

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

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

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

2.8 Subd. 2. **Staffing plan.** (a) By July 1, 2013, all hospitals licensed under section
2.9 144.55 shall adopt and implement a staffing plan that sets out the maximum number of
2.10 patients that may be assigned to a direct care registered nurse for each unit of the hospital
2.11 in order to ensure adequate staffing levels for patient safety. Staffing plans adopted and
2.12 implemented under this section shall establish staffing levels that include the flexibility
2.13 to increase the number of nurses required for a unit when necessary for patient safety.
2.14 The staffing plans must be developed in agreement with direct care registered nurses
2.15 and must comply with the requirements in subdivision 3. The staffing plans developed
2.16 under this section must require that direct care registered nurses be assigned less patients
2.17 than provided in subdivision 3 if the staffing for patient safety committee defined in
2.18 subdivision 5 determines lower assignment limits are necessary for patient safety based on
2.19 the following additional considerations:

2.20 (1) results of the assessment performed by the staffing for patient safety committee,
2.21 as required in subdivision 5, paragraph (c);

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

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

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

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

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

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

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

2.35 (9) nursing-sensitive quality outcomes.

3.1 (b) Staffing plans must include staffing levels as developed by the staffing for patient
3.2 safety committee for specialty units including but not limited to procedural, observation,
3.3 bariatric, interventional radiology, and electrophysiology units. Staffing for patient safety
3.4 committees must use the considerations in paragraph (a), clauses (1) to (9), to develop
3.5 staffing levels for specialty units.

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

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

3.13 (e) By July 1, 2013, every hospital licensed in the state must submit its staffing
3.14 plan to the commissioner.

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

3.18 (1) one registered nurse to one patient in: (i) operating rooms; (ii) trauma units; (iii)
3.19 for patients in the second and third stages of labor; and (iv) for unstable patients requiring
3.20 transfer to another unit;

3.21 (2) one registered nurse to two patients: (i) in postanesthesia care units; (ii) in critical
3.22 care units; and (iii) for patients in the first stage of labor;

3.23 (3) one registered nurse to three patients in: (i) intermediate care newborn nurseries;
3.24 (ii) telemetry units; and (iii) emergency departments;

3.25 (4) one registered nurse to four patients: (i) in medical and surgical units; (ii) in
3.26 pediatric units; and (iii) for noncritical antepartum patients;

3.27 (5) one registered nurse to five patients in: (i) rehabilitation care units; (ii) acute
3.28 psychiatric mental health units; and (iii) chemical dependency units; and

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

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

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

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

4.3 Subd. 4. **Assignment adjustments.** (a) Hospitals must assign nursing personnel
4.4 to each patient care unit according to its staffing plan. If a direct care registered nurse
4.5 determines, based on the nurse's professional judgment, that adjustments in staffing levels
4.6 are required due to patient acuity and nursing intensity, then shift-to-shift adjustments in
4.7 staffing levels must be made according to the procedures developed by the staffing for
4.8 patient safety committee.

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

4.12 Subd. 5. **RN Staffing for Patient Safety Committee.** (a) By July 1, 2012, every
4.13 hospital licensed in the state must establish an RN Staffing for Patient Safety Committee
4.14 either by creating a new committee or assigning the functions of a staffing for patient
4.15 safety committee to an existing committee.

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

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

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

4.21 Hospitals must compensate registered nurses who are employed by the hospital and
4.22 serve on the staffing for patient safety committee for time spent on committee business.

4.23 (c) Staffing for patient safety committees shall:

4.24 (1) complete a staffing for patient safety assessment by December 1, 2012, that
4.25 identifies the following:

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

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

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

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

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

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

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

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

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

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

5.15 Sec. 2. **NURSING AND QUALITY PATIENT OUTCOMES STUDY.**

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