New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Restrictions on Consecutive Hours of Work for Nurses

Department of Labor

Report 2017-S-14 April 2018

Executive Summary

Purpose

To determine if the Department of Labor is adequately enforcing the Restrictions on Consecutive Hours of Work for Nurses Law. The audit covers the period January 1, 2015 through June 30, 2017.

Background

The Department of Labor (Department) is charged with protecting workers in New York State. Section 167 of the New York State Labor Law – referred to as the Restrictions on Consecutive Hours of Work for Nurses Law (Law) – and Part 177 of Title 12 of the New York Codes, Rules and Regulations (NYCRR) were established to protect the public health and quality of patient care by limiting consecutive hours of work for Registered Nurses and Licensed Practical Nurses in non-emergency situations. The Law does not preclude nurses from volunteering to work overtime. The NYCRR requires health care employers to establish Nurse Coverage Plans to address typical patterns of staff absenteeism due to illness, leave, bereavement, and other similar factors; and identify alternate staffing methods to avoid the use of mandatory overtime. Employers must document their attempts to seek alternative staffing before resorting to mandatory overtime. If nurses feel that their employers violated the Law, they may file a complaint with the Department's Division of Labor Standards (Division). In turn, the Division initiates cases to investigate single or multiple complaints against employers to determine compliance with the Law. Between January 1, 2015 and May 23, 2017, the Division closed 186 cases regarding 540 complaints.

Key Findings

- The Division lacks policies and procedures to effectively investigate complaints, resulting in inconsistent application and enforcement of the Law.
- The Division does not investigate nurse overtime complaints for State agencies on a timely basis.
- The Worker Protection Monetary (WPM) System lacks the functionality for management to oversee complaint investigations and effectively enforce the Law.
- The Division is unaware of which employers are subject to the Law, which limits the Department's ability to provide outreach and education to all employers on the requirements of the Law, increasing the risk that some employers may be unfamiliar with the Law's requirements.

Key Recommendations

- Establish policies and procedures to ensure that nurse overtime complaints are investigated timely using consistent methods and application of the Law.
- Improve the functionality of the WPM System to better assist management in tracking nurse overtime complaints and investigations in a comprehensive manner.
- Develop and maintain a listing of all employers covered by the Law.
- Establish an outreach and education program to ensure that all covered employers are aware of the Law and its requirements.
- Explore feasible actions to strengthen the Division's enforcement options.

Other Related Audits/Reports of Interest

Department of Labor: Wage Theft Investigations (2013-S-38)
Department of Labor: Wage Theft Investigations (2015-F-9)
Department of Labor: Protection of Child Performers (2016-S-70)

State of New York
Office of the State Comptroller

Division of State Government Accountability

April 23, 2018

Ms. Roberta Reardon
Commissioner
Department of Labor
Building 12, W.A. Harriman Campus
Albany, NY 12240

Dear Ms. Reardon:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively. By so doing, it provides accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Restrictions on Consecutive Hours of Work for Nurses*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The Department of Labor (Department) is charged with protecting workers in New York State, and is responsible for enforcing the requirements of Section 167 of the New York State Labor Law – referred to as the Restrictions on Consecutive Hours of Work for Nurses Law (Law). This Law, along with Part 177 of Title 12 of the New York Codes, Rules and Regulations (NYCRR), was established to protect the public health and quality of patient care by limiting consecutive hours of work by nurses in New York State in non-emergency situations. The Law, effective July 1, 2009, applies to Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) who provide direct patient care in public and private general hospitals, nursing homes, diagnostic and treatment centers (clinics), and other facilities licensed under Article 28 of the Public Health Law, or in facilities operated by the State, political subdivisions of the State, or public corporations pursuant to the Mental Hygiene Law, the Education Law, and the Correction Law. These include psychiatric centers operated by the Office of Mental Health (OMH) and correctional facilities operated by the Department of Corrections and Community Supervision (DOCCS). The Law does not apply to voluntary providers that are licensed or certified by OMH, the Office for People With Developmental Disabilities, or the Office of Alcoholism and Substance Abuse Services.

The Law and the NYCRR establish certain responsibilities and requirements for applicable health care employers to reduce nurse fatigue and decrease the risk of serious and preventable medical errors that impact the quality of patient care. Under the Law, health care facilities cannot require nurses to work beyond their regularly scheduled and agreed-upon hours. The Law does not preclude nurses from volunteering to work additional hours. However, the Law does not apply in the case of:

- A health care disaster (determined by the employer, but must be unforeseen and reasonable such as multiple serious injuries from a fire or wreck, chemical spills, and outbreaks);
- A federal, State, or local government declaration of an emergency;
- An ongoing medical or surgical procedure in which a nurse is actively engaged and his/her continued presence is needed to ensure the health and safety of the patient; or
- A patient care emergency or an unforeseen event that was unplanned and does not regularly occur. If the employer determines that the nurse needs to stay to ensure safe patient care, then it must make a good faith effort to have the overtime covered on a voluntary basis before resorting to mandatory overtime.

The NYCRR further requires employers to implement Nurse Coverage Plans (Coverage Plans) to address typical patterns of staff absenteeism due to illness, bereavement, and other similar factors, as well as typical levels and types of patients served. In addition, Coverage Plans must describe alternative staffing methods available to the employer to ensure adequate staffing through means other than mandatory overtime. This includes contracts with per diem nurses, nurse registries, and employment agencies; assignments of nursing floats; requesting an additional day of work from off-duty nurses; and posting a list or roster of nurses seeking voluntary overtime. Employers must have a Coverage Plan in accordance with the NYCRR and must document all good faith

efforts to avoid the use of mandatory overtime before requiring a nurse to remain on duty.

If nurses (or their union representatives) believe that their employer violated the Law, they may file a Mandatory Overtime Complaint form (available on the Department's website) with the Department's Division of Labor Standards (Division). The Division is responsible for investigating these complaints as well as enforcing other labor laws, including minimum wage, hours of work, child labor, payment of wages and benefits, and farm labor. The Division has eight district offices that investigate complaints based on the location of the employer. Investigations of State agency facilities, such as DOCCS, are handled by the Albany district office, whereas investigations of private and local facilities are handled by the other district offices. Division investigators review nurse shifts, Coverage Plans, and documentation substantiating employers' attempts to find alternative staffing before using mandatory overtime. Between January 1, 2015 and May 23, 2017, the Division completed 186 investigations involving 540 complaints related to possible violations of the Law.

Audit Findings and Recommendations

The Division lacks policies and procedures to guide its investigations of complaints, leading to weaknesses in its investigative process, including missing documentation, inconsistent application of the Law, and poor communication with complainants. Furthermore, the Division's Worker Protection Monetary (WPM) System does not have the functionality to provide useful information to management, thus reducing management's ability to provide effective oversight of nurse overtime complaint investigations. In addition, the Division is unaware of all the employers that are subject to the Law, limiting the Department's ability to provide outreach and education to all employers on the requirements of the Law and increasing the risk that some employers may be unaware of the Law's requirements.

The Division's ability to effectively enforce the Law is limited because there are no fines, penalties, or other consequences that can be levied on non-compliant employers. However, the Division can better protect nurses in New York State through more effective and efficient investigations of overtime complaints and better outreach to employers on the requirements of the Law.

Investigations of Nurse Overtime Complaints

Division practices have resulted in complaint investigations lacking sufficient documentation, complainants not being notified of investigation outcomes, and differing outcomes based on the same set of circumstances. Additionally, investigations of State agency facilities are often significantly delayed, resulting in State agency nurses' reluctance to submit complaints.

Inconsistencies in Investigating Complaints

The Division does not have effective policies and procedures to guide its investigations of complaints. Its Field Inspectors Manual (Manual) covers procedures for inspections of all labor laws, but has limited guidance (only 3 out of more than 1,000 pages) on nurse overtime complaint investigations. Division officials provided training to inspectors in 2014, after the Division's district offices took over responsibility for investigating complaints at private and local facilities. The training provided inspectors with a general overview of the Law and reviewed some possible scenarios that would warrant a violation. However, since investigators lack a comprehensive policies and procedures manual, they instead conduct investigations based on the Law and their own judgment. This approach has resulted in inconsistencies throughout the Division's investigation process.

The Division documents its investigations of nurse overtime complaints using both electronic and hard copy files. We judgmentally selected 23 cases to review from these files: 12 cases involved 165 complaints at four State agency facilities, and 11 cases involved 42 complaints at four private/local facilities. Based on our review, we found various inconsistencies in the Division's processes and the investigation outcomes. For example:

- The outcomes of two investigations completed by different investigators at the same facility with identical circumstances produced different results. In both cases, the facility had a Coverage Plan and attempted to fill staffing gaps by calling off-duty or per diem nurses, to no avail. In one case the Department issued a violation notice, while in the other it found the facility was in compliance, with no documentation in the file indicating why.
- Complainants were not always contacted after the Division completed its investigations. The Division failed to contact complainants for 128 of 207 (62 percent) complaints among the 23 cases. We note that private/local facility complainants were contacted in 38 of 42 instances (90 percent), whereas only 41 of 165 State agency facility complainants (25 percent) were contacted.
- There was no proof that the Division conducted its due diligence regarding complaints in some instances:
  - For 33 of the 165 State agency facility complaints (20 percent), the Division relied solely on the facility's word that no mandatory overtime occurred on the specific complaint date, with no documentation in the case files indicating the Division's decision.
  - The Division determined that no violations occurred in 28 of the 49 (57 percent) complaints involving facilities that provided no documentation of a Coverage Plan (these included State agency and private/local facilities).
  - For one complaint, the Division determined that no violations occurred, even after the facility provided no documentation indicating that it followed its Coverage Plan and acknowledged that it used mandatory overtime. In 29 other similar circumstances, we found no indication in the case files that the Division made a decision on the complaint; and for ten other similar instances, the Division issued violation notices to the facilities.
- Ten of the 23 cases (43 percent) had no record of the Division's decision in either the hard copy or electronic files.

Furthermore, we reviewed a judgmental sample of 31 electronic case files from the Division's WPM System, and noted additional anomalies in its enforcement practices based on a review of these files, as follows:

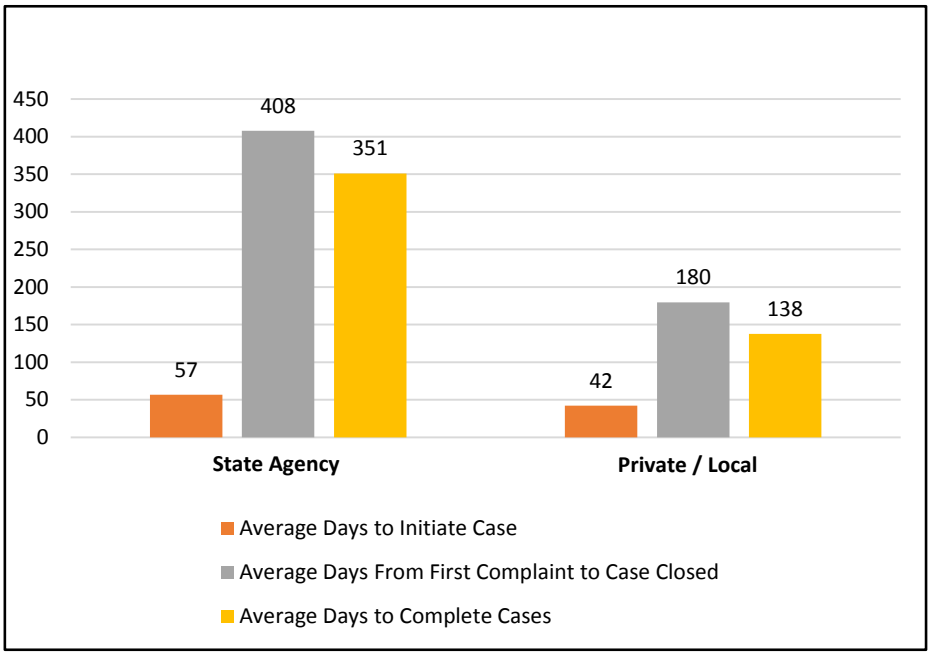
- In one case, in which the complainant indicated a potential systemic issue at the employer due to multiple instances of mandatory overtime, the Division closed the case as invalid even though it did not receive any documentation from the employer;
- Division investigators failed to adhere to the Manual and training material requirement to maintain complainants' anonymity to the extent possible, by sending correspondence to the same employer regarding two separate cases listing either the nurse's full name or the actual complaint date, thereby providing the employer with information on who filed the complaints; and
- The Division sent letters with incorrect information, such as a wrong name, address, or case number. In one case, its decision letter was returned due to an incorrect address.

Delays in Investigations of State Agency Facilities

Neither the Law nor the Division has established set time frames regarding investigations of nurse overtime complaints; however, Division officials stated that they attempt to complete casework within 180 days (about six months) of the start of the investigation. In addition, since there are no set guidelines for when to initiate an investigation after receiving a complaint, the Division's practice is to aggregate complaints and investigate them together under a single case. Under this process (which is usually reserved for larger State agency facilities, such as those run by DOCCS), the Division usually investigates the aggregated complaints once or twice per year. Based on our review of the 23 cases, investigations of State agency facilities averaged 14 complaints per case, whereas investigations of private/local facilities averaged four complaints per case.

The Division's practice of aggregating State agency facility complaints and investigating them once or twice per year has resulted in significant delays in both initiating and completing investigations.[1] As illustrated in the chart below, the average time to initiate and complete cases varies greatly between State agency and private/local facilities. For State agency facilities, the Division initiates an investigation in just under two months (57 days) from the earliest complaint date that is included on the case compared to 42 days for private/local facilities. In addition, the Division takes significantly longer to complete investigations of State agency facilities (351 days compared to 138 days for private/local facilities). This results in some complaints taking over a year (408 days on average for the 12 cases involving State facilities) for the Division to complete its investigations.

Average Days to Initiate and Investigate Complaints Between State Agency and Private/Local Facilities Based on 23 Case Files Reviewed



[1] The Department does not capture complaint-received dates. Therefore, our analysis was based on the complaint date verified on the hard copy complaint form. There may be lags between the date of the complaint and the date the complaint form is received by the Department.

Division officials stated that aggregating complaints for State agency facilities is a proactive compliance approach to identify systemic issues within these facilities and the most protective and best use of its resources. Additionally, Division officials stated that they work closely with union representatives to work out overtime issues through investigations, grievances, and arbitrations through collective bargaining units. However, union officials have expressed concerns with the Division's investigative practices, indicating that State agency nurses may feel reluctant to file complaints, as the investigation delays and lack of communication make it seem like nothing gets accomplished.

These inconsistencies and delays undermine the Division's ability to protect nurses and ensure employers throughout New York State comply with the Law. The Division needs to strengthen its controls to ensure the consistent, efficient, and effective investigation of nurse overtime complaints. Without standard guidelines, the Division cannot ensure that each case is investigated and adjudicated consistently.

The Division stated that it has started to make changes to its investigation practices, including: designating specialized staff to investigate nurse overtime complaints; expanding its automated advisory system to include notices to all claimants; expanding monthly investigator training programs to include specific nurse overtime information and expanded processes; and documenting improved investigation procedures and updating written policies accordingly.

Worker Protection Monetary System Limitations

The Division's WPM System tracks cases for all complaints that it is responsible for investigating, including those related to nurse overtime complaints. The WPM System captures certain aspects of the investigation process, including correspondence between Division investigators and employers, as well as case assignment and status. We identified deficiencies within the WPM System that greatly reduce Division management's ability to oversee nurse complaint investigations. Most notably, it does not have the functionality needed for management to make informed decisions and evaluate performance.

For optimum efficiency and effectiveness in managing investigations, the WPM System must be able to make use of its data to produce a range of criteria-specific, periodic summary reports. The WPM System lacks this functionality and flexibility, and is only capable of producing a few case management summary reports, such as the number of closed cases for nurse overtime complaints for a specific date range. Currently, the Division does not generate routine reports for nurse overtime complaints. In addition, because multiple complaints are investigated under a single case, the Division cannot readily determine how many complaints were filed or which employer(s) received the highest number of complaints.

In addition, the Division cannot easily determine how many complaints there are at any given time, and management is thus unable to accurately determine how long it takes to investigate complaints. Similar issues with the WPM System were reported to the Department by the Office of the State Comptroller from a previous audit of the Wage Theft Investigations (Report 2013-S-38) program. According to Department officials, the WPM System was originally intended to have

broader reporting capabilities; however, this functionality was never fully developed due to the State's Office of Information Technology Services (ITS) having other priorities.

Division officials stated that they will pursue expanding the case-tracking capabilities to allow for improved management reports. In addition, pending the improvements in case tracking, the Division will designate managers to centralize reporting on nurse overtime complaints.

Employers Subject to the Law

The Law and NYCRR have been effective since 2009 and 2011, respectively. Private/local health care facilities that have not had any complaints filed against them are more likely to be unaware of their requirements to comply with the Law and NYCRR. Therefore, their nurses may be unaware that they can file complaints with the Division if their employers are non-compliant. Furthermore, the Division isn't fully aware of which types of facilities are subject to the requirements of the Law and NYCRR.

Health Care Facilities Unaware of Their Requirements

We conducted site visits to 24 facilities, including 13 (eight private/local and five State agency) that had a history of complaints filed with the Division and 11 (seven private/local and four State agency) that did not. The purpose of our visits was to determine whether facilities with complaints were in compliance with the requirements of the Law and NYCRR and to identify possible best practices among facilities without complaints. We found that the facilities that were operated by State agencies or had a history of complaints were generally in compliance with the Law, with one exception. That one facility did not have a Coverage Plan, even after its complaint case files indicated that the Division educated the facility on it. However, according to the facility's nurse, no such education occurred.

Conversely, although most of the facilities without complaints were aware of the Law, they were uncertain of the requirements to comply. Officials from one facility we visited stated they were unaware of the Law. Four of the 11 facilities had Coverage Plans. However, two of those Coverage Plans were not fully compliant since they excluded certain requirements, such as typical staffing patterns and types of patients served. Each facility had methods to find nurse coverage, but could not produce documentation that they made good faith efforts to seek alternate staffing prior to using mandatory overtime. Many of the private/local facilities utilized incentives, such as bonuses or gift cards, to solicit nurses to volunteer for the overtime. For State agency facilities, nurses often volunteer to work the overtime to earn the extra pay.

Division officials stated that they do not contact facilities unless there is a complaint. If facilities are out of compliance, the Division informs them on how they can comply (e.g., creating a Coverage Plan).

Division Unaware of All Facilities Subject to the Law

The Law applies to health care facilities licensed under Article 28 of the Public Health Law and certain other facilities operated by the State, political subdivisions of the State, or public corporations that employ RNs or LPNs providing direct patient care. We found that the Division is not fully aware of which facilities are subject to the Law. In our review of complaint cases, we identified two instances where the Division issued violation notices to two facilities that were not subject to the Law. These facilities were not licensed under Article 28 of the Public Health Law. In both cases, the facilities' counsel responded to the violations stating their facilities were not subject to the Law.

The Division has not developed a listing of health care facilities subject to the Law. Maintaining such a list and cross-referencing it to complaints would help the Division ensure that facilities subject to the Law are investigated, and that facilities not subject to the Law are not.

The Division plans to develop an employer engagement plan to prioritize employer training and access to information. The engagement plan will:

- Initiate development of a database, including all facilities subject to the Law;
- Distribute guidance to all covered facilities with the assistance of industry-related organizations; and
- Host live and pre-recorded webinars on the Law.

No Consequences for Violations of the Law

There are other issues outside the Division's enforcement efforts that can affect employers' compliance with the Law, including the lack of penalties, such as fines, for employers that do not comply.

The Law was established to reduce nurse fatigue, which decreases the risk of preventable medical errors that could harm patient care, by restricting the instances where employers could force on-duty nurses to work overtime. However, the Law did not include consequences for employers that are non-compliant. A Division official stated that enforcement of the Law is difficult and a low priority (compared to other programs) because there are no penalties. According to union officials representing nurses in both the public and private sectors, the Law should include a penalty for those found in violation; otherwise, employers may not take the Law seriously.

Recommendations

1. Establish policies and procedures to ensure that nurse overtime complaints are investigated timely using consistent methods and application of the Law.

2. Improve the functionality of the WPM System to better assist management in tracking nurse overtime complaints and investigations in a comprehensive manner.

3. Develop and maintain a listing of all employers covered by the Law.

4. Establish an outreach and education program to ensure that all covered employers are aware of the Law and its requirements.

5. Explore feasible actions to strengthen the Division's enforcement options.

Audit Scope, Objective, and Methodology

Our audit was conducted to determine whether the Department adequately enforces the Restrictions on Consecutive Hours of Work for Nurses Law. Our audit scope included the period January 1, 2015 through June 30, 2017.

To achieve our audit objective, we reviewed relevant laws and regulations, Division procedures, manuals, and case files. We also interviewed Division officials, union representatives, and facility officials. We became familiar with, and assessed the adequacy of, the Department's internal controls as they related to its performance and our audit objective.

According to the Division's WPM System, between January 1, 2015 and May 23, 2017, the Division completed 186 investigations involving 540 complaints related to possible violations of the Law. The Division does not track complaints, so we manually determined the total number of actual complaints to be 540 by reviewing WPM System case data. We reviewed the electronic files in the WPM System for a judgmental sample of 31 closed cases to determine the reliability of the data and to obtain an understanding of the Department's investigation process. We drew an initial judgmental sample of 26 cases, based on facility name and high number of cases. We then pulled an additional judgmental sample of five cases using the same criteria as the initial sample. Both samples had similar issues, and we have reported our findings out of 31 rather than reporting each sample separately. Because both samples were judgmental, we cannot project our findings to the population as a whole and have not done so.

In addition, we reviewed a judgmental sample of both electronic files in WPM and hard copy files for 23 nurse overtime complaint cases among eight employers (four State agency and four private facilities), based on high number of cases, to assess the timeliness of investigations and the Division's documentation to support investigation outcomes.

Lastly, we conducted site visits to 24 employers that we judgmentally selected based on several factors, including facilities with a high number of complaints, different facility types, facilities with and without a history of complaints, and different Department district offices.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

A draft copy of this report was provided to Department officials for their review and comment. Their comments were considered in preparing this final report and are attached in their entirety at the end of it, along with our own State Comptroller's Comments, which address some of the Department's specific statements. Although the Department took exception to some of our assessments of its investigative process, we are pleased that officials are taking steps to address our recommendations.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Labor shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews, and evaluations of New York State and New York City taxpayer-financed programs.

Agency Comments

Roberta Reardon
Commissioner
Department of Labor

New York State Department of Labor
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November 28, 2017

Mr. Brian Reilly
Office of the State Comptroller
110 State Street, 11th Floor
Albany, NY 12236

Dear Mr. Reilly:

Below, are the Department of Labor's responses to your draft report dated October 27, 2017, regarding the audit of the Department of Labor, Restrictions on Consecutive Hours of Work for Nurses 2017-S-14. Your letter summarized recommendations from your office's ongoing examination of Consecutive Hours for Nurses from January 1, 2015 through August 31, 2017.

Recommendations and Responses:

Below are the Comptroller's recommendations and the Department's response:

Comptroller's Recommendations

1. Establish policies and procedures to ensure that nurse overtime complaints are investigated timely using consistent methods and application of the Law.

2. Improve the functionality of the WPM System to better assist management in tracking nurse overtime complaints and investigations in a comprehensive manner.

3. Develop and maintain a listing of all employers covered by the Law.

4. Establish an outreach and education program to ensure that all covered employers are aware of the Law and its requirements.

5. Explore feasible actions to strengthen the Division's enforcement options.

Department's Response

Timely and Comprehensive Strategies to Enforce the Law

As previously explained, OSC attempted to audit timeliness without an understanding of the unique nature of nurse overtime investigations. Because the regulatory target area is so vast, the Department evaluates the total compliance picture at an identified facility. The Department's experience with these cases is that a single allegation almost always leads in quick succession to other cases. Some time is then used to aggregate the multiple complaints at a given facility and produce a regulatory response that works for the entire worksite. That OSC confuses this effort with a lack of timeliness is an error on its part. Given the lack of penalties available to the regulator, this compliance model is the single best use of resources. OSC notes that ALL cases are concluded in under a year.

* Comment 1

In addition, the Department works closely with employee representatives, including labor unions, that closely monitor overtime and other workplace conditions facing nurses. Indeed, a large percentage of the 298,000 registered RN and LPNs in New York belong to a collective bargaining or advocacy entity. Overtime issues are worked out through Department investigations and through grievance and arbitration provisions in collective bargaining agreements. This working relationship with employee representatives was not captured in OSC's case count, yet it accounts for an appreciable part of the enforcement approach.

Similarly, the Department is uniquely situated to work with state agencies that oversee facilities where section 167 would apply. Thus, a resolved complaint at one DOCCS facility will enable changes at all the 54 DOCCS facilities. These numbers also were not captured in OSC's audit and should have been. Along with DOCCS, the Department works with the Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), SUNY Hospitals and others. Hundreds of facilities are overseen by these agencies and the Department's engagement can produce system wide changes in each. Again, OSC's audit does not capture this significant part of the Department's 167 enforcement regime.

* Comment 2

Despite disagreements the Department has with the OSC audit here, the Department's drive to improve combined with the audit process and recommendations have led to the following additions to the Department's practice:

- Designate specialized staff to investigate these complaints;
- Expand our current automated advisory system to include notices to all claimants;
- Pursue expansion of current case tracking capabilities to allow for improved management reports;
- Designate managers to centralize reporting on Nurse Overtime cases pending improved technology for case tracking;
- Expand monthly investigator training programs to include specific Nurse Overtime information and expanded processes;
- Document improved investigation procedures and update written policies accordingly.
- Initiate investigation for each complaint to improve tracking and communication with complainants and education for the regulated community.

NEW YORK STATE OF OPPORTUNITY. Department of Labor

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* See State Comptroller's Comments, page 19.

In addition, given the lack of penalties in the statute, the Department is developing an employer engagement plan to prioritize employer training and access to information. The plan, available to OSC on October 15, 2017, will include the following elements:

- Initiate development of database of all covered employers;
- Distribute guidance to all covered employers with assistance of industry related organizations;
- Host live and recorded webinars regarding Restrictions on Consecutive Hours of Work for Nurses.

We expect that this expanded access to information will support and supplement the employers' obligation to be fully familiar with all laws and regulations that apply to the industry.

If you have any comments, please contact Michael Vaccaro, Director Internal Audit (518) 457-9076.

Sincerely,

Roberta Reardon

cc: Mario Musolino
Jim Rogers
Milan Bhatt
Maura McCann
Michael Vaccaro

State Comptroller's Comments

1. As described and illustrated in our audit report, the impact of aggregating complaints has been detrimental to the willingness of Registered Nurses and Licensed Practical Nurses, particularly those working in larger New York State facilities, to file complaints with the Department. Although the report shows that complaint investigations, once initiated, are completed in just under one year, it also shows that many complaints for State nurses go well over a year from complaint receipt to investigation completion. Also, as described in the audit report, union officials representing State nurses expressed concerns regarding the time it takes for the Department to investigate complaints, and indicated that nurses, consequently, are reluctant to file complaints.
2. We disagree. While it is unclear what numbers the Department is referring to, our audit report focused on complaints and cases reported in the Department's WPM System and the Department's investigation efforts for those cases. We did not find, and Department officials did not provide, evidence to show that resolving a complaint at one facility enables changes at other related facilities.