State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 3042

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The bill was read for the first time and referred to the Committee on Health and Human Services

A bill for an act

relating to health; requiring hospitals to develop staffing levels for direct care registered nurses; amending Minnesota Statutes 2006, section 144.7067, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 144.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[144.591] REGISTERED NURSE STAFFING FOR PATIENT SAFETY.**

Subdivision 1. **Definitions.** (a) "Assignment" means the provision of care to a patient for whom a direct care registered nurse has responsibility within the nurse's scope of practice.

(b) "Assignment limit" means the maximum number of patients for whom one direct care registered nurse can be responsible during a shift. Assignment limits may vary by nursing unit.

(c) "Direct care registered nurse" means a registered nurse, as defined in section 148.171, who is directly providing nursing care to patients.

(d) "Nursing intensity" means a patient-specific, not diagnosis-specific, measurement of nursing care resources expended during a patient's hospitalization. A measurement of nursing intensity includes the complexity of care required for a patient and the knowledge and skill needed by a nurse for surveillance of patients in order to make continuous, appropriate clinical decisions in the care of patients.

(e) "Patient acuity" means the measure of a patient's severity of illness or medical condition including, but not limited to, the stability of physiological and psychological parameters and the dependency needs of the patient and the patient's family. Higher patient acuity requires more intensive nursing time and advanced nursing skills for continuous surveillance.

(f) "Skill mix" means the composition of nursing staff by licensure and education including, but not limited to, registered nurses, licensed practical nurses, and unlicensed personnel.

(g) "Surveillance" means the continuous process of observing patients for early detection and intervention in an effort to prevent negative patient outcomes.

(h) "Unit" means an area or location of a hospital where patients receive care based on similar patient acuity and nursing intensity.

Subd. 2. **Staffing plan.** (a) By July 1, 2009, all hospitals licensed under section 144.55 shall adopt and implement a staffing plan that sets out the maximum number of patients that may be assigned to a direct care registered nurse for each unit of the hospital in order to ensure adequate staffing levels for patient safety. Staffing plans adopted and implemented under this section shall establish staffing levels that include the flexibility to increase the number of nurses required for a unit when necessary for patient safety. The staffing plans must be developed in agreement with direct care registered nurses and must comply with the requirements in subdivision 3. The staffing plans developed under this section must require that direct care registered nurses be assigned less patients than provided in subdivision 3 if the Staffing for Patient Safety Committee defined in subdivision 5 determines lower assignment limits are necessary for patient safety based on the following additional considerations:

(1) results of the assessment performed by the Staffing for Patient Safety Committee, as required in subdivision 5, paragraph (c);

(2) the number of patients in each unit, the acuity of patients, and the level and variation in the nursing intensity needed for patients;

(3) anticipated admissions, discharges, and transfers of patients during each shift;

(4) specialized experience or knowledge required of direct care registered nurses for a particular unit;

(5) the skill mix of regularly scheduled direct care registered nurses, licensed practical nurses, and unlicensed nursing personnel;

(6) staffing levels, availability, and services provided by other health care personnel who provide direct patient care, including ancillary and temporary staff;

(7) work environment factors that affect staffing needs and the delivery of care including, but not limited to, building architecture and layout, available technology, and staff familiarity with hospital practices and policies;

(8) relevant national nursing and specialty organizations' standards for staffing; and

(9) nursing-sensitive quality outcomes.

(b) Staffing plans must include staffing levels as developed by the Staffing for Patient Safety Committee for specialty units including, but not limited to, procedural, observation, bariatric, interventional radiology, and electrophysiology units. Staffing for Patient Safety Committees must use the considerations stated in paragraph (a), clauses (1) to (9), to develop staffing levels for specialty units.

(c) In addition to the requirements in paragraph (a), hospital staffing plans must include the information gathered and developed in accordance with subdivision 5, paragraph (c), clauses (1) to (4).

(d) Compliance with staffing levels for direct care registered nurses does not permit a hospital to inadequately staff other health care workers including, but not limited to, licensed practical nurses, unlicensed assistive personnel, respiratory therapists, occupational therapists, physical therapists, and health unit coordinators.

(e) By July 1, 2009, every hospital licensed in the state must submit its staffing plan to the commissioner.

Subd. 3. **Assignment limits for direct care registered nurses.** (a) Staffing plans developed under subdivision 2 may not permit direct care registered nurses to be assigned more patients than the following for any shift:

(1) one registered nurse to one patient in operating rooms, trauma units, for patients in the second and third stages of labor, and for unstable patients requiring transfer to another unit;

(2) one registered nurse to two patients in postanesthesia care units and critical care units, and for patients in the first stage of labor;

(3) one registered nurse to three patients in intermediate care newborn nurseries, telemetry units, and emergency departments;

(4) one registered nurse to four patients in medical and surgical units, pediatric units, and for noncritical antepartum patients;

(5) one registered nurse to five patients for rehabilitation care units and acute psychiatric mental health or chemical dependency units; and

(6) one registered nurse to six patients, or three couplets, in uncomplicated postpartum or routine well-baby units.

(b) The registered nurse staffing levels represent the maximum number of patients to which a direct care registered nurse may be assigned at all points during a shift and is not an average number of patients to a total number of nurses on a unit during a shift.

(c) Nothing in this section requires a hospital with lower patient assignment limits than those set out in clauses (1) to (6) to increase its assignment limits.

(d) Nothing in this section limits the rights of organized nurses to bargain on the issue of assignment limits.

Subd. 4. **Assignment adjustments.** (a) Hospitals must assign nursing personnel to each patient care unit in accordance with its staffing plan. If a direct care registered nurse determines, based on the nurse's professional judgment, that adjustments in staffing levels are required due to patient acuity and nursing intensity, then shift-to-shift adjustments in staffing levels must be made in accordance with the procedure developed by the Staffing for Patient Safety Committee.

(b) A direct care registered nurse may not be disciplined for refusing to accept an assignment if, in good faith and in the nurse's professional judgment, the nurse determines that the assignment is unsafe for patients due to patient acuity and nursing intensity.

Subd. 5. **RN Staffing for Patient Safety Committee.** (a) By July 1, 2008, every hospital licensed in the state must establish an RN Staffing for Patient Safety Committee either by creating a new committee or assigning the functions of a Staffing for Patient Safety Committee to an existing committee.

(b) Membership of the committee must include, but is not limited to, the following members:

(1) at least half of the membership must be registered nurses who provide direct patient care; and

(2) union-appointed members to proportionately represent its nurses.

Hospitals must compensate registered nurses who are employed by the hospital and serve on the Staffing for Patient Safety Committee for time spent on committee business.

(c) Staffing for Patient Safety Committees shall:

(1) complete a staffing for patient safety assessment, by December 1, 2008, that identifies the following:

(i) problems of insufficient staffing including, but not limited to, inappropriate number of registered nurses scheduled in a unit, inappropriately experienced registered nurses scheduled for a particular unit, inability for nurse supervisors to adjust for increased acuity or activity in a unit, and chronically unfilled positions within the hospital;

(ii) units that pose the highest risk to patient safety due to inadequate staffing; and

(iii) solutions for problems identified under clauses (i) and (ii);

(2) develop staffing levels for each unit of the hospital that meet the requirements set out in subdivisions 2 and 3;

(3) recommend a mechanism for tracking and analyzing staffing trends within the hospital;

(4) develop a procedure for making shift-to-shift adjustments in staffing levels when such adjustments are required by patient acuity and nursing intensity; and

(5) conduct evaluations, at least semiannually, of staffing plans and progress toward goals established in the policy and submit any changes made to staffing levels to the commissioner.

Subd. 6. **Posting staffing levels.** Once developed, the staffing levels for each unit must be conspicuously posted in each unit and in waiting areas. The postings must be visible to hospital staff, patients, and the public.

Subd. 7. **Enforcement.** (a) If a hospital fails to develop and submit its staffing plan to the commissioner, the commissioner may suspend, revoke, fail to renew, or place conditions on the hospital's license to operate.

(b) The commissioner may sanction a hospital for failure to comply with the provisions of this section, including failure to staff patient care units at levels required in its staffing plan.

Sec. 2. Minnesota Statutes 2006, section 144.7067, subdivision 1, is amended to read:

Subdivision 1. **Establishment of reporting system.** (a) The commissioner shall establish an adverse health event reporting system designed to facilitate quality improvement in the health care system. The reporting system shall not be designed to punish errors by health care practitioners or health care facility employees.

(b) The reporting system shall consist of:

(1) mandatory reporting by facilities of 27 adverse health care events;

(2) mandatory completion of a root cause analysis and a corrective action plan for each adverse event by the facility and reporting of the findings of the analysis and the plan to the commissioner or reporting of reasons for not taking corrective action;

(3) mandatory reporting by facilities of staffing levels in the unit where the adverse event occurred and analysis of whether staffing levels were inadequate for patient safety;

(4) mandatory reporting of nursing-sensitive quality outcomes, including incidence of falls, prevalence of stages one and two pressure ulcers, incidence of medication errors, hospital-acquired urinary tract infections, hospital-acquired pneumonia, failure to prevent clinically severe deterioration of a patient's condition during hospitalization, and analysis of whether staffing levels were inadequate for patient safety at the time of the incident;

(5) analysis of reported information by the commissioner to determine patterns of systemic failure in the health care system and successful methods to correct these failures;

~~(4)~~ (6) sanctions against facilities for failure to comply with reporting system requirements; and

~~(5)~~ (7) communication from the commissioner to facilities, health care purchasers, and the public to maximize the use of the reporting system to improve health care quality.

(c) The commissioner is not authorized to select from or between competing alternate acceptable medical practices.

Sec. 3. **NURSING AND QUALITY PATIENT OUTCOMES STUDY.**

The commissioner of health, in consultation with hospitals, the Minnesota Board of Nursing, and the Minnesota Nurses Association, shall study how nursing care should be identified and reimbursed in hospital cost reports to more adequately reflect nurses' contributions to quality patient outcomes.