In Opposition to Senate Bill 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)

Submitted by: Maryland Organization of Nurse Leaders (MONL)

Position: ***OPPOSE***

February 17, 2026

Senate Finance Committee

Chair, Vice Chair, and Members of the Committee:

Position

On behalf of the **Maryland Organization of Nurse Leaders (MONL)** we appreciate the opportunity to comment on the ***opposition to Senate Bill 411/ HB 624***.

The Maryland Organization of Nurse Leaders is a statewide community of 277 nurse executives, directors, managers, educators, and emerging leaders representing acute care hospitals, academic medical centers, community hospitals, ambulatory, and post-acute settings across Maryland.

We respectfully oppose SB 411 / HB 624.

1) Staffing Committees and strict staffing plans do not address the underlying nursing shortage, and can reduce access to care

Maryland, like the nation, is navigating a prolonged nurse workforce challenge. The American Organization of Nurse Leaders (AONL) notes that staffing committees and strict written staffing plans do not guarantee more nurses and have not shown to be stronger or improve outcomes, and can force hospitals that cannot meet written staffing plan minimums to **close beds, divert patients, or delay care**, reducing access to care for Maryland communities.

2) Unintended consequences will include closed beds, service limitations, ED crowding, and heightened risk for workplace violence against health care workers

When inpatient beds are closed, or services are reduced to meet written staffing plan minimums, **emergency department (ED) boarding and crowding** predictably worsen—leading to longer waits, degraded patient experience, and operational strain. ED crowding is a **patient safety crisis**, and

multiple studies link crowding and prolonged boarding to **increased risks of workplace violence** toward staff.

Downstream effects we anticipate if SB 411 / HB 624 pass include:

- **Longer ED wait times** and **increased ED boarding** due to fewer staffed inpatient beds;
- **More crowded EDs** because EDs cannot turn patients away; and
- **Higher instances of workplace violence** in crowded ED environments.

3) The bill is redundant with additional Joint Commission regulatory oversight now in effect with National Performance Goal 12 (NPG 12)- Effective January 1, 2026.

Effective **January 1, 2026**, The Joint Commission (TJC) elevated **Nurse Staffing** to **National Performance Goal (NPG) #12: Health Professional Resource Management**, requiring leadership accountability and **nurse executive oversight** of staffing plans, competency, and safe, quality care **across the organization**. These expectations supplement CMS Conditions of Participation and require **data-driven, ongoing performance improvement**—including evaluation of staffing adequacy when trends or variations exist. This **independent, external oversight** already holds CNOs and hospital leadership accountable without written staffing plans or additional administrative oversight, making the proposed legislation **duplicative**.

4) Flexibility is essential during surges, disasters, and other crises

Maryland hospitals must be able to **flex staffing in real time** to respond to **storm-related surges, infectious disease outbreaks, mass casualty events, and seasonal variation**. Fixed numerical staffing plans risk **hindering surge response**, when rapid redeployment, innovative care models, and temporary practice adjustments are critical to sustaining access and safety. TJC's NPG 12 specifically expects leaders to evaluate and adapt care models (e.g., **virtual nursing**)—the kind of agility that written, numeric static staffing plans constrain.

5) Flexibility in staffing and scheduling is a proven recruitment and retention strategy

To stabilize Maryland's nursing workforce, organizations need the ability to **offer flexible schedules and models of care** that attract and retain nurses at different life stages and experience levels. Prescriptive written staffing plans can **limit creative scheduling,** used by high-performing organizations to improve well-being, autonomy, job satisfaction, and unit stability while maintaining safe and high-quality patient care,

6) Shared governance: Staff have a voice in staffing

Maryland has a strong culture of **shared governance**, particularly among Magnet-designated organizations, where **nurses at all levels have a formal voice** in decisions about practice, staffing, resources, and quality. Shared governance is a hallmark of Magnet culture and a core element of professional nursing practice that **elevates outcomes and engagement**. MONL supports **staffing committees and shared decision-making** structures that keep decision authority **with frontline nurses and nurse leaders**, not statutory numeric formulas.

Context: 30% of acute care hospitals (12 hospitals) in Maryland hold a Magnet designation. The national average is 10%. Four hospitals have the Pathways to Excellence designation. Ten hospitals are planning to pursue Magnet or Pathways in the next two years. These designations prioritize shared governance and support for the nursing workforce. reflecting the state's strong commitment to professional governance and nursing/organizational excellence.

7) Safe staffing is complex and requires nursing clinical judgment and critical thinking

Safe staffing is dynamic, grounded in real-time professional nursing judgment that considers patient acuity, care complexity, team skill mix and experience, unit layout and workflow, available technology, and interprofessional resources. This legislation would replace clinical judgment with a fixed formula and shift authority away from nurse leaders and direct-care nurses who are best positioned to align staffing with patient needs. Nationally, the American Organization for Nursing Leadership (AONL) has stated that strict written staffing plans and staffing committees are not the answer and that staffing should be determined by nursing leaders in collaboration with front-line, direct-care nurses.

What MONL Supports (Constructive Alternatives)

- **Acuity- and competency-based staffing plans** are owned by **nurse executives, managers, and direct-care nurses**, with transparent metrics, collaboration, and continuous quality improvement—rather than additional administrative burdens of Staffing committees and fixed written staffing plans.
- **Strengthening shared governance** ensuring frontline staff have a voice and participate in staffing decisions and accountability for outcomes.
- **Leveraging innovation and team-based care** (e.g., virtual nursing, optimized skill mix, interprofessional models) to improve safety and efficiency.
- **Full adherence to The Joint Commission's NPG 12** expectations for leadership oversight, RN presence and supervision, competency assurance, and ongoing staffing evaluation.

Conclusion

For these reasons, the **Maryland Organization of Nurse Leaders respectfully urges an unfavorable report on SB 411 / HB 624**.

Safe staffing is **essential**—and is best achieved through **nursing clinical judgment, shared governance, flexible and evidence-based staffing plans, and robust accountability mechanisms** already in place with **The Joint Commission's National Performance Goal 12**—not through mandated staffing committees and staffing plans that may compromise access to patient care, ED flow, and clinician safety.

Thank you for the opportunity to testify.
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