State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2289

03/13/2025 Authored by Johnson, P.; Berg; Stephenson; Norris; Rehrauer and others
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health; requiring hospitals to provide registered nurse staffing at levels consistent with nationally accepted standards; requiring reporting of staffing levels; prohibiting retaliation; imposing civil penalties; appropriating money; amending Minnesota Statutes 2024, sections 144.7055; 148.264, 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. **[144.592] QUALITY PATIENT CARE ACT.**

Subdivision 1. **Title.** Sections 144.592 to 144.596 may be cited as the "Quality Patient Care Act."

Subd. 2. **Definitions.** (a) For purposes of sections 144.592 to 144.596, the following terms have the meanings given.

(b) "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.

(c) "Charge nurse" means a nurse who:

(1) oversees and supports a nursing staff for each shift;

(2) serves as a unit resource and carries out duties that include assigning patients to nurses in the oncoming shift, coordinating patient flow, relieving staff for breaks, and operating as a safety valve in addressing emergency patient care issues and fluctuations in patient acuity and nursing intensity on the unit; and

(3) has received special orientation and training to serve as a charge nurse for a unit or department in a hospital.

(d) "Commissioner" means the commissioner of health.

(e) "Direct-care registered nurse" means a registered nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and nonmanagerial and who directly provides nursing care to patients more than 60 percent of the time.

(f) "Health care emergency" means a situation that creates an actual or imminent serious threat to the health and safety of persons and that may require hospitals and other health care facilities to provide an exceptional level of emergency services or other health care services. A health care emergency may include a natural or man-made disaster or an illness or health condition caused by bioterrorism or an infectious agent that causes a high probability of a large number of deaths, serious or long-term disabilities, or substantial future harm.

(g) "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 the surveillance of patients in order to make continuous, appropriate clinical decisions in the care of patients.

(h) "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; the dependency needs of the patient and the patient's family; and any other factors influencing the perceived health care needs of an individual patient as determined by a licensed provider, direct-care registered nurse, or other licensed health care professional whose primary job duties include providing care to patients more than 60 percent of the time. Higher patient acuity requires more intensive nursing time and advanced nursing skills for continuous surveillance.

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

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

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

Subd. 3. **Compliance.** A hospital licensed under sections 144.50 to 144.56 must comply with this section and sections 144.593 to 144.595 as a condition of licensure.

Subd. 4. **Staffing.** A hospital 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 this section and professional nursing specialty organizations. A direct-care registered nurse assigned to a patient shall directly provide the planning, supervision, implementation, assessment and evaluation of nursing care to the patient, and is responsible for the provision of care to a particular patient within the nurse's scope of practice.

Subd. 5. **Staffing plans.** A hospital must adopt and implement a staffing plan that specifies 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 subdivision must establish staffing levels that include the flexibility to increase the number of nurses required for a unit when necessary for patient safety. Staffing plans must also include patient-to-staff ratios for nursing assistants and other direct-care staff providing nursing services directly to patients. Staffing plans must be developed in agreement with direct-care registered nurses and must comply with the requirements in subdivision 6. The staffing plan must be made available to all employees within the facility, officers or other representatives of labor unions with collective bargaining agreements in place with one or more employees in the facility, and the Department of Health. The staffing plan must be agreed upon by any existing collective bargaining units impacted by the staffing plan before it may be approved by the commissioner.

Subd. 6. **Assignment limits for direct care registered nurses.** (a) A staffing plan developed under subdivision 5 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:

(i) in operating rooms;

(ii) in trauma units;

(iii) for patients who require immediate lifesaving interventions;

(iv) for hemodynamically unstable patients whose care needs include immediate response to life-threatening conditions;

(v) for patients demonstrating compromised or otherwise unstable vital signs creating life-threatening conditions requiring immediate response;

(vi) for pregnant patients in active delivery;

(vii) for patients in postanesthesia;

(viii) for patients with conditions or health care needs that pose an immediate threat to life or limb;

(ix) for trauma patients requiring lifesaving interventions or patients with other conditions qualifying as a trauma code activation; and

(x) for unstable patients requiring transfer to another unit;

(2) one registered nurse to two patients in:

(i) postanesthesia care units;

(ii) critical care units;

(iii) intensive care units;

(iv) any units treating intensive care unit patients within the emergency room;

(v) neonatal intensive care;

(vi) labor and delivery;

(vii) coronary care;

(viii) acute respiratory care; and

(ix) burn units;

(3) one registered nurse to three patients in:

(i) intermediate care newborn nurseries;

(ii) antepartum units;

(iii) adult medical and surgical units;

(iv) units providing both labor and delivery and postpartum services;

(v) postpartum couplets units providing services for infants and mothers;

(vi) step-down units;

(vii) telemetry units;

(viii) pediatric units; and

(ix) emergency departments;

(4) one registered nurse to four patients in:

(i) acute psychiatric units;

(ii) rehabilitation care units;

(iii) chemical dependency units;

(iv) immediate care nursery or Level II nursery; and

(v) any other specialty care or patient care units organized to provide care for a specific medical condition, disease, diagnosis, or patient population for which specific assignment limits are not established in this paragraph; and

(5) one registered nurse to five patients for skilled nursing units.

(b) Nothing in this subdivision:

(1) requires a hospital with lower patient assignment limits than those established in paragraph (a) to increase its assignment limits;

(2) requires a hospital to establish patient assignment limits for any units named within this subdivision in which the hospital does not organize, operate, and maintain a unit that provides the same services as those units listed in this subdivision; and

(3) limits the rights of organized nurses to bargain on the issue of patient assignment limits.

(c) In determining ratios for each unit, there shall be no averaging of the number of patients and the total number of licensed bargaining unit nurses on the unit during any one shift nor over any period of time. Only licensed bargaining unit nurses providing direct patient care shall be included in the ratios, and no other staffing combinations or utilization of nonnursing staff may be deployed to reduce or otherwise alter the number of nurses assigned to a given unit. The ratios established shall be in place for all shifts throughout the calendar year.

Subd. 7. **Schedule for compliance.** Hospitals must comply with the assignment limits in subdivision 6 no later than August 1, 2027, except that hospitals in a rural area, as defined in United States Code, title 42, section 1395ww(d)(2)(D), must comply no later than August 1, 2029. The commissioner of health shall establish a schedule by which hospitals must comply with assignment limits and shall establish, maintain, and enforce proper implementation of assignment limits within licensed hospitals.

Subd. 8. **Application of assignment limits to hospital nursing practice standards.** A patient assignment may be included in the calculation of direct-care registered nurse-to-patient assignment limits established in subdivision 6 only if care is provided by

a direct-care registered nurse and the provision of care to the particular patient is within that direct-care registered nurse's validated competence.

Subd. 9. **Nursing administrators and supervisors.** A hospital shall not include a nursing administrator or supervisor in the calculation of direct-care registered nurse-to-patient assignment limits established in subdivision 6. For purposes of this subdivision, "nursing administrator or supervisor" includes a nurse administrator, nurse supervisor, nurse manager, charge nurse, chief nursing officer, or any other nursing staff whose regular job duties do not include providing direct patient care during at least 60 percent of working hours.

Subd. 10. **Application of assignment limits.** The assignment limits established in subdivision 6 represent the maximum number of patients to which a direct-care registered nurse may be assigned at all points during a shift. A hospital is prohibited from averaging the number of patients and the total number of direct-care registered nurses assigned to patients in a unit during any one shift or over any period of time in order to meet the assignment limits established in subdivision 6.

Subd. 11. **Assignments, assignment adjustments, and adding additional registered nurses.** (a) A hospital must assign nurses, nursing assistants, and any other nursing or direct-care personnel to the patient population consistent with the hospital's staffing plan and the assignment limits established in subdivision 6. For each patient population, a direct-care registered nurse shall evaluate the following factors to assess and determine adequacy of staffing levels to meet patient care needs:

(1) composition of skill mix and roles available;

(2) patient acuity;

(3) experience level of registered nurse staff;

(4) unit activity level, such as admissions, discharges, and transfers;

(5) variable staffing grids;

(6) availability of a registered nurse to accept an assignment; and

(7) nursing intensity.

(b) A hospital shall not:

(1) assign or otherwise direct nursing staff to provide patient care to a patient unless the direct-care registered nurse is able to demonstrate current competence in providing care to any relevant patient populations and has received orientation, training, and experience sufficient to provide competent care to the patient and that patient population;

(2) assign a direct-care registered nurse to provide patient care to a patient if the nurse's professional opinion leads the nurse to believe that accepting the additional patient assignment would force the nurse to violate any provisions of the Minnesota Nurse Practice Act, under sections 148.171 to 148.285;

(3) assign nursing personnel from a supplemental nursing services agency to provide patient care to a patient population until the agency nurse is able to demonstrate validated competence in providing care to that patient population and has received orientation sufficient to provide competent care to the patient population; or

(4) assign unlicensed personnel to:

(i) perform direct-care registered nurse functions in lieu of care delivered by a direct-care registered nurse;

(ii) perform tasks that require the assessment, judgment, or skill of a direct-care registered nurse; or

(iii) perform functions of a direct-care registered nurse under the supervision of a direct-care registered nurse.

(c) If any direct-care registered nurse determines that a unit's staffing levels are inadequate and notifies the unit's charge nurse and a manager or administrative supervisor, the manager or administrative supervisor shall consider the following:

(1) current patient care assignments for potential redistribution;

(2) the ability to facilitate discharges, transfers, and admissions;

(3) the availability of additional staffing resources; and

(4) the hospital-wide census and staffing.

(d) If the staffing inadequacies cannot be resolved and resources cannot be reallocated by the manager or administrative supervisor after considering the factors in paragraph (c), the hospital shall call in extra staff to ensure adequate staffing to meet safe patient standards.

(e) Until extra staff arrive and begin to receive patient assignments:

(1) the hospital must suspend nonemergency admissions and prescheduled elective surgeries that are not life-threatening but routinely lead to in-patient hospitalization; and

(2) the charge nurse for the unit with inadequate staffing levels is authorized to close the unit to new patient admissions and in-hospital transfers after all good-faith efforts to bring in additional staffing to alleviate excessive boarding issues in the emergency department

have been explored by appropriate hospital management staff, and that any open beds and available units within the facility are being operationalized to the fullest extent in order to meet patient needs.

Subd. 12. **Prohibited actions.** A hospital must not take any of the following actions as a means to meet staffing standards:

(1) use mandatory overtime;

(2) assign or transfer a direct-care registered nurse to a patient care unit until after the nurse has been adequately trained and oriented to work on the unit;

(3) assign a direct-care registered nurse to a patient care unit to relieve another direct-care registered nurse during breaks, meals, or other routine and expected absences from a unit, until after the nurse being assigned demonstrates current competence in providing care on a particular unit and has received orientation to that hospital's unit sufficient to provide competent care to patients in that unit;

(4) impose layoffs of licensed practical nurses, licensed psychiatric technicians, certified nursing assistants, or other ancillary staff to meet the assignment limits established in subdivision 6; and

(5) assign a direct-care registered nurse any patient assignments that would, in the nurse's professional judgment, require the nurse to violate the Minnesota Nurse Practice Act, under sections 148.171 to 148.285, if the nurse were to accept a patient assignment as directed by a supervisor or manager. A hospital may not discharge, discipline, penalize, interfere with, threaten, restrain, coerce, or otherwise retaliate or discriminate against a nurse who communicates their objection to a patient assignment based on the requirements of the Nurse Practice Act.

Subd. 13. **Exemption; emergency situations.** The assignment limits established in subdivision 6 do not apply during a health care emergency if a hospital needs to provide an exceptional level of emergency services or other health care services. If a health care emergency causes a change in the number of patients on a unit, a hospital must make prompt and diligent efforts to maintain staffing levels consistent with the assignment limits in subdivision 6. The commissioner shall provide guidance to hospitals describing situations that constitute a health care emergency for purposes of this subdivision.

Subd. 14. **Charge nurse; inclusion in staffing grid.** In order to facilitate optimal patient care, a charge nurse shall not be included in the unit's staffing grid that is regularly reviewed and determines the unit's staffing budget. This subdivision does not limit the ability of a

charge nurse to take a patient assignment in the event of an emergency when taking a patient assignment, in the charge nurse's professional opinion, will not jeopardize overall patient care for all patients on the unit at that time.

Sec. 2. **[144.593] PATIENT CARE; USE OF TECHNOLOGY.**

Subdivision 1. **Patient-acuity adjustable units prohibited.** Patients shall be cared for only on units or patient care areas where the level of intensity, type of care, and direct-care registered nurse-to-patient assignment limits meet the individual requirements and needs of each patient.

Subd. 2. **Use of technology.** (a) A hospital shall not employ video monitors or any form of electronic visualization of a patient as a substitute for the direct observation required for patient assessment by a direct-care registered nurse or required for patient protection. Video monitors or any form of electronic visualization of a patient shall not be included in the calculation of assignment limits in section 144.592, subdivision 6.

(b) A hospital shall not employ technology that limits a direct-care registered nurse from performing functions that are part of the nursing process, including full exercise of independent professional judgment in assessment, planning, implementation, and evaluation of care, including the use of artificial intelligence technology in lieu of the expertise of licensed health care professionals.

Sec. 3. **[144.594] SAFE PATIENT ASSIGNMENT COMMITTEE.**

Subdivision 1. **Committee required.** By October 1, 2026, a hospital 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.

Subd. 2. **Membership; compensation.** At least 60 percent of the committee's membership must be nonsupervisory and nonmanagerial registered nurses who provide direct patient care, as defined in section 144.592, subdivision 2, paragraph (e). The committee must include members appointed by a collective bargaining unit, if one exists, to proportionately represent the bargaining unit's nurses. Hospitals must compensate registered nurses who are employed by the hospital and serve on the Safe Patient Assignment Committee for time spent on committee business.

Subd. 3. **Duties.** A Safe Patient Assignment Committee shall:

(1) complete a staffing for patient safety assessment by March 31, 2026, and annually thereafter that identifies the following:

(i) problems of insufficient staffing, including but not limited to an 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 assignment limits in section 144.592, subdivision 6;

(3) convert assignment limits in section 144.592, subdivision 6, 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 consistent with section 144.592, subdivision 11, when adjustments are required by patient acuity and nursing intensity; and

(6) identify any incidents when the hospital has failed to meet the assignment limits in section 144.592, subdivision 6, and recommend a remedy.

Sec. 4. **[144.595] RETALIATION PROHIBITED.**

A hospital shall not retaliate against or discipline a direct-care registered nurse, either formally or informally, for:

(1) refusing to accept an assignment if, in good faith and in the nurse's professional judgment, the nurse determined that the assignment is unsafe for patients due to patient acuity and nursing intensity;

(2) reporting a concern regarding safe staffing levels; or

(3) communicating an objection, based on the nurse's own professional judgment, that accepting a specific or additional patient assignment would force the nurse to violate the Minnesota Nurse Practice Act under sections 148.171 to 148.285.

Sec. 5. **[144.596] ENFORCEMENT.**

(a) The commissioner shall impose a civil penalty of not less than $25,000 for each incident of a hospital failing to comply with sections 144.592 to 144.595, including failure to staff patient care units to required levels.

(b) The commissioner must publicly report on the department website all incidents of noncompliance with sections 144.592 to 144.595 on a quarterly basis, beginning September 1, 2026.

Sec. 6. Minnesota Statutes 2024, section 144.7055, is amended to read:

144.7055 STAFFING PLAN REPORTS.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Core staffing plan" means the projected number of full-time equivalent nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit.

(c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and other health care workers, which may include but is not limited to nursing assistants, nursing aides, patient care technicians, and patient care assistants, who perform nonmanagerial direct patient care functions for more than 50 percent of their scheduled hours on a given patient care unit.

(d) "Inpatient care unit" means a designated inpatient area for assigning patients and staff for which a distinct staffing plan exists and that operates 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not include any hospital-based clinic, long-term care facility, or outpatient hospital department.

(e) "Staffing hours per patient day" means the number of full-time equivalent nonmanagerial care staff who will ordinarily be assigned to provide direct patient care divided by the expected average number of patients upon which such assignments are based.

~~(f) "Patient acuity tool" means a system for measuring an individual patient's need for nursing care. This includes utilizing a professional registered nursing assessment of patient condition to assess staffing need.~~

(f) "Direct-care registered nurse" means a registered nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and nonmanagerial and is directly providing nursing care to patients more than 60 percent of the time.

Subd. 2. **Hospital staffing report.** (a) The chief nursing executive or nursing designee of every reporting hospital in Minnesota under section 144.50 ~~will~~ shall develop a core staffing plan for each patient care unit.

(b) Core staffing plans shall specify the ~~full-time equivalent for each patient care unit for each 24-hour period.~~ following:

(1) the definition of the patient care unit;

(2) the number of beds available in each patient care unit;

(3) the average number of patients per day in each patient care unit; and

(4) the full-time equivalent for each patient care unit broken down by:

(i) shift, based on eight-hour shifts of 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m.; and

(ii) type of staff assigned, including but not limited to registered nurses, licensed practical nurses, certified nursing assistants, and other additional care team members.

(c) Prior to submitting the core staffing plan, as required in subdivision 3, hospitals shall consult with and obtain consent from representatives of the ~~hospital medical staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about~~ nonmanagerial care staff and all affected exclusive bargaining representatives of nonmanagerial care staff regarding the core staffing plan and the expected average number of patients upon which the staffing plan is based. Direct-care registered nurses must certify the report as accurate and clearly presented by majority vote of direct-care registered nurses on staff at the hospital or by the exclusive bargaining representative if represented by a collective bargaining unit.

Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core staffing plans to the Minnesota Hospital Association ~~by January 1, 2014~~ on a quarterly basis. The Minnesota Hospital Association shall include each reporting hospital's most recently submitted core staffing plan on the Minnesota Hospital Association's Minnesota Hospital Quality Report website ~~by April 1, 2014~~ within three months after submission. Any substantial changes to the core staffing plan shall be updated within 30 days.

(b) The Minnesota Hospital Association shall include on its website for each reporting hospital on a quarterly basis the actual direct patient care hours per patient, per shift, based on eight-hour shifts of 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m., and per unit. Hospitals must submit the direct patient care staffing report to the Minnesota Hospital Association ~~by July 1, 2014, and quarterly thereafter.~~ each quarter, and the Minnesota Hospital Association must post the actual direct patient care staffing report on the hospital quality reporting website within three months of receiving the reports.

Subd. 4. **Enforcement of reporting requirements.** (a) The commissioner shall impose a civil penalty of not less than $25,000 for each hospital that fails to comply with subdivisions 2 and 3, including failure to report by the deadline or failure to provide information according to the requirements of this section. Each day of the violation shall constitute a separate

violation and the penalties prescribed shall be applicable to each separate violation unless otherwise indicated.

(b) At a minimum, the commissioner must publicly report on the department website all incidents of noncompliance with subdivision 2 or 3.

Subd. 5. **Staffing grid; compliance; enforcement.** (a) A hospital must submit its staffing grid to the commissioner quarterly and, when scheduling staff for a patient care unit, must schedule at least the number and skill mix of staff specified in the staffing grid for that unit.

(b) The commissioner shall accept complaints from persons employed by a hospital regarding situations in which a hospital scheduled fewer staff for a patient care unit than the number of staff specified in the hospital's staffing grid, or a skill mix that differed substantially from the skill mix specified in the hospital's staffing grid. The commissioner shall impose a civil penalty of not less than $25,000 for:

(1) a hospital that fails to submit its staffing grid according to paragraph (a); or

(2) situations in which the commissioner determines that a hospital scheduled fewer staff for a patient care unit than the number of staff specified in the staffing grid or scheduled a skill mix of staff that differed substantially from the skill mix specified in the hospital's staffing grid; and

(3) situations in which the commissioner determines that persistent understaffing within a facility has led to an increase in adverse health events or instances of workplace violence, or continues to pose safety risks for workers or patients.

Sec. 7. Minnesota Statutes 2024, section 148.264, subdivision 1, is amended to read:

Subdivision 1. **Reporting.** (a) Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting in good faith a report to the board under section 148.263 or for otherwise reporting in good faith to the board violations or alleged violations of sections 148.171 to 148.285. All such reports are investigative data as defined in chapter 13.

(b) Any registered nurse or health care worker who experiences and subsequently reports a level of staffing that, in the registered nurse's or health care worker's professional judgment, could reasonably be expected to result in unsafe or ineffective patient care cannot be disciplined under section 148.261, subdivision 1, clause (8). These reports may include a report from a registered nurse or health care worker to the registered nurse's or health care worker's supervisor at the supervisor's place of employment, the Board of Nursing, the

commissioner of health, or a professional nursing organization. Reports must be made within ten calendar days after the incident occurred in order to be covered under this paragraph.

Sec. 8. **APPROPRIATION.**

$..... in fiscal year 2026 and $..... in fiscal year 2027 are appropriated from the general fund to the commissioner of health for enforcement activities in Minnesota Statutes, section 144.7055, subdivision 5.