State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 588

02/14/2013 Authored by Atkins, Fritz, Abeler, Anzelc and Metsa
The bill was read for the first time and referred to the Committee on Labor, Workplace and Regulated Industries

A bill for an act

relating to health; requiring hospitals to provide staffing at levels consistent with nationally accepted standards; requiring reporting of staffing levels; 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] STANDARDS OF CARE ACT.**

Subdivision 1. **Title.** This section may be cited as the "Standards of Care Act."

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

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

(c) "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.

(d) "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.

(e) "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.

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

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

Subd. 3. **Staffing.** (a) As a condition of licensure, hospitals must, at all times, provide enough qualified registered nursing personnel on duty to provide the standard of care that is necessary for the well-being of the patients, consistent with nationally accepted evidence-based standards established by professional nursing specialty organizations, including, but not limited to, the following:

(1) Association of Women's Health, Obstetric and Neonatal Nurses;

(2) Association of Operating Room Nurses;

(3) Emergency Nurses Association; and

(4) American Association of Critical Care Nurses.

(b) In the absence of an evidence-based standard established for a specific hospital care unit as provided in paragraph (a), a working group must be created by the commissioner to review evidence-based research and develop a standard. The working group must be staffed by the commissioner or the commissioner's designee and must include, but is not limited to, the following members appointed by the governor:

(1) one member who represents the Minnesota Hospital Association;

(2) one member who represents the Minnesota Nurses Association;

(3) two members of the public;

(4) two members who are registered nurses and represent greater Minnesota;

(5) two members who are registered nurses and represent the metropolitan area;

(6) two members who are registered nurses and represent hospitals licensed for 25 beds or less; and

(7) two members who are registered nurses and represent hospitals licensed for more than 25 beds.

Costs incurred for staffing and managing this working group shall be paid for with hospital licensing fees.

Subd. 4. **Assignment adjustments.** (a) Hospitals must assign nursing personnel to each patient care unit consistent with nationally accepted nursing clinical standards. 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 according to procedures developed by the Safe Patient Assignment Committee, established pursuant to subdivision 5. Hospitals must not use mandatory overtime as a means to meet staffing standards.

(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. **Safe Patient Assignment Committee.** (a) By July 1, 2014, every hospital licensed in the state must establish a Safe Patient Assignment 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 60 percent of the membership must be registered nurses who provide direct patient care; and

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

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

(c) Safe Patient Assignment Committees shall:

(1) complete a staffing for patient safety assessment by March 31, 2014, and annually thereafter 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 items (i) and (ii);

(2) implement and evaluate staffing standards provided in subdivision 3;

(3) convert national standards described in subdivision 3 into registered nurse hours of care per patient;

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

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

(6) identify any incidents when the hospital has failed to meet the standards provided in subdivision 3 and recommend a remedy.

Subd. 6. **Posting staffing levels.** (a) 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.

(b) The commissioner must post on the Department of Health's Web site the standards for each unit as defined under subdivision 3.

Subd. 7. **Reporting.** Hospitals must publicly report hours-per-patient direct care that registered nurses spend per patient on all patient care units. The first report is due March 31, 2014, and quarterly thereafter. The report must include actual hours worked by registered nurses per patient, not scheduled hours. This report must be submitted to the commissioner and posted on the hospital's Web site and on the Department of Health's Web site. This report must be titled the "Real Time RN Staffing Report." Beginning March 31, 2015, hospitals must publicly report patient outcomes relative to actual hours worked by registered nurses per patient.

Subd. 8. **Enforcement.** The commissioner may sanction a hospital for failure to comply with the provisions of this section, including failure to staff patient care units at required levels.