



Newfoundland and Labrador Health Services

Core Staffing Review: Guidelines for Staffing Planning in Practice

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Table of Contents

- Introduction..... 2
 - Core Decision Model for Newfoundland and Labrador Workforce Planning..... 2
 - Alignment with Leading Practice Frameworks 2
 - Applying the Approach Across Care Settings 4
- How-to-Guide..... 6
 - Step 1: Understand Patient Deman and Workload 6
 - Step 2: Determine Required Skill Mix..... 9
 - Step 3: Incorporate Organizational Considerations 11
 - Step 4: Compare Against Current Staffing 12
 - Step 5: Leverage Organizational Supports (optional – final review)..... 13
 - Step 6: Define and Document the Staffing Plan 14
 - Step 7: Monitor and Adjust..... 15
- Conclusion 16

Introduction

This guide provides Managers with a structured, evidence-informed approach to reviewing and determining core staffing requirements. It leverages existing capacity management tools and aligns with leading practices in nurse staffing to support consistent, sustainable, and patient-centered staffing decisions. The steps are meant to support medium- to long-term staffing planning; this is not a daily staffing process guide.

This document was written before the April 2026 CorCare go-live. New functionality and data made available after go-live should be considered in the context of any guidelines provided in this document.

Core Decision Model for Newfoundland and Labrador Workforce Planning

Staffing decisions should follow a consistent logic:



This recommended Core Decision Model is rooted in a simple principle: right staff, right skills, right time - aligned to patient needs and organizational sustainability.

Alignment with Leading Practice Frameworks

This guide is based on well-established, industry-leading staffing practices and is designed to strengthen current operations while setting a clear vision toward innovation and future-proofed workforce models. It aligns what already works within NLHS's existing tools, data, and ways of working, ensuring consistency today while enabling flexibility, scalability and innovative approaches overtime.

This approach draws on the following recognized frameworks:

- The Government of Canada Nursing Retention Toolkit (Canada)
- Registered Nurses Association of Ontario Second Edition of Developing and Sustaining Safe, Effective Staffing and Workload Practices (Canada)
- The Professional Judgement Framework (UK)
- The Principles for Nurse Staffing from the American Nurses Association (US)
- The Synergy Model for Patient Care from the American Association of Critical-Care Nurses (US)

Each framework contributes a distinct, complementary component to staffing decision-making:

(1) Consideration of workforce sustainability and retention

- The Nursing Retention Toolkit highlights the importance of:
 - Workload balance
 - Sustainable staffing models
 - Impact of staffing decisions on staff experience and retention
- This is incorporated in the guide by:
 - Including organizational and workforce constraints in decision-making
 - Emphasizing the need for sustainable, not just optimal, staffing models

(2) Patient need as a primary driver

- Both the American Nurses Association principles and the AACN Synergy Model emphasize that staffing must be driven by patient acuity, complexity, and care needs
- This is operationalized in the guide through:
 - Use of acuity and census data
 - Translation of patient need into workload and care requirements

(3) Alignment of patient needs to staff competencies and team skill mix

- The AACN Synergy Model establishes that optimal outcomes occur when patient needs align with provider competencies
- The guide applies this by:
 - Introducing a structured approach to skill mix of NP, RN, LPN, and PCAs
 - Requiring explicit consideration of care complexity when assigning staff roles

(4) Integration of data and professional judgement

- The Professional Judgement Framework and the RNAO Staffing and Workload guidance reinforces that data and tools support decisions, but do not replace clinical and operational judgement
- This is reflected in the guides through:
 - A defined step to compare data with observed realities
 - Use of structured decision checks to support consistency and transparency

By integrating these frameworks with existing NLHS processes, this guide supports staffing decisions that are:

- Evidence-informed and aligned with leading practice
- Data-driven by leveraging available dashboards and analytics
- Context-aware by reflecting operational and system realities
- Actionable and structured for unit-level decision-making

This alignment supports a consistent and transparent approach to staffing that balances patient needs, staff competencies, and organizational sustainability.

Applying the Approach Across Care Settings

The recommended Newfoundland and Labrador Workforce Planning Core Decision Model provides a standardized approach to core staffing decisions that can be applied across care settings while recognizing important contextual differences. The actions taken in each Step should be tailored to the care setting. The below table outlines examples of how to tailor the Steps to the specific factors that could be considered in acute care, long-term care and community care settings.

For each Step, review the column that aligns with your care setting to identify key considerations that influence staffing decisions in your environment. There may be unique, urgent or emergent situations or events (e.g., pandemics, capacity surges) that should be considered at each Step.

Step	Core Action	All Care Settings	Acute Care Factors	Long-Term Care (LTC) Factors	Community Care Factors
1. Assess Client & Staffing Factors	Define demand using data; Identify workload drivers		Acuity + volumes + time-sensitive care	Stable census; high baseline complexity; cognitive, behavioural, and functional needs	Caseload-based; distributed demand; consider geography and district allocation, visit type mix, and social complexity
2. Determine Skill Mix	Align needs to competencies	Appropriate skill mix; Access to allied health; Access to advanced scopes (e.g. NP)	RN/NP-heavy for high acuity; targeted LPN and PCA use	LPN and PCA-heavy; RN and NP for oversight and changes in condition	Independent RNs; LPN skills; broad scope;
3. Organizational Considerations	Adjust for system constraints	Access to care and/or alternative care	Flow pressure; bed capacity; hospital priorities; staffing expectations such as Hours Per Patient Day	Fixed funding; staffing expectations such as Hours Per Resident Day	Program funding; geography; volume expectations such as number of visits/services provided
4. Compared to Current Staffing	Identify gaps and inefficiencies	Burnout risk; Overtime;	Shift variability; surge in occupancy;	Chronic understaffing; missed care;	Caseload imbalance; inefficient routing; delayed visits
5. Leverage Supports	Validate with partners	Scheduling systems; Baseline rotation and staffing; Contingency for absences; Access to care	Centralized staffing; bed management and decision support; real-time data	Internal leadership; limited real-time resident data, resident behavioral needs	External partners; care networks

6. Define Staffing Plan	Document model and triggers	Frequent review; Incidents; Overtime and agency usage; Defined quality indicators	defined escalation options based on volume, acuity, or flow	Resident and family satisfaction	Caseload targets; visit prioritization; routing logic
7. Monitor & adjust	Continuous improvement		Patient flow; Capacity utilization		Access, visit completion, travel efficiency, satisfaction, and unmet/deferred demand

How-to-Guide

Step 1: Understand Patient Demand and Workload

Use organizationally approved tools and data to understand how many patients you have, how complex their needs are, and how workload changes across shifts.

Start here: Review your unit's dashboard data from the past 4-6 weeks, or an agreed upon review range.

Look at:

- Patient volumes (census, admission, discharges, transfers)
- Acuity and complexity (e.g., case mix, interRAI scores, ventilation and intervention trends, ALC rates)
- Length of stay and flow patterns
- Workload indicators (e.g., target and actual hours per patient day, workload scores)

Also consider factors not always captured in data:

- Isolation requirements
- Behavioural needs
- Equipment dependence
- Mobility/assistance needs

What this means in practice: Estimate how much care time patients require over a 24-hour period and how that demand varies by shift – focusing on trends, not single days. This is expressed in leading practice as hours per patient day, or similar indicators such as workload scores, duration of visits, or staffing ratios of required care time to realize intended patient outcomes. This can then be compared to peers as a check on workload intensity and required productive hours. Below is an example of calculating Hours Per Patient Day:

Over a 24-hour period, your unit provided 300 total productive nursing hours and recorded 60 patient days (e.g., average midnight census of 60 for one day).

Hours per Patient Day (HPPD) = Total productive hours ÷ Patient days

Input	Value	Notes
Total productive hours (24h)	300	Include direct care + other productive time per your local definition
Patient days	60	Often calculated from daily census (e.g., midnight census)
HPPD	5.0	$300 \div 60 = 5.0$ hours per patient day

*An HPPD of **5.0** means that, on average, the unit delivered 5 productive staff hours for each patient day during the period measured (use the same definitions when comparing across units or time).*

Who to involve:

- Clinical leads (e.g., charge nurse), including allied health, to map demand to workload by shift
- Analytics/data team, including capacity and flow to gather patient, capacity and demand drivers
- Central staffing teams to gather target and actual staffing hours and identify recurring pressure point

Organizational Enablers:

- Tools: Decision support dashboards, CorCare data and reports, organization approved tools and data sets for real-time census and flow visibility.
- Processes: Daily bullet rounds to review census, acuity, and anticipated discharges.
- Processes: Provincial capacity management processes to identify system pressures.
- Processes: Validate the reliability and completeness of available data sources; where digital maturity or data availability is limited, supplement dashboard review with operational judgement and partner input (e.g., decision support, staffing office).

Ask yourself:

- ✓ Do I have an accurate picture of current demand?
- ✓ Are there planned admissions, procedures, or transfers that will increase acuity/complexity?
- ✓ Are there planned discharges that will reduce occupancy or change the mix of patients remaining?
- ✓ Are there anticipated transfers (in/out) that will change care needs (e.g., step-up/step-down)?
- ✓ Are any patients expected to shift to higher observation, isolation precautions, or 1:1 needs?
- ✓ Are there known system pressures (e.g., ED surge) that may drive admissions or bed moves?
- ✓ What are the primary drivers of workload on this unit?
- ✓ Do you have adequate support needed from other interdisciplinary team members?
- ✓ Do you have support for non-nursing roles (e.g., porters, clerks)?
- ✓ How does workload vary by shift or day?

Outcome: Clear view of patient demand and workload patterns by shift, and an understanding of workload drivers with specific considerations for the patient population, care setting, and geographic context.

Example Care Setting Considerations:

- Acute Care: Patient need is variable and rapidly changing; consider acuity, volume trends, and patient flow (admissions, discharges, transfers) and workload is driven by both patient acuity and turnover (admissions, discharges, transfers).
- Long-Term Care: Patient need is relatively stable but characterized by high baseline complexity, including cognitive and functional impairment and Workload is driven by high volumes of routine and functional care, including mobility, hygiene, feeding, and behavioral support, with additional non-clinical workload related to documentation and coordination.
- Community Care: Patient need is defined by caseload, visit frequency, and social determinants of health, with demand distributed across geography and workload is influenced by visit duration, travel time between clients, care coordination requirements, and geographic dispersion.

Step 2: Determine Required Skill Mix

Match patient needs to the right mix of staff roles and competencies.

Start here: Use your workload estimate from Step 1.

Look at:

- Care activities required (by acuity level)
- Scope of practice for each role
- Current competencies mix on your unit

What this means in practice:

Translate workload into the right combination of:

- NP
- RN
- LPN
- Unregulated staff (e.g., PCAs)

This can be done by mapping tasks and interventions to appropriate scope of practice for each of the skill levels, while ensuring:

- Higher-acuity patients align with higher-skill staff
- All staff are working to full scope

Who to involve:

- Clinical educators / professional practice regarding scope of practice considerations
- Clinical/program leadership for validation of proposed skill mix

Organizational Enablers:

- Tools: Staffing templates and scheduling systems aligned with skill mix expectations.
- Processes: Collaboration with central staffing to align staff allocation with patient needs.
- System Supports: Use of CorCare to understand patient complexity and care needs where applicable.

Ask yourself:

- ✓ Does the skill mix reflect patient complexity?
- ✓ Are staff being used to full scope?
- ✓ Is the balance of regulated and unregulated staff appropriate?

Outcome: A defined target skill mixes by role.

Example Care Setting Considerations:

- Acute Care: Prioritize RN/NP capacity to match patient acuity and support rapid clinical decision-making.
- Long-Term Care: Skill mix is weighted toward LPNs and PCAs to deliver predictable routine and functional care, with RN capacity focused on clinical oversight, escalation, and changes in resident condition.
- Community Care: Skill mix emphasizes autonomous practitioners with broad assessment and coordination skills, reflecting limited on-site supports and the need for independent clinical decision-making across dispersed settings.

Step 3: Incorporate Organizational Considerations

Adjust your staffing model to ensure safe patient, client, and resident care delivery.

Start Here: Review your target staffing and skill mix against current constraints.

Look at:

- Funded staffing levels and budget constraints
- Workforce availability (vacancies, sick time, recruitment challenges)
- Scheduling model impacts (mandating, self-scheduling, attendance management)
- Organizational priorities (e.g., patient flow, quality indicators)
- Availability of support roles (clerical, portering, etc.)

What this means in practice: Ensuring that staffing models are appropriately aligned to support safe patient, client, and resident care delivery.

Who to involve:

- Finance to validate budgeted FTE
- HR / recruitment to understand labor relations and impacts of recruitment and retention activities
- Program/site leadership to align with operational priorities and dependencies, including priorities related to reduction in agency staffing

Organizational Enablers:

- Tools: Decision Support financial and staffing data (FTEs, overtime, vacancy trends).
- Processes: Alignment with provincial capacity management priorities and directives.
- System Supports: Coordination with leadership and central staffing to balance system needs.

Ask yourself:

- ✓ Are there recruitment needs that may need to be addressed?
- ✓ Are there system constraints that will impact delivery?

Outcome: Feasible safe staffing approach aligned with operational realities.

Example Care Setting Considerations:

- Acute Care: Staffing decisions are closely linked to patient flow, bed capacity, and hospital-wide operational priorities.
- Long-Term Care: Consider fixed funding models, staffing ratios, and regulatory requirements that shape staffing flexibility.
- Community Care: Staffing decisions must reflect program-based funding, workforce availability, and geographic constraints that influence service capacity and delivery.

Step 4: Compare Against Current Staffing

Identify gaps between required staffing and what is currently in place.

Start Here: Review scheduled vs. actual staffing data.

Look at:

- Scheduled vs actual staffing levels
- Overtime and agency use
- Vacancy and sick time trends
- Staffing variation across shifts

What this means in practice: Identify where staffing does not match patient volume, patient complexity, or required staff competencies. Typical flags that may indicate a need for staffing adjustment include:

- Persistent staffing gaps due to short staffing (e.g., call outs)
- Mismatch between patient needs and staff competencies
- Inefficiencies in staff allocation

Who to involve:

- Central staffing team to review schedule staffing patterns, coverage gaps and opportunities
- Analytics/data teams to validate trends in workforce planning data
- Clinical leads to validate impacts of identified gaps on workflows and patient outcomes

Organizational Enablers:

- Tools: Scheduling systems, central staffing reports, and decision support variance data.
- Processes: Daily review of staffing gaps during bullet rounds.
- System Supports: Escalation through central staffing for coverage and redeployment.

Ask yourself:

- ✓ Where are the consistent gaps?
- ✓ Is the staffing mix appropriate on each shift?
- ✓ Are there inefficiencies in how staff are allocated?

Outcome: Clear list of staffing gaps and improvement opportunities.

Example Care Setting Considerations:

- Acute Care: Assess for shift variability, surges, and misalignment with peak admission and discharge times.
- Long-Term Care: Identify persistent staffing gaps, reliance on overtime or informal coverage, and indicators of missed or delayed care that may signal misalignment with resident needs.
- Community Care: Review caseload distribution, service delays, and travel inefficiencies, recognizing that staffing gaps often present as deferred or unmet care rather than reduced workload.

Step 5: Leverage Organizational Supports

Test and strengthen your staffing approach using available expertise.

Start here: Share your proposed model and assumptions.

Look at:

- Trends and comparisons (internal or peer units)
- Scenario testing (e.g., surge, staffing shortages)
- Alternative staffing approaches

What this means in practice: Use available supports to confirm your plan is accurate, realistic and sustainable.

Who to involve

- Central staffing team to validate final assumptions regarding availability
- Analytics/data team, including capacity and flow, to validate final assumptions, including projections
- Clinical leadership and professional practice/clinical educators to validate skill mix assumptions
- Peer managers to sense-check comparators and operational feasibility

Organizational Enablers:

- Tools: Central staffing systems, decision support analytics.
- Processes: Engagement with central staffing, capacity teams, and cross-unit collaboration.
- System Supports: Provincial capacity management for escalation and system-level coordination.

Ask yourself:

- ✓ Have I validated this with the right partners?
- ✓ Are there risks I haven't considered?
- ✓ Are there better or more flexible approaches?

Outcome: Refined and validated staffing plan.

Example Care Setting Considerations:

- Acute Care: Utilize centralized staffing teams, real-time data, and bed capacity management functions.
- Long-Term Care: Establish stable baseline staffing models with clearly defined contingency and escalation triggers tied to changes in resident acuity, behavioural complexity, or staffing availability.
- Community Care: Leverage scheduling and routing systems, and coordinate with external providers and community partners to manage distributed demand.

Step 6: Translating Insights into a Safe Staffing Plan

Translate your analysis into a clear, actionable staffing model.

Start Here: Outline your core staffing by shift and develop an appropriate contingency plan.

Include:

- Core staffing levels by shift
- Skill mix by role
- Coverage and adjustment approach (e.g., float, redeployment), including contingency plans
- Escalation pathways
- Contingency plans

What this means in practice: Ensure a safe staffing model that is flexible, utilizes appropriate skill mix, is understood by staff, and applied consistently.

Who to involve:

- Senior leadership, site operations, budgeting, and quality teams
- Central staffing teams to support scheduling management
- Clinical leads and professional practice/clinical educators to support role clarity and competency requirements

Organizational Enablers:

- Tools: Scheduling systems and internal staffing plan templates.
- Processes: Validation with central staffing and leadership prior to implementation.
- System Supports: Alignment with insights from decision support and CorCare (where applicable).

Decision Check:

- ✓ Can this be operationalized in scheduling?
- ✓ Have I collaborated with quality and considered any adjustments?
- ✓ Do I have a contingency plan?
- ✓ Are escalation pathways defined?

Outcome: Documented, actionable staffing plan.

Example Care Setting Considerations:

- Acute Care: Develop flexible staffing plans with defined escalation triggers to respond to changes in volume and acuity.
- Long-Term Care: Establish stable baseline staffing models with clearly defined contingency and escalation triggers tied to changes in resident acuity, behavioural complexity, or staffing availability
- Community Care: Document caseload targets, visit prioritization criteria, and routing logic, with defined thresholds for adjusting service delivery during staffing or demand pressures.

Step 7: Monitor and Adjust

Regularly review safe staffing compliment and adjust as needed.

Start Here: Schedule a regular huddle with your team to assess safe staffing compliment and adjust as needed.

Look at:

- Patient outcomes and flow metrics
- Variance from planned staffing
- Overtime and workload indicators
- Feedback from front-line staff

What this means in practice: Based on changing patient needs, operational experience and data trends, continuously improve your staffing approach through regular reviews.

Ask yourself:

- ✓ Is staffing meeting patient needs?
- ✓ Are there recurring gaps or pressures?
- ✓ Do adjustments need to be made?

Outcome: Continuous alignment of staffing with patient and organizational needs.

Example Care Setting Considerations:

- Acute Care: Monitor frequently, focusing on patient flow, staffing variances, overtime, and safety indicators.
- Long-Term Care: Monitor quality indicators such as falls, pressure injuries, and missed or delayed care to assess alignment between staffing and resident needs.
- Community Care: Monitor access to care, visit completion rates, travel efficiency, and unmet or deferred demand to inform ongoing adjustments.

Conclusion

Planning for safe staffing requires consideration of all of the practice guidelines noted within this document, with consideration for organizational policies and procedures, and inclusive of patient experience, patient needs and outcomes, professional judgement, organizational context, data trends, quality and safety, and appropriate skill mix. Incorporating these guidelines into the staffing process supports a consistent approach to staffing for safe, quality care.