DEPARTMENT OF HEALTH

Minnesota's Hospital Nursing Workforce

A STUDY ON TURNOVER AND EXITS AMONG MINNESOTA'S HOSPITAL-BASED NURSES

Due to the Minnesota Legislature, 2026

Minnesota's Nursing Workforce, 2025

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Executive Summary

In 2023, the Minnesota Legislature directed the Minnesota Department of Health (MDH) to conduct a study focusing on Minnesota's nurses; specifically, the reasons nurses leave direct care hospital positions or nursing as a profession. MDH planned the study in 2023 and executed it during 2024 and 2025. To respond to the legislative charge, MDH administered a survey with a representative sample of over 50,000 Minnesota nurses; conducted six in-depth focus groups with nurses who had left hospital positions or the profession altogether; convened an expert nursing workforce panel to provide regular in-depth feedback; and had dozens of additional conversations and interviews with nurses, nurse hospital leaders, stakeholders including the Minnesota Hospital Association, the Minnesota Board of Nursing, the Minnesota Nurses Association, and other partners.
The findings tell a compelling and detailed story about Minnesota's hospital bedside nurses.

1) The total number of licensed registered nurses (RNs) has increased steadily in Minnesota over the last fifteen years, and the share of RNs working in hospital bedside care, while experiencing a drop in 2022, has recovered to pre-COVID levels. Additionally, RNs are working roughly the same number of hours as before COVID. There are signs that hospital bedside nursing in Minnesota is rebounding.

2) There is evidence that both the hospital RN workforce and patient populations have changed substantially since COVID. As hospital employment levels have rebounded since COVID, many experienced, retiring RNs have been replaced by early-career nurses. The hospital nursing workforce is now younger and less experienced than before, with nearly 40% of bedside RNs under the age of 35, and one in five with fewer than two years of nursing experience. Meanwhile, patients are entering hospitals with both more acute illnesses and more complicated clinical or psycho-social circumstances. It is all but certain that these broad shifts have created significant challenges for hospitals and the nurses who work there.

3) Minnesota's hospitals are not a monolith. There is strong evidence that many are successfully navigating the ever-changing health care landscape *while* preserving the well-being of their frontline staff. Indeed, nearly one-quarter of hospital bedside nurses reported being "very satisfied" with their career in the last 12 months. However, compared to pre-COVID levels, work satisfaction has declined considerably among hospital bedside nurses, more than any other group of providers, signaling a problem that may be unique to these important clinicians. This drop in work satisfaction is not isolated to a specific region or age group. All this being said, it is also worth noting that the vast majority of bedside nurses (86.2%) were either "very satisfied" or "satisfied" with their career, and the 2023-2024 trend indicates that conditions might be improving.

4) When the 14% of hospital RNs who reported feeling dissatisfied with their career were asked to report what was driving their feelings of dissatisfaction, the top reasons included not feeling appreciated, feeling burned out, feeling that patient loads are too high, and feeling that management does not listen to nurses' concerns.

5) Focus group discussions as well as open-ended survey responses allowed us to examine in more depth nurses' reasons for dissatisfaction and/or exiting their hospital jobs. **These responses and conversations reinforced, clarified, and deepened themes from the survey data**, with discussions and comments centering primarily around two main topics: insufficient staffing and problematic organizational culture.

a. The theme of **insufficient staffing** reflected nurses' significant concerns (sometimes bordering on alarm) about heavy or unsafe workloads, inadequate orientation or training, stress and fear over negative outcomes to patients or nurses' own careers, and inadequate work-life balance. As one nurse put it, "We're being overworked and overwhelmed."

b. Conversations about **problematic organizational culture** reflected concerns around physical, sexual, or emotional abuse or mistreatment coming from patients or families; bullying or otherwise unsupportive coworkers; ineffective or unsupportive management; and poor support for nurses from the organization at large. "I don't want a placard," said one nurse. "I just want someone to say 'we really appreciate your dedication to this job for so long, you know, and we couldn't have done it without you.'"

6) Recognizing that many of Minnesota's hospitals are already doing these things well, this report concludes with several suggestions for addressing the findings identified:

a. Ensure that nurses' workloads are manageable by accounting not for only patient acuity, but also for patient intensity, and the skill and experience levels of nurses;
b. Foster supportive organizational cultures by prioritizing clear, responsive, and authentic communication with front-line staff to help nurses feel valued;
c. Maintain and enforce reliable nurse-informed policies and measures to protect hospital staff from physical and emotional mistreatment from patients or their families;
d. Promote and prioritize nurses' professional growth.

Introduction

Nurses are the backbone of Minnesota's health care workforce. In 2025, Minnesota had more than 151,000 actively licensed Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Advanced Practice Registered Nurses (APRNs) combined, together comprising nearly 60% of all licensed health care providers. In terms of sheer size and time spent caring for patients, nursing dwarfs every other health profession. The vast majority of nurses (80%) are RNs, half of whom work in hospitals. It is not an overstatement to say that we cannot understand health care in Minnesota without understanding the work of Minnesota's hospital nurses. We cannot ensure access to care for Minnesotans without a vital and engaged hospital nursing workforce. SARS-CoV-2 (hereafter, COVID) was unquestionably a sudden shock to health care systems, hospitals, and the nurses and other clinicians working within them. State and national-level conversations abound about both the immediate and continued impact of COVID on hospital staff. But hospitals and their staff are constantly anticipating, reacting, and adapting to evolving health threats, mergers and closures, resource scarcity, business model changes, technical and scientific advances, and changes in overall population health. COVID shone a light on the challenges that hospitals and their workers face, but those challenges pre-dated COVID and in some ways have amplified now that the worst of the pandemic has passed.

During the 2023 Minnesota legislative session, the Legislature passed into law the Nurse and Patient Safety Act. Among other provisions, the Act directed the Minnesota Department of Health (MDH) to conduct a study on the current status of the state's hospital nursing workforce. The study was to center around "an investigation of the supply of active licensed nurses and reasons nurses are leaving direct patient care at hospitals" and to be based on (1) data that MDH collects in collaboration with the Board of Nursing as directed under Minnesota Statutes, sections 144.051 and 144.052; (2) data from the Minnesota Hospital Association (MHA) on retention by hospitals of licensed nurses; and (3) an "independent study on reasons licensed nurses are choosing not to renew their licenses and leaving the profession."

Following this legislative direction, this report is organized as follows:

- **Background information** on Minnesota's nursing workforce supply: how many there are, who they are, and where they work—and how has this changed over time.

- **Hospital nurses' work satisfaction (a strong predictor of intent to leave):** Are hospital-based nurses experiencing lower levels of job satisfaction than other Minnesota clinicians? If so, what is driving that dissatisfaction? This focus on overall satisfaction helped us to understand and quantify how widespread any problems may be.

- **Hospital nurses' work exits (in direct response to the Legislative charge):** Are hospital-based nurses more likely to leave their jobs in hospital settings? And if so, what are the key reasons nurses report for having left hospital-based care or the profession of nursing altogether?

- **Discussion and recommendations:** Based on the data presented, what are the most critical concerns, and what are some effective solutions?

This report proceeds as follows. Section 1 offers background on Minnesota's current nursing workforce, providing important context for the more substantive findings in following sections. Section 2 investigates nurses' levels of work satisfaction before and after the COVID-19 pandemic, providing insights into whether and how hospital-based nurses differ from other professions in terms of their work satisfaction and the drivers behind it. Section 3 then shares in-depth quantitative and qualitative information on why some nurses have opted to leave hospital-based work settings in favor of other roles both within and outside of direct patient care,

or outside nursing altogether. Finally, Section 4 provides a discussion of the main points and offers actionable recommendations. The report also contains Appendices providing supplementary data analyses, complete methodological details on our data collection and analysis, and a list of partners and stakeholders who supported the development of this report.

A Note on Impartiality

Discussions about the nursing workforce at both the state and national levels are not dispassionate. Much is at stake. Various interest groups have different, often opposing viewpoints that can lead to contentious arguments and divergent conclusions about the best policy steps to take. This research—and the recommendations it provides—can only be as trustworthy and impartial as our processes. We have sought authentic partnerships, listened carefully to all voices, synthesizing and incorporating feedback from a wide variety of nurses, nurse leaders (e.g., chief nursing officers) in hospitals, educators, scholars, expert groups, and other stakeholders. We have used the most rigorous scientific methods available to us, reporting only data (both qualitative and quantitative) that meets a high threshold for reliability and validity, recognizing that the survey itself is of nurses, not other stakeholders. We have, however, examined the issues from many perspectives in order to find answers that will do the most good to protect, maintain, and improve the health of all Minnesotans.

Our Focus on Registered Nurses

There are three licensed nursing professions in Minnesota (and in most states): licensed practical nurses (LPNs), registered nurses (RNs), and advanced practice registered nurses (APRNs). All three professions play critical roles in patient care; however, the remainder of this report focuses almost exclusively on RNs. This is for two reasons. First, of the three nursing professions, RNs are most commonly employed in hospitals (approximately 50% of RNs, compared to 36% of APRNs and 6% of LPNs work in hospitals). Secondly, and more importantly, APRNs and LPNs occupy very different roles in hospitals than most RNs. Most APRNs have broader scopes of practice, varied practice settings, and more autonomy to make treatment decisions for their patients. On the other hand, hospital-based LPNs provide basic direct patient care under the supervision of RNs or other hospital staff. Though all three roles are vitally important, bedside RNs are by far the largest segment of the hospital-based nursing workforce, and are the group that stakeholders are generally thinking of when expressing concern about turnover and work dissatisfaction among bedside nurses.

What this Report Does Not Include

The nursing workforce is complex, and there is a huge variety of phenomena that impact it. Some of these include: preparation of new nurses for licensure (i.e., nurse education); the large influx of traveling nurses into the workforce during COVID or otherwise; and the increasing diversity of the nursing workforce. While extremely important and interesting in their own right, our investigations have led us to understand that they do not play a key causal role in the main focus of this report. For this reason, these issues are generally out of scope for this report.

Data Sources

Our findings come from two primary data sources—one quantitative and one qualitative. The quantitative findings come from MDH's Health Care Workforce Survey, which in 2024-2025, had a 97% response rate among RNs and included responses from 50,000 Minnesota RNs, about half of whom provide patient care in hospitals.

The qualitative findings are from six focus groups with a total of 16 participants, as well as input from a five-member nursing expert panel. Additionally, we gathered background information from interviews with hospital nurse leaders and partner organizations. Readers can find complete details on our methodology in Appendix B.

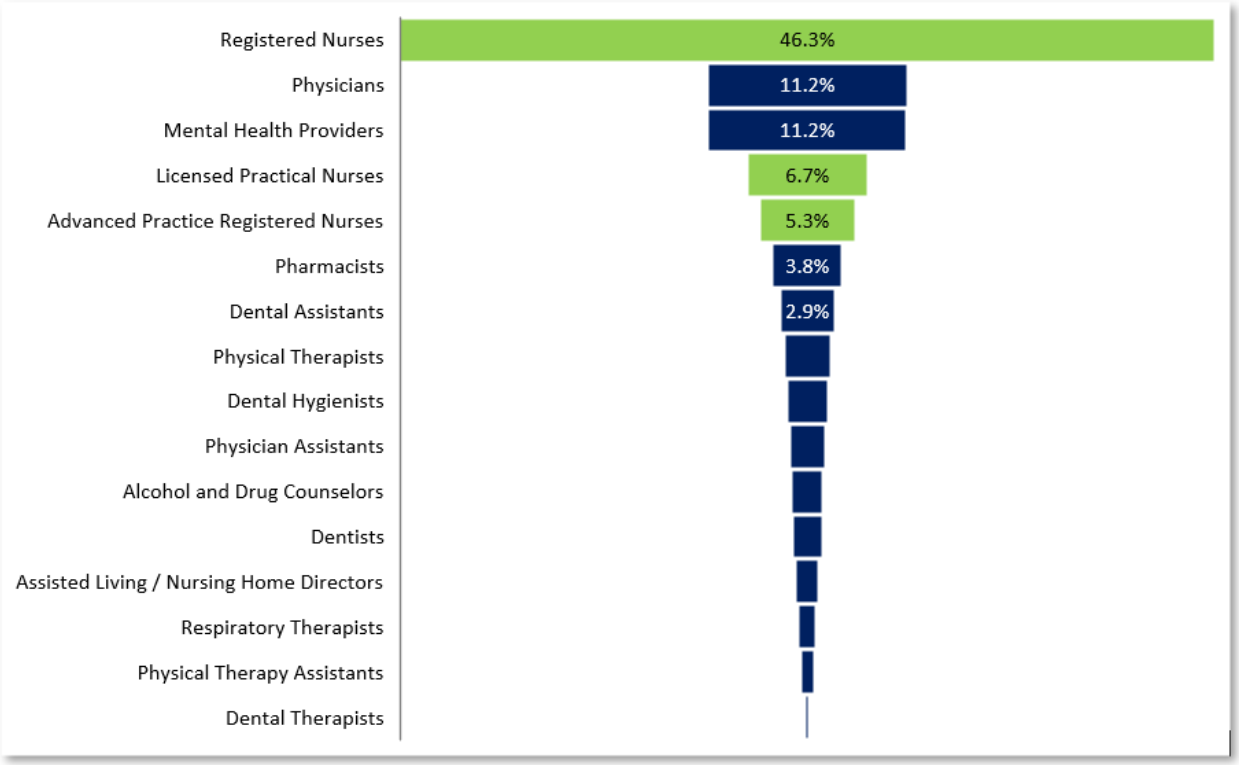
Section 1: Overview of Minnesota's RN Workforce

This section provides important background and context on the RN workforce in Minnesota. It is based primarily on data from the Minnesota Department of Health's Health Care Workforce Survey; data sources are noted under each chart. See Appendix B for complete details on the survey methodology.

Minnesota's Current Health Care Workforce, by the Numbers

As of March 2025, RNs comprised nearly half—46.3%—of the entire licensed health care workforce. Adding in the shares of LPNs (6.7%) and APRNs (5.3%), all three types of nurses make up just under 60% of the licensed clinicians in the state (see Figure 1.1).

Figure 1.1. Nurses as a share of the licensed health care workforce

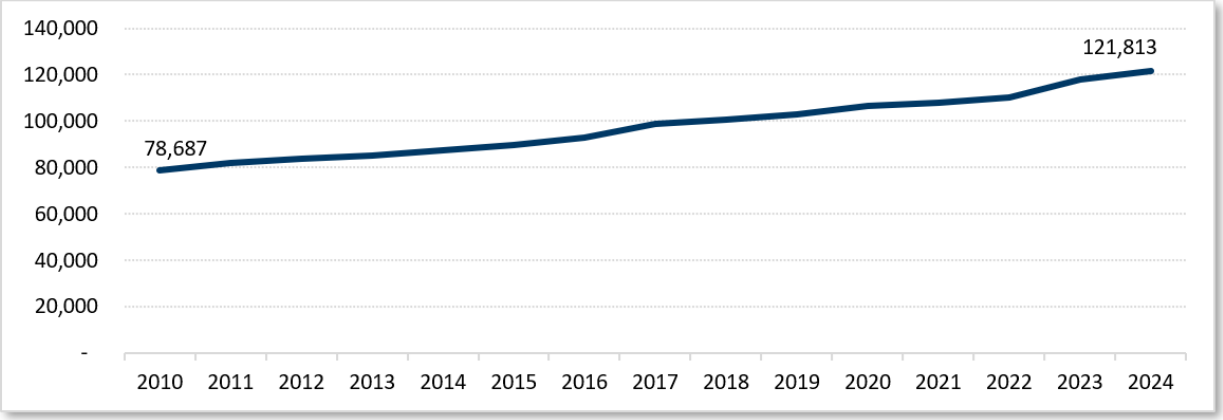


Data source: MDH's analysis of administrative records from the Minnesota health licensing boards, March 2025.

Minnesota's RN Workforce Over Time

The broadest measure of workforce supply is the count of active licensees in a profession. Nurses cannot practice in Minnesota without an active Minnesota license, so the number of active nursing licensees represents the upper limit of supply. Figure 1.2 shows that the number of actively-licensed RNs grew substantially over the last 15 years, both overall and during the 2020-2025 COVID period. Indeed, the rate of growth showed a slight uptick between 2020 and 2023 compared to previous years.

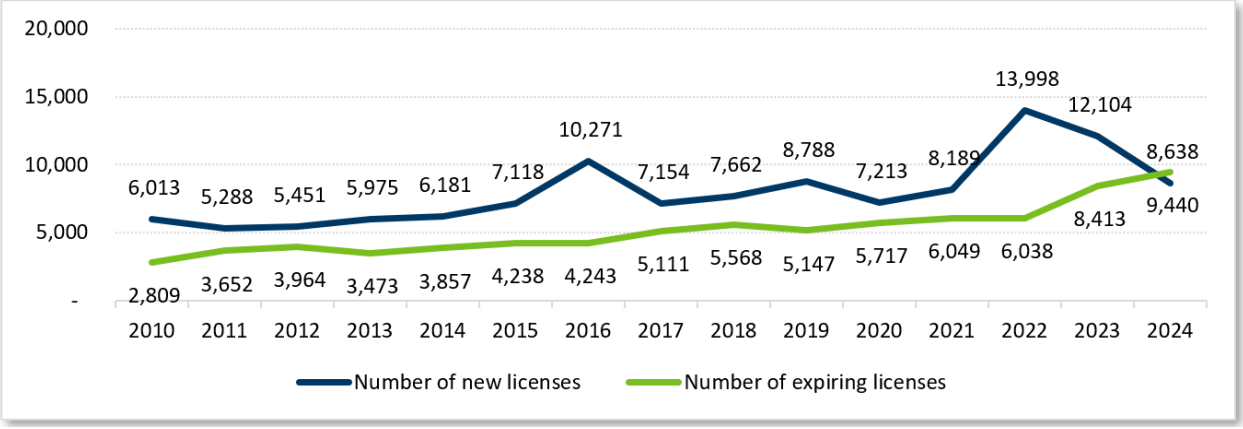
Figure 1.2. Estimated* Number of Active RN Licensees, 2010-2024



Data: MDH's analysis of administrative records from the Minnesota Board of Nursing. *These are not official counts from the licensing board. They are estimates based on a calculation of first licensure date, and may represent a slight over- or under-count of the actual number of licensees. The purpose of this chart is to show a trend over time.

For a deeper look at the inflow and outflow of RNs to the Minnesota labor pool, Figure 1.3 shows the number of new and expired RN licenses over time. There were sharp increases in the number of new licenses in both 2016 and 2022, in both cases due to an influx of traveling nurses obtaining Minnesota licenses as employers prepared for strikes. 2024 is the first year in which RN workforce losses (as measured by the count of expired licenses) outnumbered gains. This is likely the result of traveling nurses leaving the rolls of Minnesota licensees rather than the beginning of a broader trend of workforce decline, but it will be important to watch, nonetheless.

Figure 1.3. Number of new vs. expired RN licenses, 2010-2024



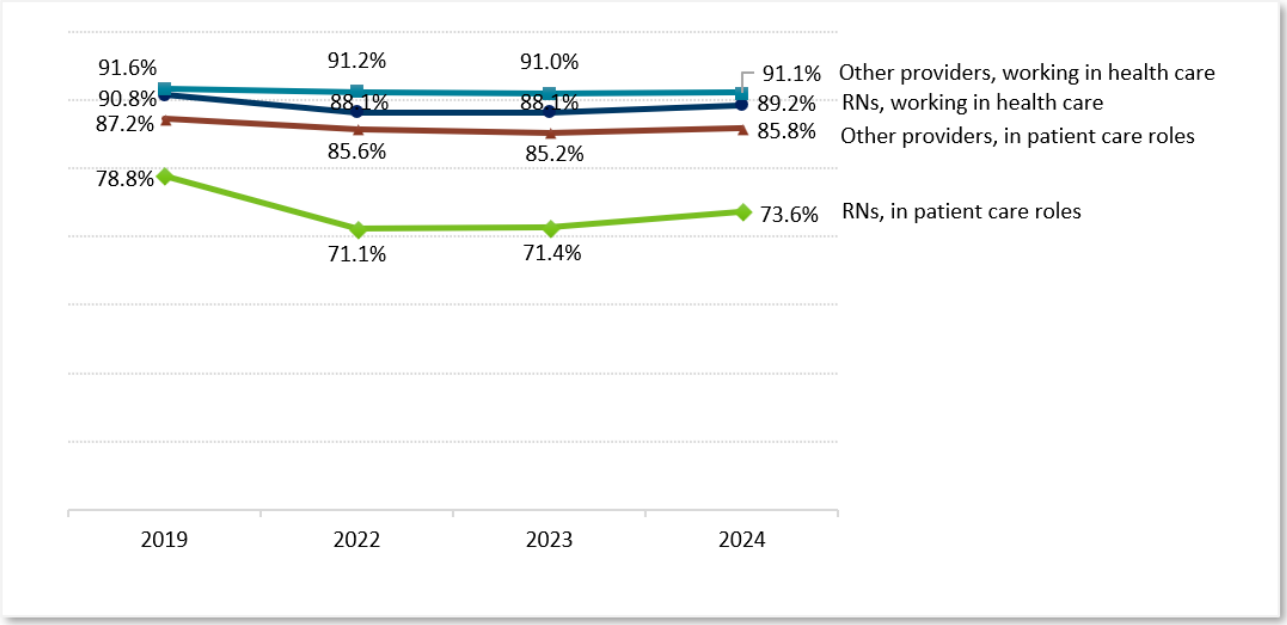
Data: MDH's analysis of administrative records from the Minnesota Board of Nursing. These are estimates based on a calculation of first licensure date. They are not official counts from the licensing boards. Note that the Board of Nursing has no way to identify traveling nurses or separate them from the "regular" supply of nurses in Minnesota.

Counting licensees is the broadest measure of workforce supply, but at all times there is a share of licensees in every profession who opt out of the workforce either temporarily or permanently. Additionally, among those who are working in a position that requires a license, some choose jobs that do not involve patient care; for example, administration, insurance, teaching, research, or others. All else being equal, a net drop in workforce participation and/or in the share of licensees choosing direct patient care positions could signal increased disillusionment, dissatisfaction, or burnout among licensees. Figure 1.4 shows these percentages for RNs and for a comparison group of providers (LPNs, APRNs, physicians, and physician assistants, combined).

Several patterns emerge. First, relative to other providers, licensed RNs are slightly less likely to be participating in the health care workforce than other health care professionals, and this trend predates COVID. In 2019, for example, 90.8% of RNs compared to 91.6% of other providers were working in their respective fields. Second, immediately after the COVID years, the comparison provider group showed a very modest decline (approximately half a percentage point) in workforce participation. The decline for RNs was larger: more than two percentage points between 2019 and 2022. Finally, we see that by 2024, both RNs and other providers had nearly rebounded to pre-COVID levels of workforce participation.

In terms of providers working in patient care positions, however, the picture is more concerning: RNs are far less likely than their counterparts in the comparison group to choose patient care roles. Again, this trend predated COVID, but worsened substantially in the years just after COVID and has only partially rebounded. As of 2024, less than three in four licensed RNs were choosing positions that involved patient care. (Although there is not perfectly comparable national data, evidence suggests that these Minnesota-specific trends mirror what is happening at the national level [see, e.g., Smiley et. al 2025]).

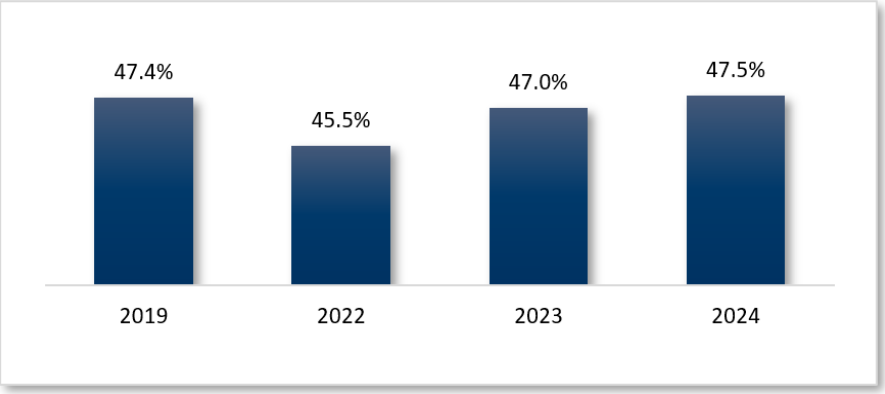
Figure 1.4. Share of licensees working in health care and in patient care roles (RNs versus other providers*, 2019, 2022, 2023, and 2024)



Data source: MDH, Health Care Workforce Surveys, administered in 2019, 2022, 2023, and 2024. The percentages shown here represent the share of providers *out of the total number of active licensees* who are (1) working in a position related to health care and (2) providing patient care, respectively. *"Other providers" includes APRNs, LPNs, physicians, and physician assistants.

There are national-level accounts of nurses' "mass exodus" from hospital bedside care (see, e.g., Adams 2025; Khan 2024). To what extent do we see evidence for this in Minnesota? Figure 1.5 provides a partial answer by showing the share of RNs who provide patient care in hospitals as a share of all Minnesota RNs, from 2019 through 2024. There was a perceptible drop in the total share of RNs who were working at the hospital bedside in 2022, but by 2024, the share had rebounded, even surpassing pre-COVID levels. In short: there is no evidence of a *net loss* in hospital bedside RNs in Minnesota. However, these overall trends shed no light on the considerable churn and transformation of the workforce that has been happening below the surface. We turn to those issues next.

Figure 1.5. RN licensees working in hospital patient care roles (as a share of all actively licensed RNs, 2019, 2022, 2023, and 2024)



Data source: MDH, Health Care Workforce Surveys, administered in 2019, 2022, 2023, and 2024. The percentages shown here represent the share of providers *out of the total number of active licensees* who are working in patient care positions in hospitals.

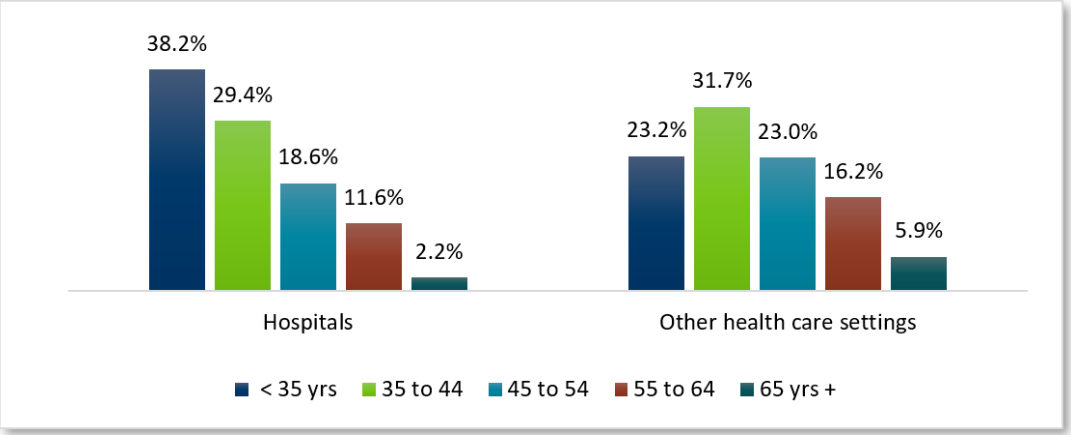
Patient Acuity and Intensity

While the share of RNs providing hospital care is roughly the same as pre-COVID levels, there is both anecdotal and statistical evidence to suggest that work in hospitals is intensifying. Patients often enter hospitals sicker and with more complicated conditions than in the past. In addition, anecdotal accounts suggest that on average, patients are admitted to hospitals with more complex social or psycho-social situations, such as communication challenges, complicated family structures, substance use disorders, and/or mental health problems. Traditional measures of acuity do not account for these factors. Later sections of this report, including a supplementary analysis in Appendix A, provide additional data and insights on patient acuity and intensity.

Minnesota's Hospital Bedside RNs: Demographics and Hours Worked

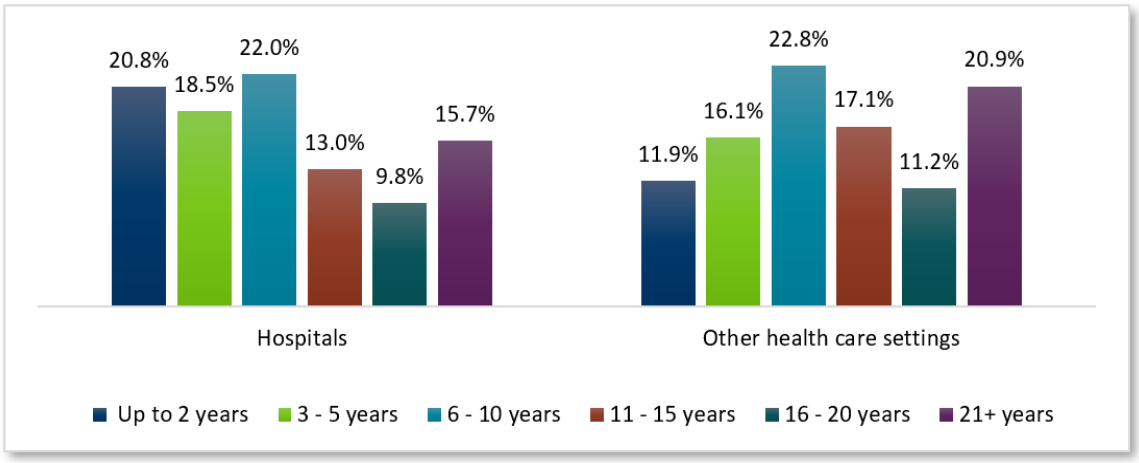
As a group, hospital-based bedside nurses are younger (see Figure 1.7) and have fewer years of nursing experience (see Figure 1.8) than nurses providing patient care in other settings such as ambulatory care and others. Over one in three bedside RNs (38.2%) is below the age of 35, and one in five (23.2%) has less than two years of nursing experience. In hospital settings, in fact, nearly 40 percent of all RNs have less than five years of nursing experience. The trend toward younger hospital bedside nurses accelerated since COVID: hospital bedside nurses are slightly younger now than they were in 2019, when 36.2% were under the age of 35 (2019 data are not shown below). But more concerning is the loss of many experienced RNs from the hospital workforce: in 2019, approximately 20% were age 55 or over, compared to 13.8% in 2024. Consistent with national trends, this indicates that significant numbers of experienced hospital bedside RNs left hospital positions between 2019 and 2024, likely to retire, and have now been replaced largely by early-career nurses.

Figure 1.7. Age of hospital beside RNs versus RNs in other health care settings, 2024



Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only nurses who are providing patient care. "Other health care settings" include ambulatory care settings (such as clinics), long-term care settings, community-based settings, schools, telehealth settings, academic, and others.

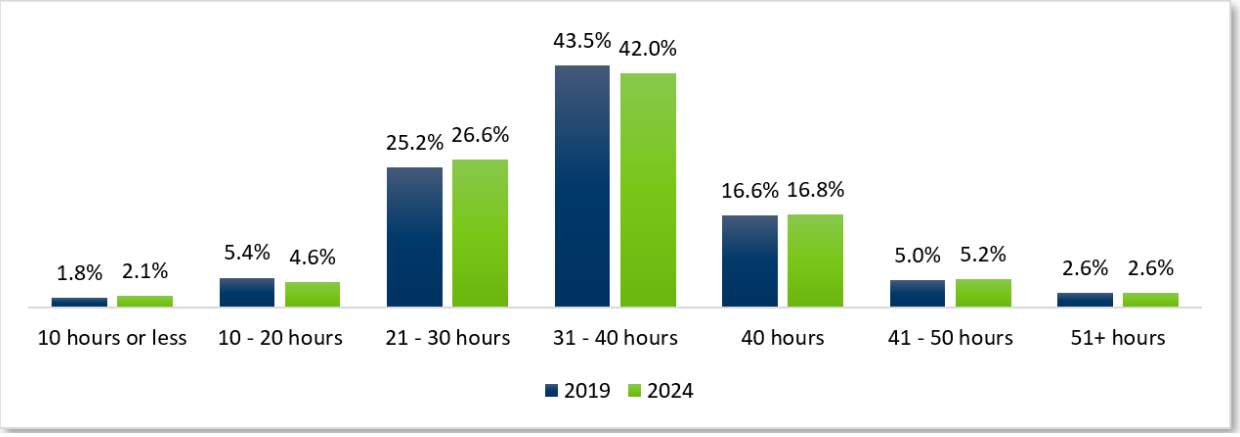
Figure 1.8. Years of nursing experience: Hospital bedside RNs versus RNs in other health care settings, 2024



Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only nurses who are providing patient care. "Other health care settings" include ambulatory care settings (such as clinics), long-term care settings, community-based settings, schools, telehealth settings, academic, and others.

There have been anecdotal reports that hospital bedside nurses are choosing to work fewer hours or reduced schedules in recent years; however, the quantitative evidence does not support this (see Figure 1.9), and instead shows that on average, hospital bedside RNs are working approximately the same number of hours that they were before COVID.

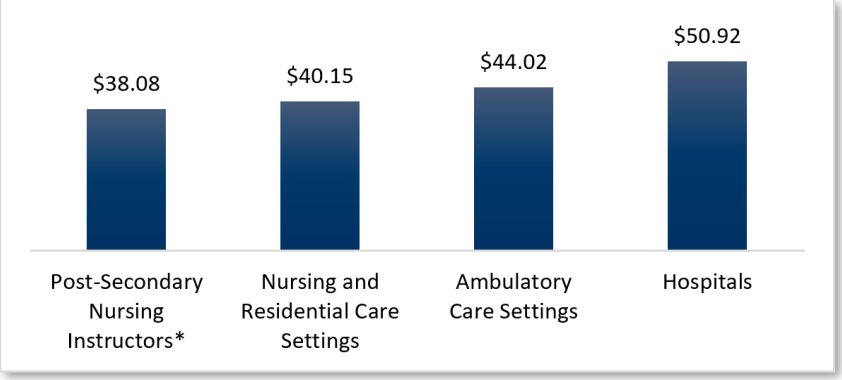
Figure 1.9. Typical weekly hours worked among hospital bedside RNs, 2019 versus 2024



Data source: MDH, Health Care Workforce Survey, 2019 and 2024-2025. The data in this chart include only nurses who are providing patient care. Nurses are asked to report the typical number of hours they work per week including all duties of their job(s). They are instructed to provide an average or estimate if their work schedule varies.

The last piece of background data involves nurses' average pay: Figure 1.10 shows the median hourly wage for Minnesota's RNs by setting and type of work. As these data make clear, Minnesota's RNs who work in hospitals can expect to earn a premium compared to RNs working in all other settings.

Figure 1.10. Median hourly wages for Minnesota's RNs by work setting, 2024



Data source: Minnesota Department of Employment and Economic Development, Occupational Employment and Wages program. *Note that the category of Post-Secondary Nursing Instructors is comprised of both RNs and APRNs.

Section 2: Work Satisfaction Among Bedside RNs

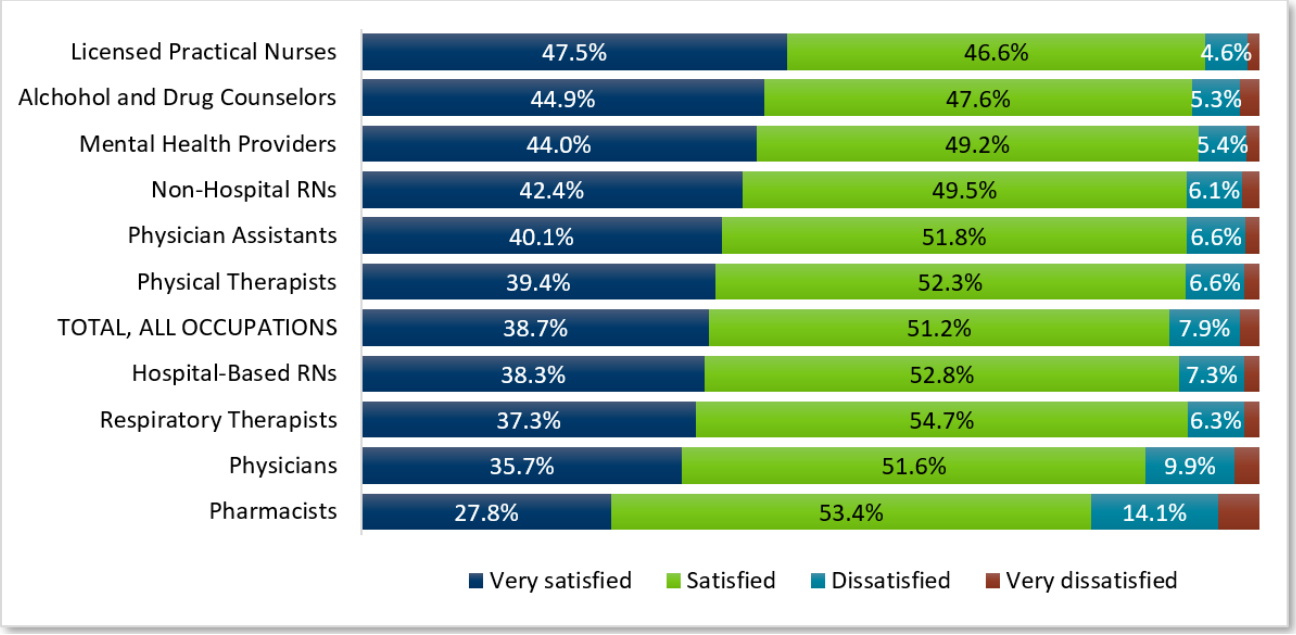
This section turns to bedside RNs' work satisfaction, looking first at the overall picture (how many bedside RNs are dissatisfied? How does this compare to other professions, and has the picture changed since COVID?), then providing deeper insights into what causes dissatisfaction. The findings in this section are based on thousands of hospital bedside RNs' responses to the MDH survey question, "*How satisfied have you been with your career in the last 12 months*?" in both 2019 and 2024.

How Has Work Satisfaction Changed Since COVID?

The next two figures provide a broad look at work satisfaction among ten different groups of licensed health care providers in 2019 (Figure 2.1a) and 2024 (Figure 2.1b). As in the previous section of this report, we use data from 2019 as a comparison point to represent pre-COVID experiences of providers. Taken together, Figures 2.1a and 2.1b offer both good and bad news about the work satisfaction among hospital bedside RNs.
First: it is important to point out that *all* licensed professions, including hospital bedside RNs, report lower levels of work satisfaction in 2024 than in 2019. This suggests that providers across all sectors and occupations are facing greater challenges—or responding to challenges with more difficulty—than they were in 2019. While not the focus of this report, this overall finding is concerning and worthy of further study and attention.
Second: the decline in work satisfaction among bedside RNs is *even greater* than the decline in all other professions. In 2019, nearly 40% of RNs indicated that they were "very satisfied" with their career within the last twelve months. By 2024 that share had dropped to 24%. Likewise, the share of "dissatisfied" or "very dissatisfied" bedside nurses increased from 8.9% in 2019 to 13.8% in 2024. Finally, in both 2019 and 2024, bedside RNs were among the least-satisfied group of providers in Minnesota.

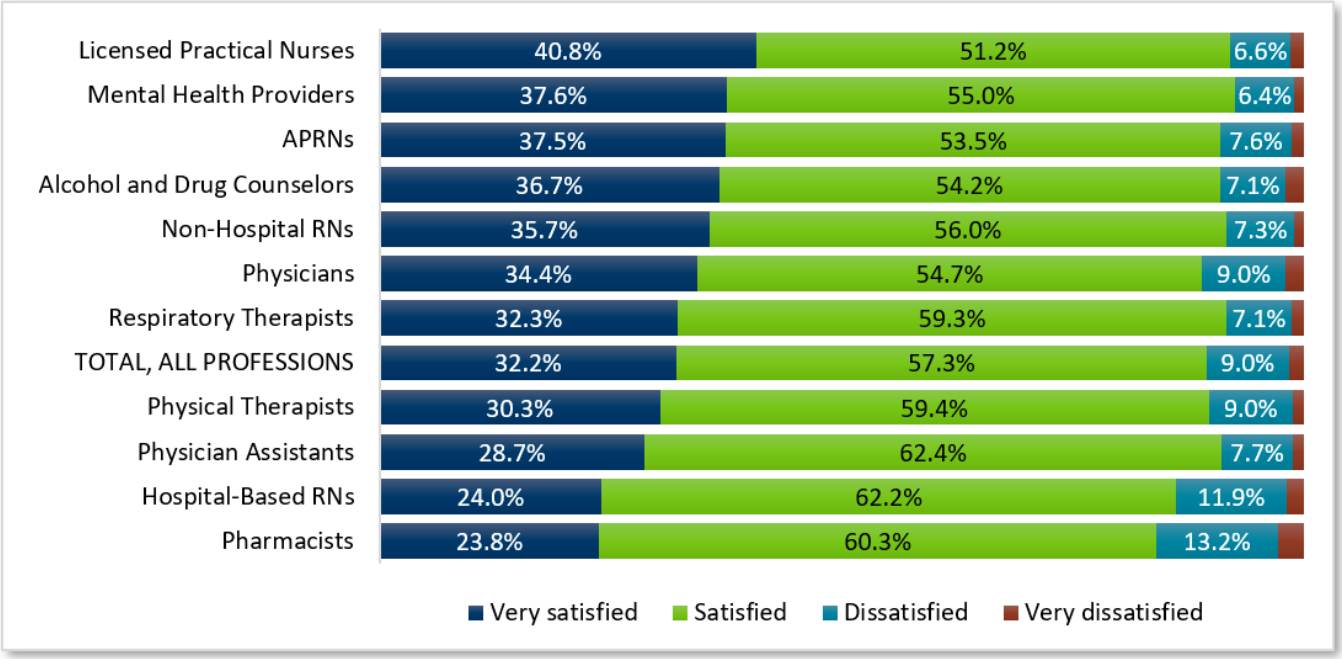
These points notwithstanding, it is important not to overlook the fact that the vast majority of hospital bedside nurses (86.2%) are either "satisfied" or "very satisfied" with their career in 2024—and that even in 2024, more bedside RNs were very satisfied than were dissatisfied or very dissatisfied. This is strong evidence to suggest that many of Minnesota's hospitals are supporting their frontline nursing staff even while weathering demographic, technological, financial, and other changes in the health delivery landscape.

Figure 2.1a. Career satisfaction within the last 12 months, 2019



Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only clinicians who are providing patient care. Providers were asked to respond to the question "*How satisfied have you been with your career in the last 12 months?*"

Figure 2.1b. Career satisfaction within the last 12 months, 2024

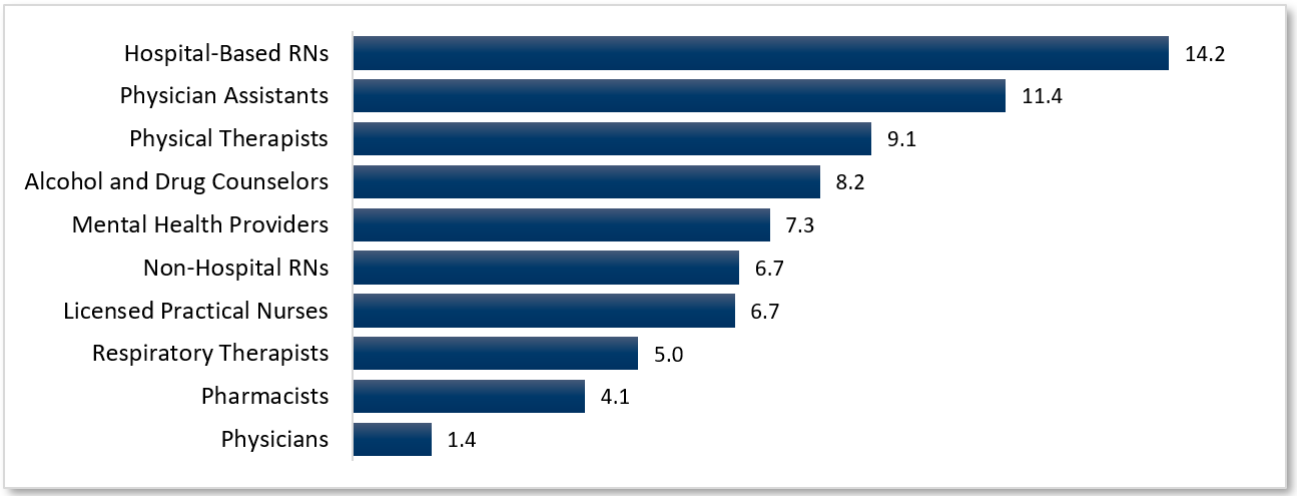


Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only clinicians who are providing patient care. Providers were asked to respond to the question "*How satisfied have you been with your career in the last 12 months?*"

Figure 2.2 highlights the difference in satisfaction levels between 2019 and 2024 for each profession, focusing on the change in the share of providers who indicated that they were "very satisfied" with their career. While all professions experienced a general decline in satisfaction, the data show that the decline has been greatest among hospital bedside RNs. Not only did 14 percentage points fewer indicate that they were very satisfied in

2024 compared to 2019, but the share of those indicating that they were dissatisfied or very dissatisfied increased by almost five percentage points (this last data point is not shown below).

Figure 2.2. Percentage point *decline* in the share of providers reporting that they are "very satisfied" with their career between 2019 and 2024



Data source: MDH, Health Care Workforce Survey, 2024-2025. This chart includes only professionals who are providing patient care.

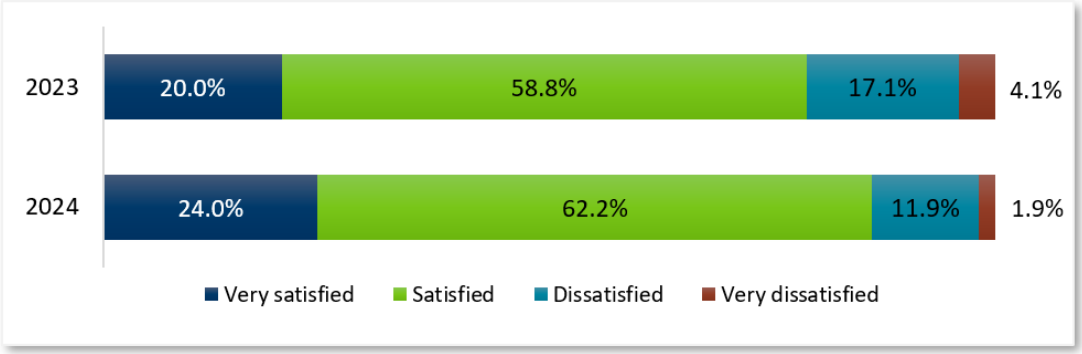
Are Specific Age Groups or Region Driving this Change?

Appendix A provides supplementary analyses about work dissatisfaction. In particular, the tables indicate that work satisfaction among hospital bedside RNs has decreased in all regions of the state and among all age groups; these trends are not being driven by a single system or demographic.

Are We in a Period of Improvement?

Thus far, we have compared satisfaction levels between two time points: 2019 and 2024. However, it is important to note that between 2023 and 2024, the data reveal a marked *improvement* in satisfaction among bedside RNs (see Figure 2.3). In 2023, just 20% of bedside RNs indicated that they were very satisfied, and over 20% (combined) indicated that they were either dissatisfied or very dissatisfied; by 2024 these shares had shifted to reflect more satisfaction and less dissatisfaction. (MDH did not collect comparable data during 2020, 2021, or 2022, so it is not possible to include those comparison points.) This suggests that while 2024 levels of work satisfaction are substantially lower than 2019 levels, we may nevertheless be in the middle of a gradual improvement in work satisfaction. There is additional evidence at both the state and national levels to support the interpretation of a gradual but unmistakable rebound: data from the Minnesota Hospital Association also indicate that hospital job vacancy rates have decreased; and scholarly research indicates that employment levels have rebounded (Auerbach 2024).

Figure 2.3. Career satisfaction within the last 12 months, 2023 vs. 2024, hospital bedside RNs only



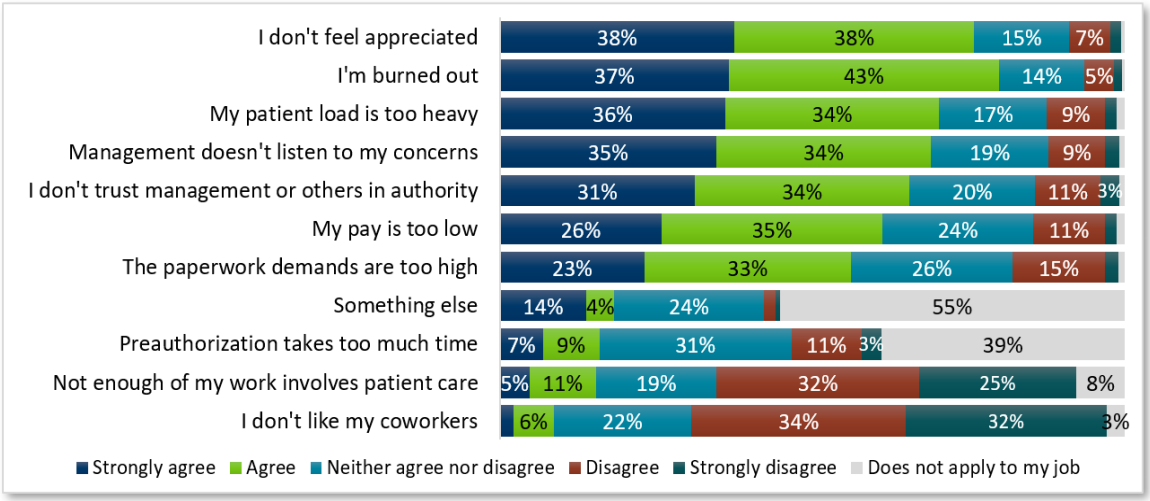
Data source: MDH, Health Care Workforce Survey, 2023; and 2024-2025. The data in this chart include only clinicians who are providing patient care. Nurses were asked to respond to the question "*How satisfied have you been with your career in the last 12 months?*"

Why are Some Nurses Dissatisfied?

In the 2024 MDH survey, the 13.8% of bedside RNs who registered dissatisfaction with their career were asked additional questions about what was contributing to their dissatisfaction. The survey first asked respondents to rate a set of statements using a scale of "strongly agree" to "strongly disagree."

Figure 2.4 displays bedside RNs' responses to these questions, and shows that, among the choices offered, the top four drivers of work dissatisfaction among this group were (1) not feeling appreciated; (2) feeling burned out; (3) feeling that their patient load was too heavy; and (4) feeling that management did not listen to their concerns. Somewhat smaller shares of bedside RNs strongly agreed with the statement "I don't trust management or others in authority"; "my pay is too low"; and "paperwork demands are too high."

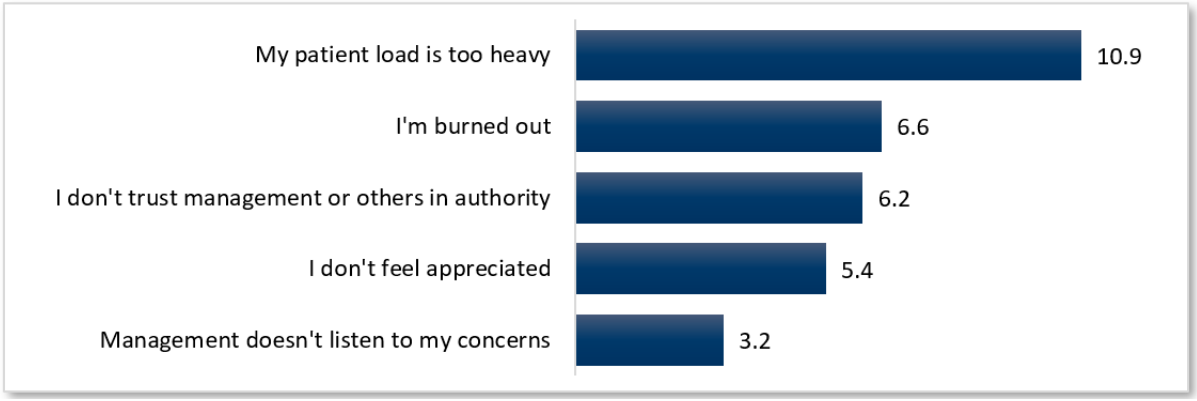
Figure 2.4. "I feel dissatisfied with my work because…" Hospital bedside RNs, 2024



Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only clinicians who are providing patient care. Nurses were asked to respond to the question, *"For policy planning purposes, please tell us more about why you have been experiencing dissatisfaction with your work. How much do you agree with each of the following statements?"* with response options ranging from "strongly agree" to "strongly disagree" and including an option to indicate that the statement did not apply to one's job.

Do hospital RNs differ from non-hospital RNs in what causes their dissatisfaction? Figure 2.5 shows the percentage point difference (between the two groups) of those who "strongly agree" with each statement. The concern that most clearly differentiates hospital bedside RNs from those working in other settings is the perception that their patient loads were too heavy. Hospital bedside RNs were also significantly more likely to strongly agree with statements that reflected feelings of burnout, mistrust of leadership or others in authority, and lack of appreciation. It is worth underscoring the point that while both groups of nurses share many common complaints, hospital bedside RNs generally endorse them more strongly.

Figure 2.5. Differences in percentage of hospital bedside RNs versus non-hospital RNs who "strongly agree" with the following statements



Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only clinicians who are providing patient care. This chart shows the percentage point difference between hospital versus non-hospital RNs in the share of those who strongly agree with each statement.

More Detail on the Causes of Dissatisfaction

The survey respondents who indicated that they were either "dissatisfied" or "very dissatisfied" with their career in the last 12 months or overall were given the option of sharing additional detailed comments about their dissatisfaction. A total of 965 bedside RNs provided usable open-ended responses, which MDH analysts then grouped into common themes. We have provided that supplementary data in Appendix A. The survey responses are very consistent with focus group findings in Section 3, and together the two sets of findings form a clear signal about nurses' concerns.

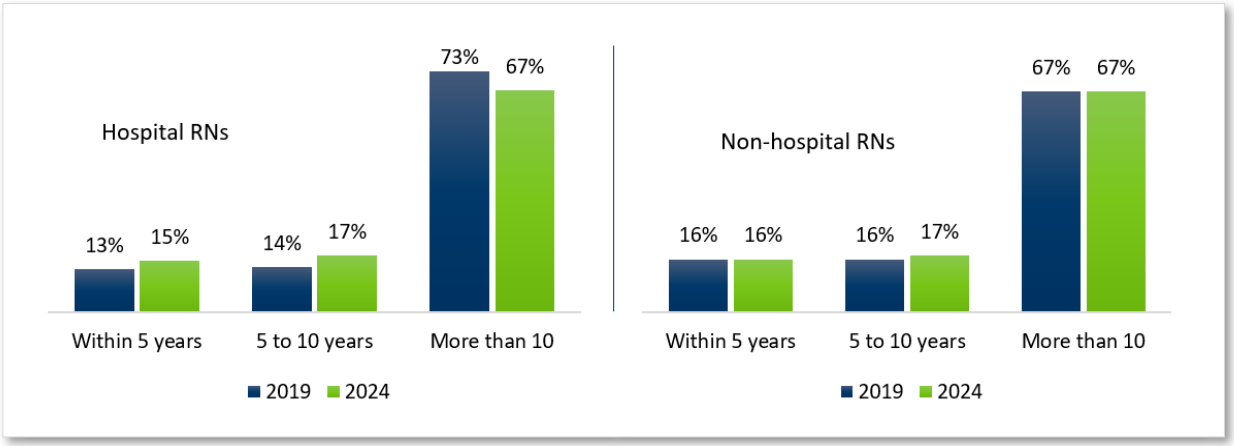
Section 3: Why Do Nurses Leave?

Having examined the work satisfaction of hospital bedside nurses, this section investigates the reasons RNs *plan to leave* or *have left*—either the profession of nursing as a whole, or their specific job working within a hospital. We begin with MDH survey data to quantify the scale of the problem and then delve more deeply into nurses' perspectives based on focus groups with nurses who made the decision to leave hospital bedside nursing within the last two years.

Plans to Leave the Nursing Profession

Figure 3.1 shows nurses' responses to the MDH survey question "how many more years do you plan to work in this profession?" The figure includes data from 2019 and 2024, for both hospital bedside RNs and RNs providing patient care in other settings. The results point to two key findings: First, hospital bedside RNs were less likely than non-hospital RNs to report that they planned to leave their profession within the next five years, both in 2019 and 2024. This is likely due to the fact that hospital nurses are younger, on average, than nurses working in other settings. We discuss this more fully below. Second, among hospital RNs, there was a two percentage point increase (13% to 15%) from 2019 to 2024 in the share who indicated that they planned to leave the nursing profession within five years. That share remained unchanged for non-hospital RNs.

Figure 3.1. How many years do RNs plan to continue working in nursing? Hospital bedside RNs vs. RNs in other settings, 2019 and 2024



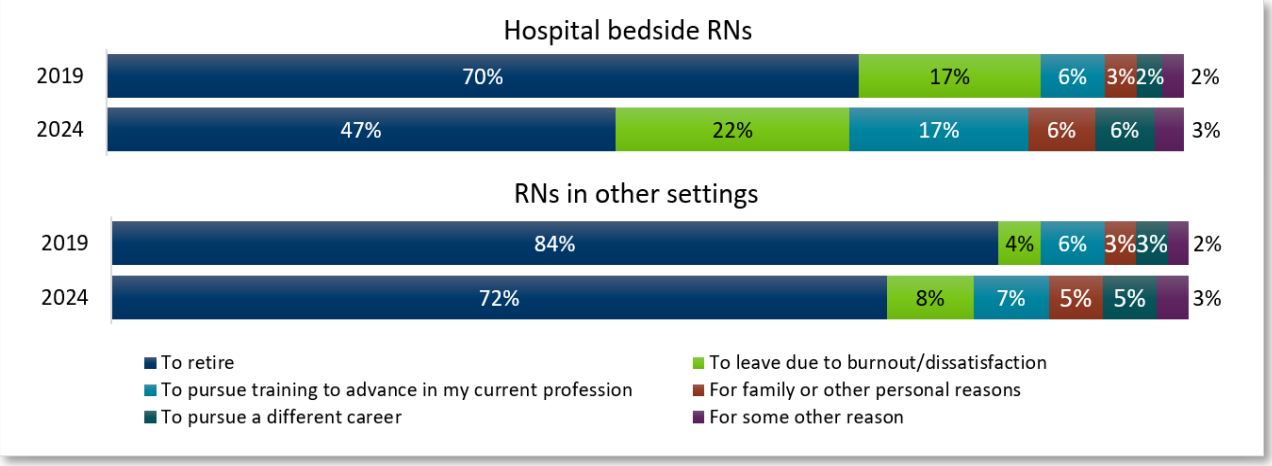
Data source: MDH, Health Care Workforce Survey, 2019 and 2024-2025. The data in this chart include only nurses who are providing patient care. Nurses were asked the question, *"How many more years do you plan to work in this profession?"*

Nurses who indicated that they planned to leave their profession within the next five years were asked to report the main reason they planned to leave by choosing from several survey options. Figure 3.2 presents those findings, again, for the two time points and the two groups of nurses. The findings are concerning.

Among hospital bedside RNs who planned to leave nursing, retirement was the key reason in 2019. By 2024, however, retirement accounted for *less than half* of the planned exits from the profession, and burnout accounted for 22% of planned exits (compared to 17% in 2019). Other reasons—pursuing education, a different career, or family or personal reasons—were all more commonly reported in 2024 than in 2019. Hospital bedside nurses are unique in this regard. For nurses working in other settings, it is clear that burnout and other factors have also become more common, but the overall share of nurses exiting their career for reasons other than

retirement has remained fairly modest. In short: in 2024, non-retirement career planned departures accounted for 53% of hospital-based RNs exits, but just 28% of exits for RNs in other settings.

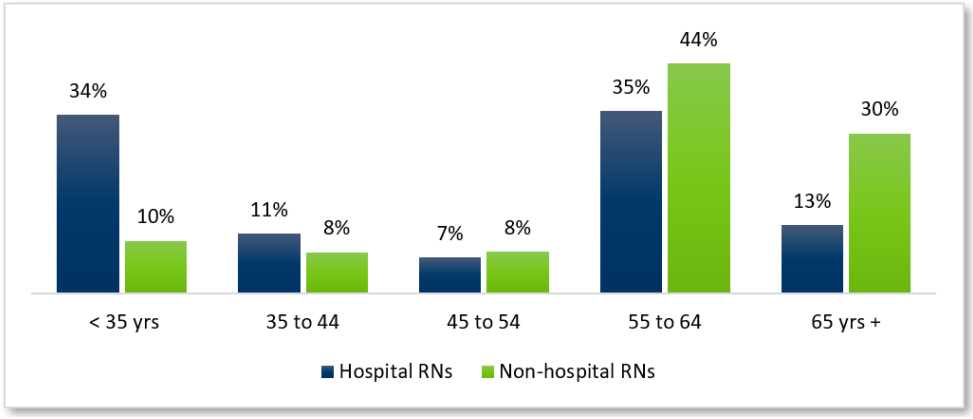
Figure 3.2. "What is the main reason you plan to leave your profession within five years?" Hospital bedside RNs vs. RNs in other settings, 2019 and 2024



Data source: MDH, Health Care Workforce Survey, 2019 and 2024-2025. The data in this chart include only nurses who are providing patient care.

We know that hospital RNs are younger on average than non-hospital RNs (see Figure 1.7), so it is important to investigate whether age plays a role in these differences. Among nurses who plan to leave the profession, are hospital RNs younger than non-hospital RNs? The answer is yes. The data in Figure 3.3 shows that among hospital bedside nurses, 34% of those who plan to leave the profession are younger than 35, compared to 10% of non-hospital nurses. Stated another way, among the youngest age cohort *hospital RNs are more than three times as likely as non-hospital RNs to plan to leave the nursing profession within five years.* Combining the two youngest groups, nearly half—45%—of all hospital RNs who plan to leave the nursing profession are under the age of 44. **This represents approximately 4.5% of the entire RN workforce providing patient care**—just over 4,400 RNs. To put this loss in perspective, this is a few hundred more than the total number of all graduates from Minnesota nursing programs in 2024.

Figure 3.3. Age distribution of nurses who plan to leave their profession within five years (Hospital vs. Non-hospital RNs, 2024)

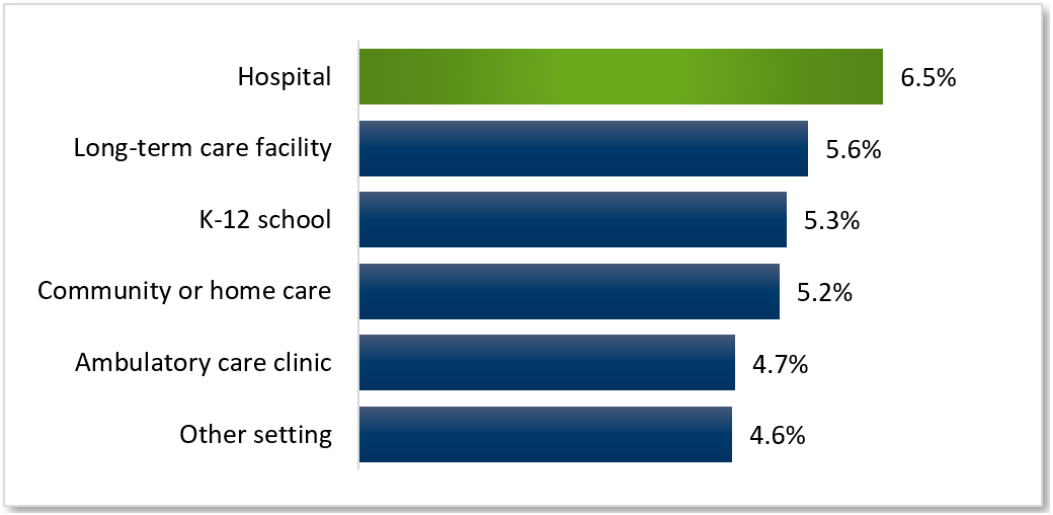


Data source: MDH, Health Care Workforce Survey, 2019 and 2024-2025. The data in this chart include only nurses who are providing patient care.

Nurses' Plans to Leave their Current Job

This section narrows the focus to RNs who said that they planned to leave not the nursing profession as a whole, but rather their *current job*. Figure 3.4 shows the share of RNs who indicated that they "very likely or definitely" planned to leave their current job within the next six months. Hospital RNs were slightly more likely than RNs in any other setting to report that they planned to leave their job. This question did not ask respondents to specify where they planned to work, so it is impossible to know whether this 6.5% planned to seek work in another hospital; another setting; or to leave nursing altogether.

Figure 3.4. Share of RNs who say they plan to leave their current job within the next six months, by setting

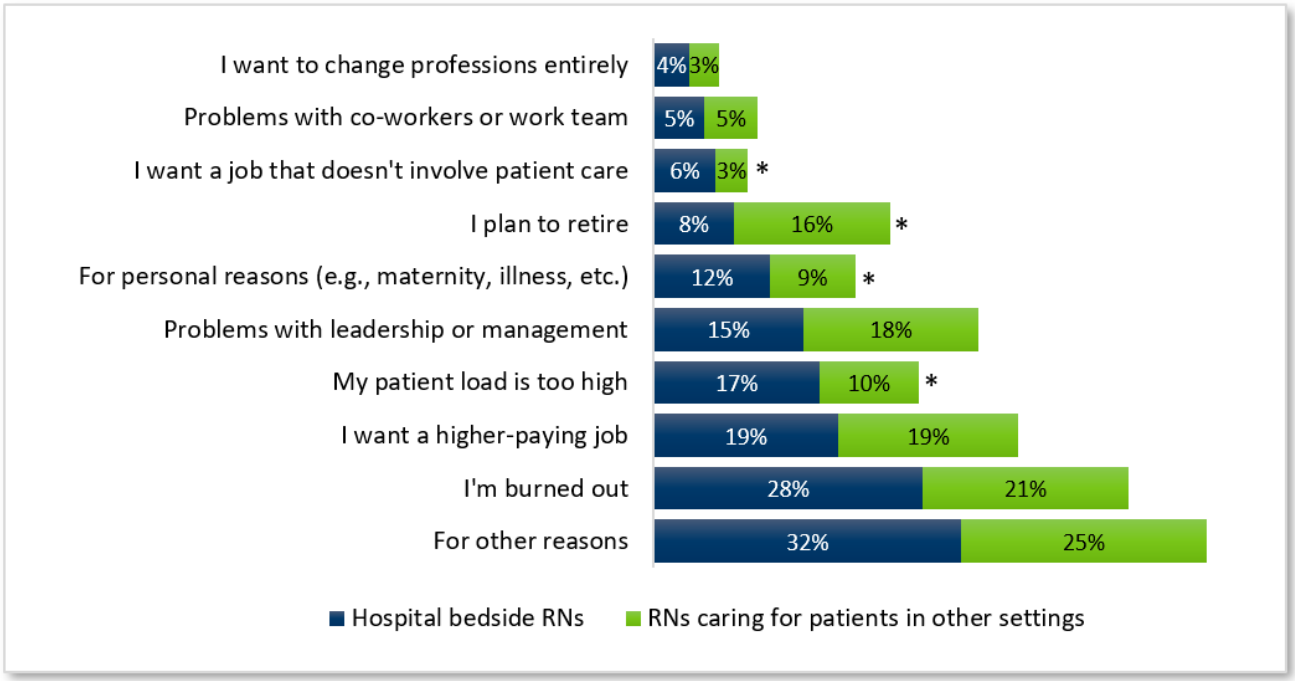


Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only nurses who are providing patient care.

Nurses who responded that they "very likely or definitely" or "maybe" planned to leave their current job were then asked to share their reason(s) for considering leaving, with the option to check all reasons that applied to them. Figure 3.5 displays the results for both hospital and non-hospital RNs. Consistent with the results in Figure 3.2, hospital RNs were less likely to report retirement as a reason for leaving, and more likely to report that (1) they wanted a job that didn't involve patient care; (2) their patient load was too high; (3) they were burned out; or (4) personal or "other" reasons. Indeed, non-hospital RNs were twice as likely to report retirement, and hospital RNs were seven percentage points more likely to report a high patient load as their reason for leaving.

Large shares of both groups of nurses (32% of hospital RNs and 25% of RNs working in other settings) selected "other" as a reason. When they did so, they were given the opportunity to provide more detail in an open-ended response. MDH analysts reviewed those responses and coded them into categories (see Table 3.1). The most common "other" response for hospital bedside RNs was that the position in which they were currently working was a travel or contract position which was ending. Other common responses included: seeking a position with a shorter commute (or preparing to move themselves); to earn a higher degree or to seek a position that was consistent with a degree that they had recently earned; to take a different job in a different area of nursing; or to seek a job with a different schedule. This could include finding a job with fewer hours, with only certain types of shifts (commonly weekdays), or in some cases, jobs that required more hours. Non-hospital nurses also frequently mentioned these reasons for opting to leave their current position.

Figure 3.5. Reasons RNs plan to leave their jobs within six months (Hospital vs. Non-hospital RNs)



Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only nurses who are providing patient care. *Hospital vs. non-hospital RN differences are statistically significant at p <.05.

Table 3.1: "Other" reasons for leaving current job within six months

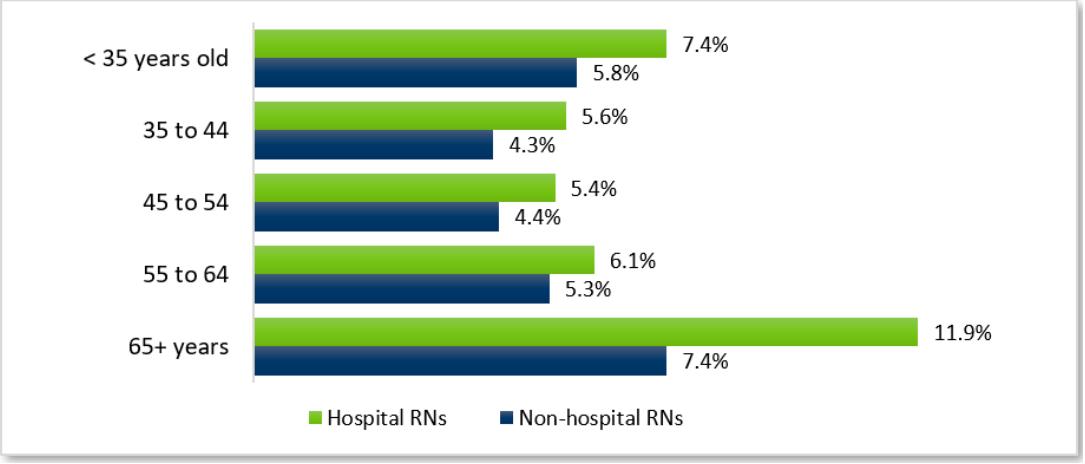
Reason	Hospital	Non-Hospital
To leave a temporary (travel) position, or to start a new one	26%	9%
Moving or seeking a position with shorter commute	16%	16%
To earn a higher degree, or to seek a position consistent with a higher degree	15%	13%
To take a different job or to try a different type of nursing	10%	14%
To take a job with hours that were a better fit for one's lifestyle	10%	10%
A perceived problem with the organizational culture or management	7%	6%
Seeking a challenge/to use skills in different ways	4%	10%
Violence/mistreatment from patients	2%	1%
For personal reasons (e.g., injury, illness, family reasons)	2%	2%
For better pay or benefits	1%	4%
Some other reason	7%	15%
Total, all "Other" responses	100%	100%

Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only nurses who are providing patient care.

Finally, Figure 3.6 provides a look into which age groups are most likely to plan to leave their current nursing position. This helps us to understand the extent to which hospital turnover is simply a function of the large share of early-career nurses working in hospitals. Two patterns emerge here. First, the two groups most likely to report that they planned to leave were the youngest and oldest cohorts, both among hospital- and non-hospital RNs. Among hospital RNs, 7.4% of the youngest group and 11.9% of the oldest group reported that they very

likely or definitely intended to leave their current job (and the same pattern, though less pronounced, is true of non-hospital nurses). The second key finding, however, is that across *all* age groups, hospital RNs were most likely to have reported that they planned to leave their current job within the next six months. This makes clear that hospital nurses are more likely to leave their job *regardless* of age.

Figure 3.6. Nurses who reported that they "very likely or definitely" planned to leave their current position within six months, by age group, 2024



Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only nurses who are providing patient care.

In Nurses' Own Words: Why They Left the Hospital Bedside

Having reviewed the broad statistical findings on nurses' plans to leave either the profession as a whole or their current position, we turn now to results based on small group discussions with nurses. During the spring of 2024, MDH analysts conducted six focus groups with a total of 16 participants. Participants represented a variety of age groups and experience levels; they came from different parts of the state and had worked in different hospital systems and settings. They shared a key characteristic: each had, within the last two years, made the decision to leave hospital bedside nursing. Complete methodological details on the focus groups, including participant selection, protocol design, and data analysis (in nVivo version 15) are provided in in Appendix B.

In addition to the focus groups, MDH analysts convened an expert panel of five nurses who met a total of four times to provide additional feedback on the focus group study design, analysis, findings, and interpretations. Expert panels are an important way to gain critical real-world context around a particular research topic; they provide a place to ask questions and correct any misunderstandings. They are also an important way to include the voices of those who are most likely to be affected by the research. The expert panel for this study was comprised of five RNs with a wide range of professional experiences as well as geographic and ethnic backgrounds. Appendix B provides additional details on the selection and contributions of this panel.

The aim of the conversations with focus groups and the nursing expert panel was to understand in greater specificity nurses' reasons for leaving hospital settings. "Burnout," "lack of appreciation," and other survey responses are very broad and not particularly actionable. It was critical to go beyond these broad sentiments in order to offer more specific solutions. It is important to establish at the outset that the intent of this qualitative research was not to generalize the experiences of the participants to all hospital bedside nurses; rather, it was to shed light on the intricacies and nuances of decision-making in a way that the statistical data in this report cannot.

It was also a way to ensure that we heard from nurses who actually *left* bedside nursing, as opposed to those who reported that they planned to leave.

In sharing their reasons for leaving hospital bedside nursing, focus group participants were prompted to think about both "push" factors—that is, conditions or characteristics in their hospital positions that they wanted to leave, as well as "pull" factors—conditions or characteristics in a new position or situation that attracted them to it. Pull factors might have included personal or lifestyle reasons such as commute time, family considerations, or others. It became clear during the discussions that for these 16 participants, push factors far outweighed pull factors. These nurses were primarily motivated to leave hospitals due to perceived problems or challenges they faced there, not because they felt especially drawn to different work or to leave for personal or family reasons.

Common themes emerged across all six groups. What follows is a summary of those themes, along with quotes that illustrate each. For more details on how MDH analysts identified and coded these themes, see Appendix B. In addition, Appendix A offers a supplementary analysis based on 965 open-ended comments from nurses who reported that they were dissatisfied with their work, in part as a way to reinforce the focus group findings which are based on a small number of respondents. The survey results corroborate the focus group findings and indicate that the problems identified during the focus group conversations, while not necessarily representative of all nurses, are not isolated to just a handful, either.

Issues Related to Staffing

The first theme to emerge during the discussions related broadly to **staffing** issues. Staffing involved four distinct sub-topics: perceptions of heavy workloads, inadequate training, high levels of stress, and lack of work-life balance (see Table 3.2a). Though conceptually different, these four themes were often discussed in combination. For example, when nurses talked about heavy workloads, they might also mention feeling stressed about patient outcomes or the inability to find work-life balance. Table 3.2a provides more details on each theme, as well as quotes from nurses to represent the specific ways in which each theme was discussed.

Workload problems typically involved three challenges: (1) nurses felt they were assigned too many patients; (2) patients often had high acuity levels; and (3) the higher/more acute patient load also sometimes came with increased administrative demands. For some focus group participants, the combination made the work untenable. Some nurses commented that their hospitals did not take into account acuity levels when assigning patients, which meant that a nurse could be in the position of trying to balance too many patients with complex medical needs or complicated circumstances. As one nurse put it, "we have a staffing grid…[but] they don't go by the acuity of the patients…if you're in a bed, you count as one." Another said, "[I was] always working double-time…working bigger caseloads, higher acuity, [with] less people." Nurses expressed the opinion that these conditions had changed over time. As one nurse said, "the initial piece that I loved. I loved taking care of the patients. It wasn't short-staffed. If you needed help, you could get help."

Also related to staffing, focus group participants frequently commented on **inadequate training**. This could refer to (1) inadequate onboarding or orientation to a new hospital; (2) inadequate orientation to a new hospital unit or floor (for any nurse, but particularly for new nurses); or (3) inadequate clinical training in general. Nurses discussed feeling uncomfortable being in situations where they could not locate critical supplies to help patients in emergencies. One nurse mentioned that she worked across different units within her hospital but was given "zero orientation" to new units, saying, "We would just be expected to go to different floors and show up and take care of patients." Another nurse said she felt it would be important to have "more guidance around new grad nurses coming into facilities. [R]equired minimum orientations for people would be a recommendation I would have…I didn't feel like I was ready, but luckily I had some great mentors on my specific unit and we had sort of that guaranteed orientation program so I felt like I was going to have a long time to feel comfortable."

Table 3.2a. Focus Group Findings: Staffing Problems

Workload Themes	
Workload was too high due to one or more factors: • Too many patients assigned • Higher patient acuity • Increased administrative demands	*And I have to say the patients back when I started were not as sick as they are today. You know, patients didn't live as long with multiple comorbidities.... But now they have a [heart attack], it's probably their third. The whole different level of care that those patients need, and I feel like they've taken away staff…to take care of these sicker and sicker patients.* *So, we're working at higher capacity. You know, higher workloads and then they're adding in extra things like, "Oh well, you know, this update is only an extra click of the button." Okay, but you do 100 clicks of the button every, you know, you add in an extra one every two weeks. All of a sudden, I'm drowning in documentation while trying to do patient care, while running short-staffed.*
Training Themes	
Inadequate training to be able to perform in a given nursing role or situation: • Inadequate onboarding to a new hospital • Inadequate orientation to a new floor or unit • Inadequate nursing clinical training	*"What if that patient eventually did code? I don't know where the supplies are. I don't know the codes to the machines in the patient's room to unlock basic things like flush syringes, gauze, things like that. Everything just takes longer when you're not familiar with the unit. So a seasoned nurse could probably get through their rounds very quickly because they know where everything is, [but it's] going to take a float nurse at least probably twice as long."* *It depends on who you landed with that day. Sometimes it was nurses who weren't expecting to precept students and were very surprised by it and were like, "Oh, great, I'm really busy today. I need you to just be out of the way." Which wasn't their fault either. But that would…be a waste of your time. A whole clinical day is just, ok, well, I'm not gonna get taught today. I just need to stay out of the way.*
Stress Themes	
High stress and the fear of negative outcomes: • Not being able to provide safe or quality care • Poor patient outcomes leading to negative career outcomes	*I was so afraid that I was going to lose my [nursing] license because they kept cutting corners, kept pushing us. You can't do that, not in surgery, not in any floor, maternity, ICU, ER. You can't. You need the time to spend with your patient because unless you get a full assessment, you don't know what you're dealing with.* *And we can't do our job the way we used to and go home feeling like I made a difference. Now we go home and we're like, well, I didn't get hit. I forgot to do this. I forgot to do that. I didn't get to this. I discharged that patient, but I really didn't say much to the parents. I don't feel like I was really a good nurse.*
Work-Life Balance Themes	
Problems with work-life balance: • Working too many hours • Working a schedule that lacked needed flexibility • Not being able to take earned time off (PTO)	*Scheduling in general became a problem…because if you ever needed to try to switch a day, it was virtually impossible. If you were not the senior nurse, you were not getting time off...If you wanted a vacation, even if you planned it a year ahead of time, you were not promised that time off. Ever. So, it's like you could never feel secure about your time off. I worked for [the same hospital] my whole life and so I get eight or ten weeks of vacation a year. Even so, you could never use your vacation…you could never get time off.* *I got really burnt out, just really exhausted and I feel like if there was more support, but there just wasn't anybody...I don't think that they considered what they put their staff through. Just the amount of hours we were working and then we felt guilty if we didn't pick up shifts because then, our coworkers were drowning. And if you have a heart in that field, it's really tough. That was really hard for me and that's kind of what drove me away from that role because the hours are just too unpredictable. I wasn't prioritizing my family anymore at that point.*

Nurses also discussed themes related to **stress and worry over negative outcomes**, both for themselves and their patients. Concerns for themselves generally centered around professional sanctions (such as losing a nursing license). For example, as one nurse said, "in the back of my mind I have a license and if something happens and I screw up something and I lose my license, I could lose my home. I could lose everything I have for my family. I carry all the insurance. I carry everything....I could lose our entire life." Concerns for patients were expressed as concern over missing something important or being too busy to take care of needs that seemed basic. For example, one nurse described a situation in which she was temporarily working on a different floor and couldn't find an oxygen mask that a patient needed. "The facemasks were gone that I was supposed to put on that patient. At that point, I'm in a panic, right? You have a patient, his oxygen stats are falling, but there's no equipment in the room. I don't even know where the storage room is…it's not like a crisis but you feel like it's a crisis and your patient is not doing well and it's just not safe because how long until that patient codes, right?"

The final topic to emerge under the issue of staffing involved **work-life balance**. Some nurses in the focus groups mentioned having to work too many hours, having a schedule that lacked flexibility, and/or not being able to take any earned time off. Some nurses expressed the frustration that they were not able to take vacation or days off even if they requested them well in advance. Others mentioned inflexibility in scheduling, and the perception that it was impossible to get a day off or trade shifts with another nurse once committing to a particular shift. One nurse admitted that for her, the lack of work-life balance ultimately drove her away from her work in a hospital. "You could never get time off. You could never get time away," she said, mentioning that nurses in her unit were expected to be on call 50% of the time. "So two nights a week, every other weekend, and then when we became short or when they wanted to staff differently. We couldn't get out of taking call."

Issues Related to Work Culture

The second key theme to emerge during the focus groups involved multi-faceted issues around **work culture**. Culture problems included four interconnected but distinct issues: difficult patient behaviors; problematic behaviors from other nurses or other staff; ineffective management; and perceptions of an unhealthy culture at the broad organizational level. Just as with themes discussed above related to staffing, these four topics were sometimes described together and other times were mentioned as unique, standalone problems. Table 3.2b summarizes the four themes and provides quotes to illustrate each.

The first theme was related to **behaviors from patients** (and occasionally, patients' families). Focus group participants mentioned both physical violence as well as verbal mistreatment, including threats, discrimination, or simply expectations that they regarded as unreasonable. One nurse reported, "I've been punched, kicked, tried to be stabbed, and nothing happens from it. We've actually tried to press charges against them, but the hospital says we're not pressing or the cops won't do anything because they'll say, well, they're in the ER." Another said, "We were told that we couldn't have security in our building…I know three nurses in the three years…that had career-ending injuries. They come into the ER and you can't turn people away…You know that they have hurt people in the past and you can't do anything."

Frequently during conversations about violence, nurses voiced the perception that there were no effective policies in place to prevent it and/or no recourse for nurses who had experienced it. As one nurse put it, "they don't care about your safety…to put a little plaque on the doorway as you're walking in, you know, 'bans guns'. Who cares? That doesn't do anything." Similarly, another nurse said, "I think the sad thing is that, I've heard from so many other nurses [and] from previous co-workers that like, oh yeah, this is part of the job. It happens all the time. Just yesterday I had my [butt] grabbed. Or, you know, I was called this or that or whistled at or, you know, that was just an expectation that this is part of what you deal with. And there was no real support."

Table 3.2b. Focus Group Findings: Work Culture Problems

Patients	
Difficult patient behaviors: • Physical violence • General mistreatment such as verbal threats, discrimination, disrespect, or unreasonable expectations	*There was also a lot of violence towards nurses at that point, in that ER. And then I got pregnant and had a baby, and I was on maternity leave. And was like I can't go back to that ER, like I now have a baby, and I don't want to put myself in that type of position specifically with the violence.* *There's a shortage of nurses—nurses that are willing to work in the conditions that are such right now...I still have my license, I'm active... I could be working but then I could have a head injury, or I could die. I'd rather be retired.*
Colleagues	
Difficult behaviors from nurses or other staff: • Bullying, disrespect, or intentional lack of support	*That makes it hard for me is when I come across some mean people and then to have coworkers, my own coworkers, not be supportive, and not just towards me, but when I hear them have nicknames for all my other coworkers 'cause that's their group. [Like] they're in high school and it's cool to create nicknames for people. That bullying environment is not for me. It's too negative. And the problem is with some of the cultural bullying being acceptable, is because there was nobody to work for them, so they had to just take everybody.* *They would bully the traveling nurses, and I mean it is cliquey and they were mean, and they would just pick people apart and chew them alive for no good reason and so that's a huge problem. And I think it's systemic.*
Management	
Ineffective management including: • Lack of action, or action that did not solve the problem • Lack of support or appreciation	*If you were to ask management for something, they'd have to ask somebody else or ask somebody else or ask somebody else. So, you didn't get any direct change. They couldn't make a decision on their own anymore.* *Then, as I moved to different areas, management often became an issue. It was constantly turning over. We would have new nurse managers probably every year or two. So, they wouldn't know the workload, they wouldn't know the workflow, they wouldn't know how to help you when you needed help. Even when you would bring problems to them, they wouldn't really problem solve with you. Often times the manager roles would be left vacant and so then you might be reporting to some other manager….and those people don't know [anything]. So if there were issues, nothing would ever get accomplished or solved. We would be working short. We would be working without a proper equipment. It was very unsafe, a lot of the times.*
Organization	
Unhealthy organizational culture, including: • The perception that decision-making does not prioritize nurses' concerns • Lack of genuine respect or appreciation for the work nurses do	*A lot of the things that we do are based on what money we're bringing in at the end of the day. Like we can't be doing this because it doesn't profit us and even make sure you chart every bathroom break because charting that you were in the patient's room brings us more profit. And like, oh gosh, Like I have to chart that they walk 20 feet like every time. Like, that's one more thing on top of it.* *I know that there are [patients] that 30 years ago…they probably don't remember my name, but they remember me. And I don't think [the organization] gives a crap about that anymore, because as long as a patient is ok, and as long as they make their money, they don't care that I had the time to be able to talk to them. Which nurses do not have now, because it's too busy and you're running from one pump to the next and trying to make sure that people just stay alive. And that's the biggest thing that I see is, is that corporate doesn't care.*

The second culture-related topic to arise was nurses' concerns about **mistreatment from other staff**, with severity levels ranging from subtly unwelcoming attitudes, to incivility, to bullying. As one nurse put it, "You have to be tough. These people eat you alive, chew you up, spit you back out. They chew you up just for funsies. You know, and it sucks. But why does it have to be that way? And that is what pushed me away from the hospital setting, in a nutshell." Many other focus group participants, representing different genders and hospital floors, offered similar comments. Several nurses mentioned feeling targeted by other members of their team, or being aware of name-calling, or witnessing other nurses being deliberately unsupportive or unhelpful.

An important point about nurse-on-nurse mistreatment was the evidence of clear *positive* effects that a strong team culture could have. Several comments indicated that well-functioning teams could provide a strong buffer against turnover. For example, speaking about her work team, one nurse said, "If it had stayed how it was…we were like a little family, we got along great. It was fun. We got the work done. I felt like we were a really good team. We really helped each other out. If it would have stayed like that, I would have absolutely stayed working there." Speaking about the level of intensity in hospital-based care, another nurse commented, "It's like, how long can you withstand that level of high intensity care and, you know, potentially toxic workplace? One of my friends works in the ED and she's got a great group of people and she still works the night shift. [S]he says she stays because of her coworkers. Like, that's why she goes to her job."

The third general topic to arise around workplace culture was **ineffective management**. Participants described ineffectiveness in two general ways: (1) a lack of action, or action that simply did not solve a problem; or (2) lack of support or appreciation. Several nurses described their managers as lacking preparation or competence. For example, as one nurse put it, "I went to my manager. All the time, and things are just getting worse and worse and worse...she didn't want to get involved." Another nurse commented that "we mostly saw outside people coming from other institutions or from other departments that wouldn't have the background or unit knowledge, right? They would bring in people who…they didn't usually have experience within the unit that they were coming to and most of the time they were not from within the institution." Many comments centered on the concern that, even after going to a manager to help with a problem, nothing changed. One nurse said that after a particular incident, he was told to complete an incident report. "I did write reports," he said. "Nothing would happen."

Lack of support or appreciation was a strong theme as well. As one nurse articulated the problem, "A lot of times when I would come in…my manager would be gone for the day. So, you don't even have that contact. It would be nice even to get an e-mail. Or she could stick around and then just, you know, every once in a while, say…you know, it looks like you had a really busy night last night. Thank you for all you did and you guys got it through and I really appreciate your strength as a charge nurse and things like that. But no, we just would get told we had so many falls, so many pressure injuries, all of those reportable things…so it was all like the negative feedback that we would get and not a lot of positive." As another nurse who had left her job after 38 years put it, "I don't want like a placard. I just want someone to say 'we really appreciate your dedication to this job for so long, you know, and we couldn't have done it without you.'"

As was the case with strong teams, ample focus group comments indicated the strong buffering effects of a good manager. As one nurse described, before things changed, "I had loved my job. Our unit was really unique. We had such a great leadership team when it when I first was there. You could go in. You could explain what you needed. You could say you know, I just had a baby. I need to cut down my FTE and they would just do it. So it was like really a family community based. Nobody left. If you had a position on there, it was like, how did you get it? And people stayed forever. I mean, there was no, there was no turnover in our staff."

The final theme related to culture was **organizational culture**. Many of the comments reflected the perception that hospitals, as organizations as a whole, do not prioritize nurses' concerns over the goal of making money

and/or that they do not appreciate the work that nurses do. Once again, focus group participants expressed these ideas in a variety of ways. One nurse described his perception as "the manager and the director did not care. You know, this is a hospital. We're here to make money. [The nurse's unit] makes money, so you're gonna work." As another nurse put it, "We're super short and we're all overwhelmed and we're burnt out and we're doing 16 hour shifts and then still taking another patient. They didn't care how much overtime they were paying us. It was just 'keep those beds full. Let's keep going.' So that was, like extremely frustrating. Even when we'd say please. Please don't add anybody. It didn't matter…and most of the time it was someone up higher. You know, there was always someone up higher saying, you know, Nope. We've got to fill these beds. Our beds got to stay full."

Section 4: Summary and Next Steps

Summary of Findings

Hospital bedside RNs comprise nearly one quarter of Minnesota's entire licensed health care workforce, providing the vast majority of health care in hospitals, and a substantial portion of the care consumed by all Minnesotans. As such, it is critical to understand their work experiences and proactively implement efforts to keep them engaged and thriving. Nurses and other hospital staff faced extremely challenging conditions during and immediately after the COVID pandemic. Some nurses did leave; many opted out of patient care positions or retired. However, by 2024, RN employment numbers in Minnesota hospitals had rebounded to pre-COVID levels. Hospital bedside nurses are now working roughly the same total number of hours as before COVID, and certain crucial indicators (work satisfaction changes between 2023 and 2024, and job vacancies, for example) suggest that the situation is improving for many nurses. In these ways, Minnesota mirrors national trends (Auerbach 2024; Taylor 2025). In 2024, nearly 25% of Minnesota's hospital bedside nurses reported being "very satisfied" with their career.

For a non-trivial share of the workforce, however, serious challenges persist. By both anecdotal and statistical accounts, patient acuity has increased substantially within the last five years. And it is not simply a matter of patients being sicker or more medically complex. Discussions with nurses and nursing experts indicated that workloads are also affected by other types of patient intensity—that is, the more challenging social and psychological factors that surround many patients. These changes have been happening at the same time that many older and more experienced nurses have left hospital bedside nursing and have been replaced by nurses who are earlier in their career. Broader shifts such as these have undoubtedly played a role in nurses' experiences on the floor. Bedside RNs had the largest drop in satisfaction of all licensed health care providers for which MDH collects data. The share of bedside RNs who reported being dissatisfied in MDH's 2024-2025 survey was 13.8%. Satisfaction levels decreased across all age groups and regions, signaling the existence of problems that are not isolated to a single age or location.

Work dissatisfaction drives behavior: ample evidence indicates that it leads to disengagement and ultimately quitting (Lee 1988; Wu et. al. 2024; Lai et al. 2025). In Minnesota, dissatisfaction is driving more hospital exits in 2024 than it did in 2019. Nurse turnover is higher in hospitals than in other clinical settings, and in 2024, a significant proportion of Minnesota's young hospital nurses reported that they planned to leave not just their current job, but the profession as a whole. The share of hospital nurses under age 44 who indicated that they planned to leave nursing amounted to 4.5% of the *entire* licensed Minnesota RN workforce who provide patient care, or approximately 4,400 nurses.

Why do nurses leave? Many nurses include: *workloads unsupportive or ineffective management or broader organizational culture*; *violence and mistreatment from patients*; and occasionally *poor-functioning teams and insufficient onboarding, orientation, or training*. Such experiences are clearly not representative of every bedside nurse, but where they occur, they do cause dissatisfaction and turnover. provide useful insights to even the most successful hospital leaders and teams.

Before turning to some suggested next steps, we offer two general contextual comments.

Minnesota's hospitals are not a monolith. Resources, patient populations, teams, and leadership vary widely across and even within hospital settings, and it is clear from the data presented here that many Minnesota

hospitals are doing an excellent job weathering the changing landscape while still prioritizing and valuing their nursing staff.

While not the focus of this study, it is worth noting the research on the costs of staff turnover. Especially in the face of rising health care costs, many Minnesota hospitals continue to experience significant financial pressures and operate on thin profit margins. As one of the only groups of clinicians whose work is not directly billable to insurance, hospital bedside nurses represent an unreimbursed cost to hospitals, and therefore, maintaining a lean nursing staff could seem cost effective. However, there is a growing body of evidence that in the long run, failing to address the causes of nurse dissatisfaction, burnout, and turnover is likely to cost hospitals and patients more. The average U.S. hospital is estimated to lose between $3.9 and $5.7 million annually in turnover costs (NSI 2025). Muir et. al (2021) estimated that hospitals that do not address burnout spend $16,736 per nurse per year on burnout-attributed turnover costs, compared to $11,592 per nurse per year in hospitals with burnout reduction programs. Yang (2025) estimates that turnover-related cost savings to a hospital could be as high as $313,000 for 100 RNs. And a systematic review of 16 published studies estimated that the cost of replacing one RN ranged from $21,514 to $88,000 per nurse (Bae 2022). Each percent change in RN turnover is projected to save the average hospital $289,000 annually.

There is also abundant evidence that nurse turnover is associated with poorer patient outcomes, such as a higher incidence of falls (Bae 2022); hospital-acquired pressure ulcers (Peng et. al 2023); medication errors (Bae et. al 2010) and a variety other nurse-sensitive patient outcomes (Blume, et. al 2021).

The evidence seems clear that retaining nurses saves money and promotes higher-quality patient care.

Suggested Next Steps

Ensure Nurses' Workloads are Manageable

Perhaps the most pressing problem from the perspective of many nurses in this study was heavy work/patient loads. Part of the challenge, as described earlier, may be that both the nursing workforce and patient populations have changed over time, and some staffing decisions and assignment protocols may have not yet caught up. The work satisfaction data in this report suggest that this problem is not universal, and perhaps not even applicable to the majority of Minnesota hospitals. However, where understaffing is common—or where existing safe staffing policies are not rigorously enforced—nurses are more likely to be dissatisfied and to resign, and patient care will very likely suffer. And when teams feel overworked and overwhelmed, other problems are more likely to surface.

While likely unsurprising to both nurses and hospital leaders, this research has helped to quantify the extent to which perceived overwork and unmanageable patient loads drives nurse dissatisfaction and underscores how important it is for hospitals to have ***and carry out*** staffing policies that account for the combination of patient acuity (how sick a patient is), patient intensity (other factors related to how much time it takes to care for a patient), and **nurses' skill and experience levels** when making staffing decisions and assignments.

Clear, Authentic, and Supportive Communication with Nurses

Another commonly-cited problem that seemed to evoke significant distress and frustration from nurses in this study was feeling unsupported and unappreciated. Many nurses who were dissatisfied or who had left their hospital bedside work commented that they felt their work went unnoticed and that, when they expressed

concerns, no one was listening. Others commented that they did not want pizza parties or plaques; what they felt was missing was authentic, and even informal, appreciation and support.

During the course of this study, we heard several examples of effective communication and positive, valued relationships between nurse leaders and their staff. A chief nursing officer (CNO) whom we interviewed shared the positive results that came from simple yet authentic engagement with nurses when she was making staffing and other decisions. She described situations in which it was clear that a specific suggestion from a nurse or nurses would not be financially viable. However, by having an established line of trusted communication with the nursing staff, she and the staff together were able to move past a specific solution to identify the root cause of an issue. In this way they were able to work together to find solutions that would address the nurses' concerns while still being affordable. Another CNO made a point to have lunch with her nursing staff on a regular basis, not just to learn how things were going on the floor, but also to simply get to know her staff as people. In this way she was able to understand more—and more authentically—the daily experiences of her nurses, and to foster a culture of clear and authentic communication. Finally, a third CNO mentioned that he would often share the budget details with his nursing staff so that they were able to see for themselves what solutions or ideas might be possible to implement and what likely were not. He said, "our frontline staff have a seat [at the table] and a voice that is heard." This fostered an atmosphere of trust between him and his nursing staff. Efforts like these cannot not solve every problem, but they build a regular culture of trust and collaboration that make inevitable problems more manageable.

More than one nurse in our study commented that a particular nurse manager or leader was the reason they stayed in a previous job. One interviewee in particular spoke about his former manager's support for the nursing staff in a difficult unit. Even though the work was quite difficult, morale was high and turnover was low because staff felt supported. This nurse spoke about the value of a leader 'accompanying' his or her nursing staff—being present and part of the ups and downs of a nursing shift. Others mentioned similar relationships with managers and commented that managers who could step in and do the work when the workload became unmanageable were often also quick to support their staff because they saw or experienced issues firsthand. These leaders were highly valued.

Implement Reliable Policies against Physical or Emotional Abuse

Nurse comments in this report highlighted the problem of physical and emotional abuse by patients and families against front-line hospital staff.

Hospitals must continue to take affirmative steps to ensure that frontline staff can care for patients without fear of physical, emotional, or sexual abuse. While all hospitals are required to have anti-violence plans (and as of 2025 are required to submit these plans to MDH for review), some nurses felt that their hospital's anti-violence measures did not ultimately protect them from violence. For anti-violence plans to be effective, they should (and must legally) be (1) developed with input from frontline staff; (2) implemented with an eye toward continuous improvement, and (3) evaluated regularly for effectiveness. Staff must be able to trust that their leadership will follow a transparent process of follow-up that includes investigation, documentation, prevention of similar incidents, and full communication back to affected staff. It is important to note that as of 2025, hospitals must submit their anti-violence plans to MDH for review and

The Minnesota Hospital Association convenes a monthly statewide working group of hospital representatives to share best practices, tools, and innovative strategies related to violence prevention. This group has met consistently for two years and serves as a forum for collaboration, learning, and continuous improvement. This group could provide a forum to investigate more fully how and why processes sometimes break down and to highlight effective programs and processes to prevent violence.

Promote, Protect, and Prioritize Professional Growth

Nurses frequently mentioned that they felt they lacked adequate onboarding, mentoring, and/or clinical preparation, leaving some feeling ill-equipped to change units or take on new assignments. This, again, could be partly driven by shifts in the nursing workforce, with fewer experienced nurses available to onboard, train, or precept. Several nurses commented that within weeks or months of completing their own onboarding or training, they themselves were responsible for training or onboarding new staff and did not feel ready.

Assessing their own specific needs and resources, hospitals could consider structured mentorships with nurses with several years of experience, on-boarding, or other forms of training, especially for first-year or early career nurses to bridge the gap between academia and practice and to improve retention**.** To the extent possible, it is important that mentorship happen between new nurses and nurses with at least a few years of experience. Some Minnesota hospitals are doing excellent work in this regard. For example, one CNO described a comprehensive Clinical Excellence Program to support nurses as they transition from student to expert nurse. The program is multi-faceted, focusing on ethical and compassionate care and interdisciplinary collaboration; including a residency program that combines classroom learning with clinical experience. It also includes a Clinical Ladder program that recognizes nurses' contributions and offers classes to charge nurses and preceptors.

Conclusion

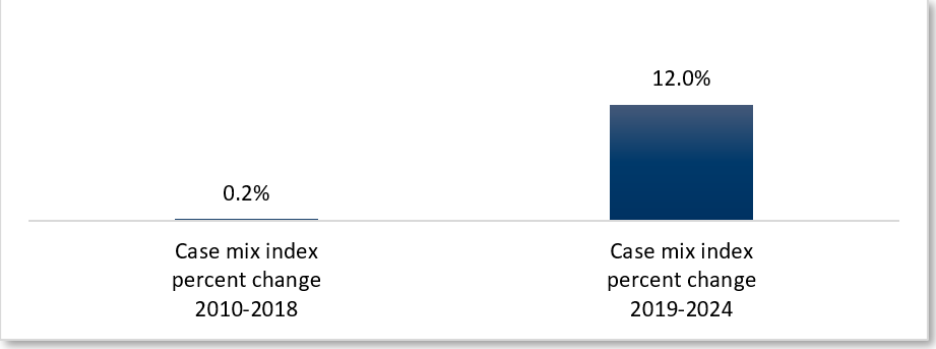
Nurses are the single largest group of health care providers in the state, and play a critical role in providing hands-on, around-the-clock care to hospitalized patients. The legislature's direction to MDH to study issues related to satisfaction and retention of hospital bedside nurses is a recognition of the importance of the nursing workforce to the health of all Minnesotans, and of the challenges that the last few years have brought to both nurses and hospitals. While the majority of hospital nurses report high satisfaction levels with their roles, and hospital nursing employment has rebounded from COVID-era lows, the 14% who report being dissatisfied represent a meaningful minority that warrants attention. Even small shifts in these numbers could significantly impact hospital staffing capacity, risk of turnover, and quality of care. The issues cited by nurses who are leaving the bedside are distress signals that merit attention. Intentionally addressing burnout and workplace dissatisfaction, routine heavy workloads and workplace violence and prioritizing authentic communication will help sustain a resilient nursing workforce, strengthen Minnesota's hospitals, and help maintain access to care for all Minnesotans.

Appendix A: Supplemental Data and Analyses

Increasing Patient Acuity and Intensity

Evidence suggests that patients are admitted to Minnesota's hospitals with sicker and more complicated conditions than they did compared to the years before COVID. For example, the American Hospital Association reported that between 2019 and 2022, patients' average length of stay in hospitals increased by 19% nationally (American Hospital Association 2022). Additionally, based on the Case Mix Index (an indicator designed to measure patients' acuity), patient acuity has also increased substantially in Minnesota (see Figure A.1). While the patient acuity changed very little (0.2%) between 2010 and 2018, it grew rapidly (12%) between 2019 and 2024 (with most of that increase occurring after 2020). This quantitative data is consistent with comments shared by focus group participants that "patients are just sicker these days."

Figure A.1. Change in Minnesota hospital patients' acuity levels (as measured by case mix index), 2010-2018 and 2019-2024



Data source: MDH calculations based on case mix index from the Centers for Medicare and Medicaid, Case Mix Index Files, 2010 through 2024. It is important to note two potential shortcomings of the case mix index (CMI) measure. First, this measure excludes data from critical access hospitals (CAHs). It is difficult to know whether or how this impacts the measure of patient acuity. Second, and perhaps more important: at roughly the same period of time that we see increases in the CMI measure, hospitals have faced increased pressure to code patient conditions more thoroughly or completely. For this reason, it is difficult to what extent the increase is truly due to increasingly complex patients, or more thorough coding, or a combination of the two.

Increased patient acuity is rather well-documented, but focus group discussions and conversations with the expert nursing panel illuminated another, perhaps more subtle shift that the case mix index does not account for: in the aggregate, patients are not just sicker, but they are also increasingly *complex*. Intensity takes the form of more challenging social and psychological factors surrounding one's case. Some examples include communication difficulties, perhaps due to limited English proficiency; complicated or problematic family structures, socioeconomic status, homelessness, untreated substance use disorder, mental illness, and related factors. All may have an additional effect over and above a patient's illness that can impact the time bedside nurses need to spend with each patient.

Is RN Work Dissatisfaction Limited to Certain Ages or Regions?

The next three tables (A.1 through A.3) investigate more deeply the work satisfaction among different demographic and geographic groups of bedside RNs. Table A.1 focuses on a comparison of work satisfaction across different age groups, and reveals that satisfaction levels are down in every age group, but particularly among the youngest cohort of bedside nurses, of whom 36% reported being very satisfied in 2019, compared to

18% in 2024. (By contrast, the oldest cohort of bedside nurses remain a highly satisfied group of workers, though less so in 2024 than in 2019.)

Table A.1. Career satisfaction among hospital bedside RNs, 2019 versus 2024, by AGE GROUPS

	2019				2024			
Age Group	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
Less than 35 yrs	36%	58%	6%	1%	18%	68%	12%	1%
35 - 44 yrs	39%	52%	7%	2%	24%	62%	12%	2%
45 - 54 yrs	40%	50%	8%	2%	30%	57%	11%	2%
55 - 64 yrs	39%	47%	11%	3%	31%	54%	13%	2%
65 yrs +	54%	37%	6%	3%	49%	41%	9%	2%

Data source: MDH, Health Care Workforce Survey, 2019 and 2024-2025. The data in this chart include only nurses who are providing patient care. Nurses were asked to respond to the question "*How satisfied have you been with your career in the last 12 months?*"

Table A.2 shows career satisfaction over time across different regions of the state. Again, we can see that work satisfaction has decreased for bedside RNs in all regions of the state. The changes are fairly uniform, although the Northeast part of the state shows the largest increase in the share of bedside RNs who report being dissatisfied with the career in the last 12 months.

Table A.2. Career satisfaction among hospital bedside RNs, 2019 versus 2024, by REGION

	2019				2024			
Region	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
Central	41%	53%	5%	1%	24%	65%	10%	1%
Northeast	35%	55%	8%	2%	20%	61%	18%	2%
Northwest	42%	50%	7%	1%	28%	60%	10%	2%
Southeast	40%	54%	5%	1%	21%	63%	14%	2%
Southwest	36%	54%	9%	2%	23%	68%	8%	2%
Twin Cities Metro	38%	53%	8%	2%	24%	63%	11%	2%

Data source: MDH, Health Care Workforce Survey, 2019 and 2024-2025. The data in this chart include only nurses who are providing patient care. Nurses were asked to respond to the question "*How satisfied have you been with your career in the last 12 months?*"

Finally, Table A.3 shows changes in career satisfaction across urban and rural areas. Here again, the findings indicate that satisfaction decreased in relatively uniform ways. There is no evidence to indicate that one region is driving dissatisfaction more than the other.

Table A.3. Career satisfaction within the last 12 months among hospital bedside RNs, 2019 versus 2024, by RURALITY

	2019				2024			
Rurality	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
Rural	38%	53%	7%	2%	30%	59%	10%	2%
Urban	41%	51%	6%	1%	30%	60%	9%	1%

Data source: MDH, Health Care Workforce Survey, 2019 and 2024-2025. The data in this chart include only nurses who are providing patient care. Nurses were asked to respond to the question "*How satisfied have you been with your career in the last 12 months?*"

Open-Ended Responses to Work Dissatisfaction Questions

In Nurses' Own Words: Poor Organizational Culture/Unsupportive Management

As shown in Table A.4, the single most common theme to emerge from these open-ended responses were feelings about **unhealthy organizational cultures** or unsupportive/ineffective management. Nearly half—44%—of the 965 open-ended responses reflected these concerns in some form or another. Sometimes nurses referred to problems with leadership at the frontline levels, such as charge nurses or nurse managers; other times they referred to higher levels of leadership such as chief nursing officers or hospital executives. Often, however, it was difficult to discern which level of leadership a comment referred to.

Underlying hundreds of comments was a considerable amount of anger, frustration, and resentment about decisions or processes that affected bedside nurses. For example, comments included sentiments such as "management does not care"; "management has no idea what we do and doesn't back us up"; and "management just pretends to value our input." One nurse described her management as "hostile and retaliatory."

Some nurses expressed the perception that administrators were making decisions for reasons other than patient care (for example, to "maximize profits"). Others expressed feeling that management did not appreciate, understand, or respect their work. Finally, many nurses felt that administrative decisions had the potential to put both nurses and patients at risk. For example, one nurse commented: "I never thought I'd see the day when the safety and care of patients would be so utterly disregarded." Another described a situation at a large hospital facility in which patients were left to sit in their own feces "on a daily basis." She continued: "brand new nurses are taking on 7-9 patients…and management expects quality care?"

Often, nurses expressed frustration and anxiety that when problems occurred at the bedside or in the hospital environment, they had no recourse. Many expressed feeling that nothing changed after they brought problems to their leadership. For example, one nurse wrote, "staff [are] getting hurt almost daily…care concerns [are] not addressed by management when brought to their attention." Another echoed the feeling that she had no support when she raised concerns to management. "[It] seems like they are more interested in having the i's dotted and t's crossed…as opposed to actual quality patient care." One nurse commented that her management "allows bullying and discrimination."

In Nurses' Own Words: Workload Concerns

The second most common theme to emerge was simply that nurses felt their **workload was too high**. Forty percent of the 965 open-ended comments reflected this sentiment. Workload concerns were expressed in many ways and included a variety of dimensions, but most commonly nurses reported that they had too many patients—or too many patients with complex or multiple conditions—to provide what they felt was good or safe care. They used words such as "unbearable," or "chaotic," and expressed sentiments such as "everyone is drowning," "it's too much to juggle," "I'm being pulled in all directions," or "we're being overworked and overwhelmed."

Hundreds of responses included references to "staffing ratios," "patient ratios," or to the lack of "safe staffing." Many nurses commented in various ways that they simply could not keep up with the workload, and that they felt that they were frequently in situations in which they had no way to provide good care. Some commented that the conditions felt unsafe, both for themselves and for their patients. One nurse said that because of her high patient load, she never left working feeling that she had a "safe" shift.

Several nurses mentioned having to work through lunch or other breaks on long shifts, either because there were too many patients to care for, because they felt they would be reprimanded for taking a break, or because they didn't want to leave another colleague in the position of having to care for double the number of patients. One nurse reported that in the past year, she had never worked a 12-hour shift where she had taken her two allotted 15-minute breaks. Another mentioned that it was common on her 12-hour shift not to have enough time to use the bathroom. Others reported that their 8- or 12-hour shifts could be extended at a moment's notice when their hospitals were short-staffed. One nurse simply stated, "no one ever goes home on time."

Finally, a theme running through comments about perceived overwork was that nurses commonly had to "pick up slack" when other professionals or ancillary personnel were absent or short-staffed. Many nurses reported having to do some of the work that other staff might ordinarily do, including janitorial staff. One nurse said that the patients she worked with were often very fragile with conditions that could change rapidly, yet she often found herself doing the work a nursing assistant might do rather than focusing on nursing tasks. Several others emphasized the lack of compensation for having to pick up this extra work.

Table A.4. Responses to the survey question, "If you wish to share more about what is contributing to your work dissatisfaction, please do so here." (Bedside RNs only)

Theme	Share of comments that included this theme
Unhealthy organizational culture/unsupportive or ineffective management	44%
Overly heavy workload	40%
Violence and/or mistreatment from patients or patients' families	18%
Stress due to negative patient or professional outcomes	13%
Inadequate pay or benefits	11%
Inadequate work-life balance	9%
Insufficient or insufficiently trained support staff	7%
Poor treatment from colleagues	5%
Emergency room being used to board patients	4%
Skills not being fully utilized, or lack of career advancement	4%
Burnout or moral injury	3%
Inadequate training	2%
Other	4%

Data source: MDH, Health Care Workforce Survey, 2024-2025. The data in this chart include only hospital bedside RNs who indicated that they were dissatisfied or very dissatisfied with their career (within the last 12 months or overall.) Note that a single comment could be grouped into more than one theme; therefore the total does not sum to 100%.

In Nurses' Own Words: Violence

The third most common set of responses centered around violence: 18 percent of comments focused on violence that nurses had experienced from patients, their families, or occasionally from other hospital staff. Some of these responses reflected nurses' perceptions that these incidents were increasing. Nurses shared examples of patients or families being "demanding" as well as more violent behaviors, including being punched in the face, having feces thrown at them, or as one nurse put it, "weekly violent physical assaults." Another nurse shared that in the eight months she had worked as a beside nurse, she had been hit by patients five times, and "verbally abused by patients or families more frequently."

Many of the comments made clear that the top three concerns that nurses noted—poor work culture/unsupportive management, higher workloads, and workplace violence—were in some cases inextricably linked. For example, some nurses pointed out that not being able to invest the time into patient care could cause patients or their families could become more impatient, demanding, or violent. And many nurses wrote that during or after violent incidents, they felt that their leadership had done nothing to remedy the situation or ensure that it would not happen again. In this way, these top three concerns, though conceptually distinct, seemed to co-occur as interrelated dimensions of one larger problem.

Many of the remaining concerns that nurses mentioned, though again distinct ideas, were also expressed in the context of the larger interrelated issues of workload, workplace culture, and violence. For example, feelings of stress due to the potential for negative outcomes (either for the patient or the nurse him or herself) were represented in 13% of all comments, but were often related to concerns about workload. For example, one nurse noted that on her shifts, she was in the position of having to manage patients that were fully intubated in addition to a full patient assignment. She wrote, "This is so dangerous and stressful…[I cannot] begin to convey how much distress this induces." Likewise, seven percent of comments mentioned the lack of support staff, but again, this was sometimes relayed in a way that made it clear that the underlying concern was workload. For example, one nurse mentioned that when hospitals are understaffed in "phlebotomy, IV teams, respiratory therapists, social workers, PT, OT, etc., the nurse is the person expected to act in all those roles." Finally, comments about moral injury were often raised in this context; for example, with one nurse describing how her heavy workload and lack of ancillary staff made her feel she could not provide adequate care for her patients.

Appendix B: Research Methodology

Minnesota Health Care Workforce Survey

Under Minnesota Statutes 144.051 and 144.052, MDH is legislatively mandated to survey licensed health care providers at the time they renew their licenses. MDH currently surveys licensees from 27 different professions spanning 11 different licensing boards, including the Board of Nursing, which licenses APRNs, RNs, and LPNs. The survey is web-based and is programmed to appear after the licensee completes his/her license renewal, but before payment. This configuration ensures that essentially all renewing licensees take the survey.

A complete survey cycle is one year, running from March to March. The data in this report were collected from March 18, 2024 through March 11, 2025. Nurses renew their licenses every other year, and the survey excludes providers who are applying for a license for the first time, since they are not yet licensed providers. Given these parameters, just under half of all nurses had the opportunity to take the 2024-2025 survey. The specific license renewal year is totally unrelated to the research questions in this study; therefore, the resulting sample represents an extremely high-quality and representative set of data on all licensed nurses in Minnesota. The total response rate for RNs was approximately 97% and the total number of survey respondents was 51,571 – including nurses of all ages, races, regions, and work settings.

Survey Questions

In anticipation of this study, MDH added several questions to the 2024-2025 survey to respond to the research questions we were charged with answering. Specific questions included items to measure work satisfaction and and/or whether or not nurses (and other providers) planned to leave their jobs within the next six months. For providers who reported feeling "dissatisfied" or "very dissatisfied," and for those who reported that they planned to leave their job within six months, we asked follow-up questions to try to measure the underlying reasons. Below are all relevant questions from the survey. This list does not include every question in the survey, as there are many questions that do not apply to nurses or to this report; however, MDH will supply a copy of the complete survey upon request.

Which of these best represents your current work status?

- ☐ Working in a position that is related to my professional license (either within or outside Minnesota)
- ☐ Not working in a position that is related to my professional license (e.g., working outside the field, retired, not working, etc.)

(If not working in a position related to one's license)
Which of these best reflects what you are doing instead?

- ☐ Retired
- ☐ Laid off or furloughed
- ☐ Between jobs or seeking work **in a health care setting**
- ☐ Working (or seeking work) **outside health care**
- ☐ Providing care to family member(s) such as children, parents, or others
- ☐ In school/continuing education
- ☐ Something else: _____

The following questions are only asked of licensees working in a position related to their license.

About how many hours do you work in a typical week, including all duties of your job(s) (e.g., patient/client care time, documentation, administrative work, etc.)? (*If your work schedule varies, an average or an estimate is fine.*)

_____

In your position(s), do you provide any direct care to patients or clients?

- ☐ Yes
- ☐ No

Approximately how many years have you been in your current job with your current employer? (*Please enter your response in years. Use decimals for partial years [e.g., 0.5 for half a year, etc.]. If you have more than one job, please respond for the one in which you work the most hours.)*

_____

Do you expect to leave your current job within the next six months? (*Reminder: all your responses are completely confidential and are not shared with your employer or your licensing board.*)

- ☐ Yes, very likely or definitely
- ☐ Maybe
- ☐ No
- ☐ Decline to answer

(If licensee responds "Yes, very likely or definitely" or "Maybe" to the previous question)
Why are you thinking of leaving your current job? (*Check all that apply. Reminder: your responses are completely confidential and are not shared with your employer or your licensing board.*)

- ☐ I'm burned out
- ☐ My patient or client load is too high
- ☐ Problems with coworkers / work team
- ☐ Problems with my leadership / management
- ☐ I want a higher paying job
- ☐ I want a job that doesn't involve patient / client care
- ☐ I want to change professions entirely
- ☐ I plan to retire
- ☐ For personal reasons (e.g., maternity/paternity, taking care of parents, illness, etc.)
- ☐ Decline to answer
- ☐ Other (*description optional*): _____

About how many more years do you plan to work in your profession in general (regardless of whether or not you change specific jobs)?

- ☐ Less than 1 year
- ☐ Between 1 and 5 years
- ☐ Between 5 and 10 years
- ☐ More than 10 years

(If licensee responds "Less than 1 year" or "Between 1 and 5 years" to the previous question)
What is the main reason you plan to leave your profession within the next five years? (*More than one of these may apply; please choose the response that best reflects your thinking right now.*)

- ☐ To retire
- ☐ To leave the profession because of burnout or dissatisfaction
- ☐ To pursue a different career
- ☐ To pursue training in order to advance in my current profession or a related one
- ☐ For family or other personal reasons
- ☐ For some other reason (*description optional*): _____

In which setting do you typically work the most hours?

- ☐ **Clinic, office, or other ambulatory care setting** (including professional offices, behavioral health or substance abuse clinics, community health centers, FQHCs, surgery centers, dental offices, private practices, health and wellness facilities, urgent care, or walk-in, retail, or convenience clinics)
- ☐ **Hospital** – **inpatient or outpatient** (including emergency departments, behavioral health/psychiatric, specialty, day surgery, transitional/rehabilitation units)
- ☐ **Long-term care facility** (e.g., assisted living, hospice, rehabilitation, group homes, residential care, skilled nursing, or transitional/sub-acute care)
- ☐ **Home health care** (including any medical or behavioral health that is provided in patients' or clients' homes, including Home Infusion)
- ☐ **A remote location** (e.g., home) to care for patients or clients via telemedicine, phone, and/or email
- ☐ **Pharmacy** (including hospitals/clinics/nursing facilities, independent community pharmacies, mail service pharmacy, or chain pharmacies)
- ☐ **Correctional facility**
- ☐ **Community or faith-based organization** (including community collaboratives, churches, non-profits, or social service agencies)
- ☐ **Public health agency** (including city/county health board, or city/county/state public health organization)
- ☐ **Mobile clinic**
- ☐ **School (Pre-K through 12)**
- ☐ **Other** (*description optional*): _____

How satisfied have you been with your career in the last 12 months?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

How satisfied have you been with your career overall?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

(If licensee responds that they are "Dissatisfied" or "Very dissatisfied" to either of the two previous questions)
For policy planning purposes, please tell us more about why you have been experiencing dissatisfaction with your work. How much do you agree with each of the following statements? (*Please note: your responses are completely confidential. They are not shared with anyone, including your employer or your licensing board.*)

I feel dissatisfied with my work because...

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**Does not apply**
My patient or client load is too heavy.						
I don't trust management or others in authority where I work.						
I don't feel appreciated.						
The paperwork demands are too high (e.g., charting, other documentation, etc.)						
Pre-authorization or other insurance-related work takes too much time.						
My pay is too low.						
I don't like my coworkers.						
I'm burned out.						
I feel that my management doesn't listen to my concerns.						
Not enough of my work involves actual patient care.						
Something else not mentioned (*description optional*):						

If you wish to share more about what is contributing to your work dissatisfaction, please do so here. (*Please note: your responses are completely confidential. MDH does not share them with anyone, including your employer or your licensing board. We will only share this information grouped (anonymously) with other responses for policy-planning purposes.*)

Focus Groups

As described in the report, MDH used focus groups to collect information and insights that were deeper and more nuanced than is possible to gather through broader survey questions. MDH's Institutional Review Board (IRB) approved the focus group data collection.

Focus Group Participant Recruitment

To help publicize the study to potential subjects, MDH engaged partner organizations to share a recruitment flyer. Partner organizations included the Minnesota Board of Nursing, the Minnesota Hospital Association, the Minnesota Nurses Association, the Minnesota Organization of Registered Nurses, and the University of Minnesota's Center for Nursing Equity and Excellence. In addition, MDH publicized the recruitment flyer via GovDelivery and LinkedIn. The flyer sought participants who either (1) had left a hospital position; or (2) had a "success story" to share about the hospital in which they worked. (Although "success stories" were not a part of our legislative assignment, we were also interested to learn more about the conditions under which nurses thrive.) We limited recruitment to nurses aged 18 and older, and, for those who wanted to share reasons for leaving a hospital position, they must have left within the last two years. The recruitment flyer provided a link where nurses could complete an online form to indicate their interest in the study and enter basic information about themselves (age, race, gender, license type and status, length of time working as a nurse, and region of Minnesota in which they lived) which MDH could then use to select a diverse group of participants.

MDH received an initial total of 484 volunteer responses. However, after an in-depth analysis, we determined that 370 were ineligible or invalid. Some volunteers lived out of state, some had never been licensed as a nurse, and others were determined to be "imposter participants," (that is, people who did not fit the criteria to be included in the study but volunteered to obtain a perceived benefit) a growing problem in qualitative study participant recruitment (Ridge, et. al. 2023). Thus, a total of 114 *valid* volunteers responded to the call for focus group participation. Of those, MDH analysts selected 63 candidates to participate. Of these, 27 did not respond to email invitations to participate; 11 responded but said they could not attend; six canceled; and three did not show up for the focus group meeting for which they had been scheduled. Sixteen of the 63 individuals ultimately took part in the focus groups. Of the 11 focus group volunteers who could not attend the meeting, MDH offered each the opportunity to share any thoughts they would like to share via email. We received five emails. Though we reviewed each email carefully to ensure that we had not missed critical themes, we used the information provided as background, and did not include them in the formal qualitative analysis of focus group findings.

Final Participant Selection and Focus Group Design

Following best practices for focus groups (Han, et. al., 2024), we designed groups to be similar on certain relevant characteristics, specifically (1) years of nursing experience; and (2) whether or not participants were still working in patient care roles. Within these criteria, we prioritized recruitment participants from diverse geographic location, racial/ethnic identity, and gender. Table B.1 provides the characteristics of the entire group of focus group participants.

We facilitated six focus groups via Microsoft Teams to record the meetings and transcripts in spring of 2025. Each focus group included between two and four participants. Participants were compensated with a $100 Visa gift card. The script that MDH followed while conducting focus groups is included below. MDH requested and received feedback on the focus group script from the Hennepin County Medical Center's Institute for Professional Worklife; from the Minnesota Hospital Association; and from this own study's Nursing Expert Panel (described below).

Table B.1. Characteristics of Focus Group Participants

Category	Characteristics	Count (%)
Group type	Nurses who left a hospital setting	16 (89%)
	Nurses with success stories	2 (11%)
License type and status	RN - active	17 (94%)
	RN - inactive	1 (6%)
Years in nursing	Less than one year	1 (6%)
	Between 1 and 5 years	6 (33%)
	Between 5 and 10 years	2 (11%)
	Between 10 and 20 years	5 (28%)
	More than 20 years	4 (22%)
Age group	21-30 years	5 (28%)
	31-40 years	2 (11%)
	41-50 years	7 (39%)
	51-60 years	2 (11%)
	60+ years	2 (11%)
Gender	Female	16 (89%)
	Male	2 (11%)
Current work situation	Left hospital to take a patient care role in a non-hospital setting	7 (39%)
	Left hospital to take a non-patient-care role; still in health care	6 (33%)
	Left health care, but still actively licensed	2 (11%)
	Left health care, no longer actively licensed	1 (6%)
	Currently working in a hospital providing patient care	2 (11%)
Race/ethnicity	White	13 (72%)
	Hispanic/Latin	2 (11%)
	Asian - Southeastern	1 (6%)
	Middle Eastern/North African (MENA)	1 (6%)
	Asian - South Asian	1 (6%)
Region	Twin Cities Region	10 (56%)
	Northwest MN	1 (6%)
	Northeast MN	3 (17%)
	Central MN	3 (17%)
	Southeast MN	1 (6%)
Rurality	Urban/Large City (e.g., Duluth, Rochester, Twin Cities, etc.)	8 (44%)
	Rural/Small Town	10 (56%)

Focus group script

Greetings! My name is [MDH researcher] and I/we work for Minnesota Department of Health on a team that supports projects to better understand workforce needs.

This workforce project is a one-time legislative study to understand why nurses are leaving direct patient care positions in hospital settings. We are interested in hearing from nurses that have recently left work in hospital settings for other opportunities – direct patient care-related or not. Specifically, we want to learn more about your experiences in the hospital settings and what deciding factors have influenced your employment decisions. Our plan is to meet with about 40+ diverse individuals who work across the state of Minnesota. We plan to combine the anonymous information that you've shared to find themes, commonalities, and unique narratives in your experiences. We will then write a final report that summarizes the experiences and feedback from focus group sessions to construct recommendations that could improve the nursing workforce.

A couple of housekeeping logistics:

- This focus group will take about 60-90 minutes to complete – it's possible we'll go a little long, we'd like to hear from people.
- Your responses will be kept confidential—when we write our report, we will not use names and we will summarize key themes from all of the group members.
- We ask that you keep what you hear today from others also confidential.
- We may not have time to hear a response from everyone on each question so I may start calling on folks to make sure we hear from each of you a few times.
- Due to our intent to record this focus group, we ask that you talk one at a time so that we can make sure the audio recording is as clear as possible.
- Voluntary – if at any point you're feeling distressed by what we talk about – or have something come up, we understand and welcome you to exit the conversation, if necessary.

In order to get the most accurate notes possible, we would like to record this conversation. The recording will be destroyed after the report is finalized.

Is it okay to record this session – ask each group member? Yes No

INTERVIEWER, PRESS RECORD.
Are there any questions before we begin? Okay, let's get started.

(**20 minutes**) **Personal narrative, expectations, and positions**. We're interested in getting to know a little bit more about each of your backgrounds – including how y'all came to work as a nurse and related expectations and experiences.

1. Tell us a little about yourself, and your journey into nursing as a profession. What attracted you to working in health care, and as a nurse in particular?

2. Think back to when you took your previous job at a hospital. What made you decide to take the job at the hospital where you were working? What were your thoughts and/or expectations as you were considering this job?

3. Share a bit about your specific position. What was your specialty, your general schedule, what was work like for you, and how long did you work in the position? What unit did you work in?

(**20 minutes**) **Retention**. Part of our project is trying to figure out what's working well for nurses so we can continue to support those efforts. The next set of questions are about why people stay in their jobs and why they leave:

4. What did you like about the position (prompts: from the very general [e.g., helping people], to very specific, [e.g., schedule, commute time, hospital-based care?]

5. Tell us what made you decide to leave your position. If possible, think about both the "push" factors (things you didn't like about your position) and the "pull" factors (things you were looking for in a new position).

    a. **PROMPT:** Also, think about the personal factors (e.g., work-life balance; changing schedule; commute time, etc.?) as well as the job-related factors that made you want to change positions (e.g., flip requirements [working overnight, e.g.], unit culture, psychological safety, management support).

(**20 minutes**) **Burnout**. We know that working directly with patients in a hospital setting is hard work. It can sometimes be rewarding and, sometimes the work can be stressful. Based on your experiences, we want to ask y'all questions that could help us understand how to better support nurse.

6. What, if anything, might have made you stay in your position? What could have made a difference?

7. We see in our data that nurses often don't feel appreciated. Was that something you experienced? What would have made you feel truly appreciated in your work?

(**15 minutes**) **Changes over time**.

8. **A) LESS EXPERIENCED NURSES**: Think back to when you left school and took your hospital job. What was it like for you stepping into this role? (Prompts: Did you feel practice-ready? Did you have adequate patient care time in school? What was your experience with orientation, onboarding, and mentoring?)

    B) MORE EXPERIENCED NURSES: How has work changed for you in the last decade? Have there been good changes as well as bad changes?

(**15 minutes**) **Future and Recommendations.** After our conversation today, we're curious about your recommendations for supporting the nursing workforce – in hospitals:

9. Governor Walz calls you on the phone and wants to know your 1-2 most important things to do in order to maintain (grow) the nursing workforce. What would you tell him? (Think as big as you want.)

[Thank participants for their time and input and give them the U.S. Bank gift card!]

Email us if you think of anything else!

Focus Group Data Analysis

Qualitative data coding is the process of systematically categorizing and organizing open-ended data, such as focus groups comments and conversations, into broader themes to identify patterns and deeper meanings. Two MDH researchers coded the focus group and individual interview transcripts for themes using NVivo 15.0. We took a three-phased approach to coding the data: 1) General coding based on the focus group questions, 2) Negative sentiments on reasons why the nurses left direct patient care in hospital settings, and 3) Positive sentiments and experiences as nurses or suggestions on how to support direct patient care nurses within hospital settings.

We began the analytic process by deductively coding based on the survey group questions themselves. For example, the first code was "Draw to nursing," based on the first question of the protocol "Tell us a little about yourself, and your journey into nursing as a profession. What attracted you to working in health care, and as a nurse in particular?" Comments that were not closely aligned with protocol questions were coded as 'other.'

Next, we coded the data inductively and categorized them based on verbatim comments from participants. Codes had to directly inform 'why are nurses leaving direct patient care positions in hospital settings.' For example, if the nurse was talking about leaving due to patient care safety concerns (e.g., "The inpatient side was very messy and I felt unorganized and definitely lots of safety issues."), we coded this information as 'care safety.' Comments not closely aligned with 'reasons for leaving' were not coded. The 'reasons for leaving' codes were then categorized into themes and organized as a conceptual model to explain why nurses are leaving direct patient care in hospital settings. Finally, with input from nationally-recognized qualitative data expert Dr. Erin Sullivan, were deductively coded based on 'reasons for leaving' codes but instead highlighted the positive sentiments/experiences of those codes. For example, if a nurse was talking about colleagues as a positive support (e.g., "We were like a little family, we got along great. It was fun. We got the work done. I felt like we were a really good team. We really helped each other out. If it would have stayed like that, I would have absolutely stayed working there."), researchers coded as 'colleagues.' Comments not closely aligned with positive supports or suggestions were not coded. The two researchers independently completed the deductive coding and inductive 'Other' coding separately, then annotated any disagreements in the NVivo program and met to review and decide on final coding agreement.

The Nursing Expert Panel

Consistent with MDH values, this study prioritized community-informed engagement throughout the process to ensure inclusive, representative, and meaningful results. An important part of this effort was to assemble an expert panel of nurses with varied backgrounds to advise the qualitative portion of the study. The panel informed our methods, interpretations, and recommendations based on their unique expertise as nurses.

To recruit the panel, MDH publicized the opportunity broadly online, and by enlisting the help of several different nursing organizations. The broad recruitment strategy ensured that the nursing panel represented diverse geographic locations, levels of experience, racial/ethnic groups, gender identities, age, and type of nursing degree. The group was comprised of five licensed RNs, with nursing experience ranging from 3 to 20+ years. Three panelists worked in rural towns and two in metropolitan areas. Two of the panelists continued to work in a hospital setting (one in administration and the other working occasional shifts). Two were in public health, and one panelist worked as a nurse in a community outpatient clinic. Three of the panelists had experience in nursing workforce policy.

Between April and September of 2025, MDH facilitated four meetings with this group. Each expert panelist devoted considerable time and energy to reviewing the study protocols and findings, and received a $100 thank-you for each 1.5 hour meeting.

In the first meeting, MDH introduced the group to the study in general, and asked panelists to provide input on a draft of the focus group questions and protocol. This discussion elicited important feedback about phrasing or terminology that would resonate most with nurses; about areas where it would be important to probe for more information; and about what to listen for specifically. During the second meeting, MDH shared initial findings from the focus groups, and asked the expert panel for their assistance in interpreting some of the language and comments that we heard during the focus group discussions. This provided important context that helped us better understand whether, how, and under what conditions certain focus groups comments reflected broader concerns for the nursing workforce. We also shared our initial qualitative coding during this meeting and asked the panel to provide feedback on its face validity (or, simply put, to do a "gut check") based on their extensive collective experience. In the third meeting, we shared the near-final version of our qualitative coding, including a complete conceptual model and related themes, again seeking feedback on language, terminology, and interpretations. In the fourth and final meeting with this group, we shared early draft versions of the recommendations for this report, and sought additional input on recommendations (especially areas where the language needed more specificity in order to be clear and actionable).

Appendix C: Acknowledgements

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