, assignment must be done with independent judgment before it is considered to be supervisory under Section 2(11)."

Id.

The meaning of "responsibly to direct" is a good deal less clear. Indeed, in *Providence Hospital*, the Board found it "preferable not to develop a full analysis of the term

⁵⁸Such distribution of tasks often is termed "delegation" within the nursing profession to the extent that it is between RNs and unlicensed assistive personnel and "assignment" to the extent it is between and among RNs. Here, we use the term "delegate" throughout to refer to *distribution of work by RNs to both unlicensed personnel and other RNs*.

‘responsibly to direct’ in the abstract.” *Id.* at 729. However, in *Providence*, the Board identified “guiding principles” involving the authority to direct:

- The distinction between “supervisors who share management’s power or have some relationship or identification with management” and “skilled non-supervisory employees whose direction of other employees reflects their superior training, experience or other skills.” *Id.* (citing *Southern Bleachery & Print Works*, 115 N.L.R.B. 787 (1956), 118 N.L.R.B. 299 (1957), *enf’d* 257 F.2d 235 (4th Cir. 1958)).
- The fact that “making decisions requiring expert judgment is the quintessence of professionalism; mere communication of those decisions and coordination of their implementation do not make the professional a supervisor.” *Id.* (citing *General Dynamics Corp.*, 213 N.L.R.B. 851, 859 (1974) “in which the Board found that professionals who were serving as project leaders were not vested with true supervisory authority because they, ‘for indeterminate periods of time, ‘supervise’ coequals who, in turn, later ‘supervise’ their equals while simultaneously being ‘supervised’ by their coequals.”)
- More broadly, that supervisory authority does not include the authority of an employee to direct another to perform discrete tasks stemming from the directing employee’s “experience, skills, training or positions such as the direction . . . which is given by an employee with specialized skills and training which is incidental to the directing employee’s ability to carry out that skill and training, and *the direction which is given by an employee with specialized skills and training to coordinate the activities of other employees with similar specialized skills and training.*” *Id.* (emphasis added).

Canon 4 of the *Code of Ethics* addresses nursing accountability and responsibility for individual nursing practice and sets forth the impact and responsibility of the delegation or assignment of tasks consistent with a nurse’s obligation to provide optimum patient care. This canon and interpretive statement provide as follows:

The nurse must make reasonable efforts to assess individual competence when assigning selected components of nursing care to other health care workers. This assessment involves evaluating

the knowledge, skills, and experience of the individual to whom the care is assigned, the complexity of the assigned tasks, and the health status of the patient. The nurse is also responsible for monitoring the activities of these individuals and evaluating the quality of the care provided. *Nurses may not delegate responsibilities such as assessment and evaluation; they may delegate tasks. The nurse must not knowingly assign nor delegate to any member of the nursing team a task for which that person is not prepared or qualified. Employer policies or directives do not relieve the nurse of responsibility for making judgements about the delegation and assignment of nursing tasks.*⁵⁹

As the *Code of Ethics* makes clear, the purpose and the manner of delegation are derived from professional practice and not from the employer's having anointed nurses with managerial prerogatives in the direction and assignment of tasks to others. The *Code of Ethics* also reveals that delegation involves tasks - and does not involve control of people as is normally a part of true supervisory authority. See, e.g., *Beverly Enterprises-Pennsylvania, Inc. v. NLRB*, 129 F.3d 1269, 1270 (D.C. Cir. 1997), in which the court found that the Board was correct in determining that Licensed Practical Nurses' assignment of "discrete patient care tasks" or assignment of certified nursing assistants to particular patients was "routine" and did not constitute the use of independent judgment.

As the many references to state Nurse Practice Acts make clear, it is within the statutory scope of practice that registered nurses delegate to others certain tasks connected to nursing.⁶⁰ See also Mich. Comp. Laws §§ 333.16104(1) (2003). "Delegation" means an

⁵⁹*Code of Ethics*, Canon 4.4: Delegation of Nursing Activities (emphasis added). See also *Code of Ethics*, Canon 1.5: Relationship With Colleagues and Others; *Code of Ethics*, Canon 2.2: Conflict of Interest for Nurses; *Code of Ethics*, Canon 2.3: Collaboration (which specifically makes reference to nurses working within health delivery systems and with other health providers).

⁶⁰See Model Practice Act, supra note 56, at Standard 2.e.

authorization granted by a licensee to a licensed or unlicensed individual to perform selected acts, tasks, or functions that fall within the scope of practice of the delegator and that are not within the scope of practice of the delegatee and that, in the absence of the authorization, would constitute illegal practice of a licensed profession.” *Id.* See also Ky. Rev. Stat. Ann. §§ 314.011(2) (2002); La. Rev. Stat. Ann. §§ 37:913(14)(f) (2003); Me. Rev. Stat. Ann. tit. 32, §§ 2102(2)(C)-(D) (2003); Mass. Ann. Laws ch. 112, §§ 80B (2003); N.C. Gen. Stat. §§ 90-171.20(8)(c) (2003); Okla. Stat. tit. 59, §§ 567.3a(2002); 22 Tex. Admin. Code §§ 48.6040(2003); Wash. Rev. Code §§ 18.135.060 (2003).⁶¹

Hospital policies, likewise, allow RNs to assign *tasks* to others, but do not contemplate that RNs, even charge RNs, direct other employees. As the Regional Director found in *Oakwood*:

RNs may assign mental health workers, nursing assistants, techs, or other less skilled employees to do certain tasks that are within their ability. . . It would be insubordination if a nurse assistant refused to listen to the RN If this did occur, RNs do not believe that they have the authority to do very much about it other than going to the clinical manager, as they have no role in disciplining employees.

Oakwood at 11.

This professional concept of delegation, described in *Oakwood*, is a fluid concept:

“A charge nurse assigning a patient to a staff nurse one day, can the next day be assigned a

⁶¹See also Colorado State Board of Nursing, Rules and Regulations Regarding the Delegation of Nursing Functions, Chapter XIII, Rule 3.3 (2002) (“Delegation’ means the assignment to a competent individual the authority to perform in a selected situation a selected nursing task included in the practice of professional nursing”); Oregon Board of Nursing, Standards for Registered Nurse Delegation of Nursing Care Tasks to Unlicensed Persons in Settings Where Registered Nurses Are Not Regularly Scheduled, Rule 851-47-010 (2003).

patient from that same staff nurse, when the roles are reversed.” *Id.* at 20. Based on the limited scope of a charge nurse’s ability to delegate, an RN acting in such capacity is not assigning or directing within the meaning of Section 2(11).

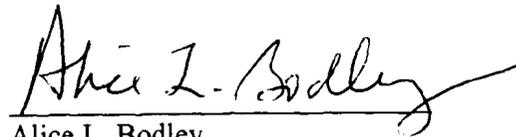
Thus, within a tightly woven web of hospital procedures, state laws and nursing guidelines, each nurse balances the needs of the patient against the employer’s need to provide care by delegating tasks. The hospital directs the nurses’ work, and consistent with ethical expectations, mandates delegation to deliver cost-effective professional nursing care. The RN must assure that the patient gets the best care possible and cannot, within the scope of hospital policies and procedures, ethical obligations, or state laws, inappropriately delegate care. To this end, the NLRB should continue its traditional support for the rights of RNs, including charge nurses who delegate tasks, to engage in collective bargaining.

VI. CONCLUSION

Registered nurses perform their work in a highly regulated environment. Each state has a Nurse Practice Act, implemented by regulations developed by the state’s board of nursing, that sets forth the details of what registered nurses may do and how they may do it. In addition, a host of hospital procedures and policies, ethical concerns, and practice standards constrain the work of registered nurses, even those working in the charge nurse capacity. Nurses must practice within the scope of their license and, in doing so, may delegate to others certain tasks that they do not have to accomplish personally. Equating such delegation with the exercise of independent judgment or with the assignment or direction of work as defined by the Act ignores the strictly circumscribed legal and ethical environment under which all RNs, including charge RNs, must operate.

The Board, in prior decisions discussed above, has recognized the many factors constraining nurses' judgment, along with the limited delegation responsibilities shared by all nurses in assigning tasks to others. In so doing, it has affirmed the rights of RNs, including charge RNs, to organize, and has rejected the notion that RNs are supervisors within the meaning of the Act. This position is firmly grounded in precedent, policy and professional standards. The Board's adherence to this view will allow RNs to continue making great strides in improving patient care and safety, and addressing the nursing shortage crises, through collective bargaining.

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