



Newfoundland and Labrador Health Services

Core Staffing Review: Current State, Gap Analysis and Workload Analysis Final Report

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0. Executive Summary

The Newfoundland and Labrador Core Staffing Review identifies that workforce pressures across Newfoundland and Labrador Health Services are driven not only by number of staff, but by a combination of rising patient complexity, inconsistent care models, and structural inefficiencies in how work is organized. Demand is increasing due to an aging population, higher acuity, and system flow constraints, while current staffing models are further strained by variability in role utilization, limited access to support staff, and fragmented digital and operational processes. As a result, highly trained clinical staff regularly execute non-clinical and administrative tasks, limiting their ability to work to full scope of practice and reducing overall system productivity.

The review concludes that while targeted increases in staffing, particularly in support roles such as PCAs and in high-acuity settings, will be required in select areas, sustainable system improvement will not be achieved through headcount increases alone. Instead, the key opportunities lie in fundamentally redesigning how care is delivered and how the workforce is deployed and supported. This includes enabling team-based care models, aligning roles to full scope of practice, reducing non-nursing workload, strengthening education and onboarding capacity, and addressing systemic barriers such as patient flow and inconsistent access to tools and supports. Central to this shift is moving away from rigid, ratio-based staffing models toward data-informed, acuity-driven approaches that better match resources to patient need and improve responsiveness to changing conditions. The review also captures that the unique characteristics of rural versus urban setting require tailored approaches to realize these opportunities.

The path to a sustainable workforce is primarily a productivity and system design challenge rather than solely a staffing shortage challenge. While additional positions may be required in targeted areas, the priority for implementation is to unlock capacity within the existing workforce through better support, more efficient processes, and precision staffing approaches. This is contingent on concurrent progress in addressing system flow constraints, workforce supply challenges, and care model supports, particularly in rural and remote settings.

0.1 Purpose and Scope of the Review

This Core Staffing Review was commissioned to provide an evidence-informed assessment of staffing models, workload drivers, and care delivery across NLHS. The review examined six representative sites spanning acute care, long-term care, and community care settings, with a focus on the core nursing workforce (Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, and Personal Care Attendants) and the factors shaping staffing demand and utilization.

The analysis integrates quantitative data (e.g., workload indicators, occupancy, staffing patterns), qualitative input from frontline staff and leaders, and comparative insights from other jurisdictions. The objective is to identify opportunities to align staffing models with patient needs, improve workforce sustainability, and support consistent, high-quality care across the province.

0.2 Key Findings

The review identified a set of interconnected findings across patient (client), staff (workforce), and system (organizational) dimensions:

Patient / Client

- Patients and residents are presenting with greater clinical, functional, and psychosocial complexity, yet staffing approaches have not consistently adapted to reflect this increased care intensity. This is most notable in the long-term care settings.
- Workload is increasingly shaped by cumulative care time and coordination needs rather than patient volumes alone. This is most notable in the acute-care and community-care settings.
- High ALC volumes and discharge delays result in patients receiving care in settings that are not consistently aligned to their needs, placing additional burden on staff and resources. This is most notable in rural communities where access to alternative care services and support is limited.
- Investments in precision staffing and the CorCare (provincial Hospital Information System) systems position NLHS to advance toward precision staffing models that better align resources with real-time patient needs.

Staff / Workforce

- Differences between urban, rural, and remote settings create variability in staffing availability, demonstrated scope of practice, and workload distribution.
- Regulated staff, particularly nurses, are frequently performing non-clinical tasks due to limited support and allied health roles, reducing time available for direct patient care.
- While effective multidisciplinary care models exist in pockets, they are not consistently scaled across the system. This was most notable in acute-care settings – where gaps in allied health and other clinical roles were most evident.
- While the use of NPs is growing in the province, there are areas where the allocation of NPs should be prioritized, such as long-term care homes where medically complex residents are present and medicine inpatient or similar units where patient flow would benefit from the scope of NPs.
- The use and scope of PCAs and other support roles remain constrained, despite opportunities to expand their contribution to care delivery.
- Staff report high administrative burden, challenges with scheduling and coverage, and increasing reliance on overtime and workaround solutions, all of which contribute to burnout, absenteeism, and retention risks.

System / Organizational

- The transition to a single health authority presents opportunities for standardization, but current variability exists in policy application, education, and staffing practices, which creates inconsistencies across sites.

- While foundational technology systems are in place, inconsistent adoption and integration of tools limit their ability to support efficient workflows and staffing decisions.
- Challenges with patient flow across the continuum of care, including limited long-term care capacity and community supports, continue to impact staffing demand and utilization. This was most notable in acute-care, where high rates of ALC may necessitate staffing model changes to match the lower patient acuity.

0.3 Conclusions and Direction

Qualitative Recommendations

The findings demonstrate that improving workforce sustainability requires a shift from viewing staffing challenges as a recruitment and retention issue to addressing them as a care delivery and system design opportunity.

The recommended future state focuses on four core directions:

- Align scope of practice, reduce non-clinical workload, and strengthen team-based care models.
- Improve onboarding, mentorship, and workforce availability.
- Embed standardized, acuity-driven approaches to staffing decisions.
- Address system flow constraints and leverage digital tools to improve efficiency.

Together, these shifts aim to improve productivity, enhance care quality, and ensure staffing models are responsive to evolving patient needs.

Delivering this transformation will require more than policy change - it will require dedicated implementation capacity.

NLHS must invest in the leadership, analytical, operational, and change management resources needed to:

- Redesign care models and staffing approaches.
- Scale leading practices across sites and care settings.
- Enable consistent use of data and digital tools.
- Engage frontline staff in sustained change.

NLHS has a clear opportunity to lead in modern, data-driven, team-based care, ensuring that staffing models are aligned with patient needs and that the workforce is supported to deliver high-quality care.

1. Context and Approach

1.1 Provincial Context

Health and community services in Newfoundland and Labrador are delivered primarily through Newfoundland and Labrador Health Services (NLHS), the province's single health authority, operating within a period of sustained system transformation. The direction for this transformation is set by the Health Accord, a ten-year framework that identifies workforce sustainability, integration of services, and alignment of care delivery models with population needs as critical enablers of system performance. The Health Accord recognizes that staffing challenges within the health system, particularly related to workload, skill mix, recruitment, retention, and equitable distribution across care settings, pose a risk to access, quality, and safety across the continuum of care. These challenges occur within the context of an aging population, rising patient complexity, geographic dispersion, and increasing demand for services across acute, long-term care, and community settings.

The province currently has a number of initiatives underway to address the health workforce challenges:

- Health Human Resources (HHR) Framework for Change has set in motion a plan to strengthen the workforce across the province, with specific commitments to stabilize supply and capacity. Reflecting the priorities of all system partners, the Framework integrates and builds upon existing strategic plans:
 - Health Accord for Newfoundland and Labrador
 - Department of Health and Community Services Strategic Plan
 - Newfoundland and Labrador Health Services Strategic Plan
 - Department of Education Strategic Plan
 - Department of Seniors Strategic Plan
- Integrated Capacity Management (ICM) is being implemented to support more consistent, data-informed approaches to staffing, patient flow, and workload management, including the use of acuity-based tools to inform staffing decisions.
- CorCare, the province-wide health information system, is expected to modernize clinical documentation and standardize workflows. The implementation anticipates downstream impacts that will provide greater insights on patient needs, enhance workforce efficiency, and improve care coordination.
- Early work has begun to build a standardized Provincial Care Coordination Centre to support efficient and consistent, province-wide processes for transfers and patient repatriation. This initiative is underpinned by the development of NLHS transfer and repatriation policies.
- Recent attention has been given to provincial surge planning with an emphasis on ensuring each zone maintains a comprehensive surge plan aligned with provincial standards.
- Alternate Level of Care (ALC) improvement work is underway, focused on improved monitoring of ALC indicators and avoiding preventable ALC stays (e.g., expediting access to equipment). The role of a discharge facilitator is being explored, to undertake early risk assessments and support patient flow.
- The Long-Term Care (LTC) and Personal Care Home Program Review has identified the need for improved staffing levels, skill mix, and working conditions, with a provincial transition toward standardized resource models to better align resources with resident needs.

Within this context, the Core Staffing Review is positioned to provide a structured, evidence-informed assessment and findings to support provincial and organizational decision-making moving forward.

This report was drafted prior to the provincial CorCare go-live and may refer to the program in the past tense. While this does not affect the site findings, readers should consider other initiatives underway or completed at the time of publication.

1.2 Overview of Project Scope and Approach

Scope and Objectives

The Core Staffing Review examined staffing and workload drivers across selected care settings in the province. The review spanned six sites representing acute care, long-term care, and community-based care settings, and considered client, staffing, and organizational factors.

The province selected the six sites as representatives of the in-scope care settings:

1. Labrador South Health Centre (LSHC).
2. Western Long-Term Care Home (WLTC), including restorative and rehabilitation services.
3. James Paton Memorial Regional Health Centre (JPMRHC).
4. Placentia Health Centre (PHC), including Lions Manor.
5. Health Science Centre (HSC) – Units 4NA and 4NB.
6. Mount Pearl Square (MPS) – Community Health.

Staffing analysis focused on the following core staff groups:

1. Nurse Practitioners (NPs).
2. Registered Nurses (RNs).
3. Licensed Practical Nurses (LPNs).
4. Personal Care Attendants (PCAs).

In 2024-2025, these four professions represented nearly 1,200 full-time equivalents (FTE) across the six sites in scope.

Key Activities

The review was structured as a four-phase initiative:

- Phase 0: Establishing governance, align interest holders on objectives and approach.
- Phase 1: Undertaking a detailed assessment of organizational, client, and staffing factors across six sites, supplemented by a literature review and jurisdictional scan to inform opportunities.
- Phase 2: Developing evidence based, provincial and site-specific recommendations.
- Phase 3: Developing an implementation roadmap and a practical guide to carry the recommendations forward.

The project deliverables support both near and long-term decision making, and implementation to optimize resources and meet the population health needs across the system. The review uses an integrated framework that triangulates quantitative data analysis, qualitative engagement, and a jurisdictional scan (J-scan)/evidence review to establish the current state, identify gaps, and inform actionable staffing recommendations across care settings.

Unless otherwise stated, “Participants” refers to those interviewed, surveyed, and engaged throughout the project and report development – including government and NLHS leadership, management, front-line staff, and other professional groups.

Data and Analytics

NLHS extracted data from NLHS enterprise reporting and operational systems, including finance and workload sources (e.g., General Ledger), hospital management information systems (MIS), patient and occupancy databases (e.g., Discharge Abstract Database), scheduling/workload systems (e.g., ANSOS/AAM/Capacity Planner), and other available dashboard/reporting outputs, to inform the current state operations for the sites in scope. Standard workload and activity indicators were used to enable comparison across sites and care settings, including calculations such as Hours Per Patient Day (HPPD), and trend analyses over a 3-year fiscal period (e.g., occupancy, length of stay, ALC volumes).

Relevant data points are presented in descriptive figures and tables in Appendix A.

Data Limitations

- Analysis is based on data extracts and reports provided through NLHS systems and site submissions
- Variability in definitions, coding, and reporting practices across sites/systems may limit direct comparability of select metrics. Some sites have advanced data collection tools while others remain paper based.
 - For targeted sites or departments, some data was not provided or only provided for targeted timeframes.
- Several indicators use available proxy measures of workload (e.g., hours-based ratios) provided by NLHS, and may not fully capture task intensity, indirect work, or non-nursing duties.
- Patient/resident complexity measures are not consistently captured or applied across all care settings, limiting standardized linkage between acuity and staffing demand.
- Trend analyses may reflect incomplete or uneven historical coverage for some services (particularly community-based services and acute care ambulatory services) and should be interpreted directionally.
- The assessment identified foundational constraints that limit sites' ability to independently conduct and sustain detailed workforce planning analyses, including limited management capacity, lack of enabling tools and analytical support, and inconsistent availability of budgeted FTE data. In several sites, budgeted FTEs were not available in the General Ledger, limiting visibility into how actual staffing compares to intended staffing levels and constraining the strength of site-level conclusions. Addressing these foundational gaps is a prerequisite to effective implementation of staffing recommendations.
- While headcount data was not provided, it is assumed that the analysis and recommendations impact a higher number of individual professionals.

Calculating Recommended Budgeted (FTE) Positions

The unit's budgeted FTE is estimated by multiplying the target nursing hours per patient (or visit) by the expected patient volume (e.g., patient days or visits). This produces the productive hours needed for scheduling, which can be converted into budgeted positions (FTE). A standard assumption is that 1 FTE equals 1,950 hours per year, plus an uplift to cover benefit time (e.g., sick and leave).

The unit-level calculations use the following assumptions, unless otherwise stated:

- MIS guidelines assume about 20% of worked hours are spent on non-patient-facing activities. This is reflected in the target UPP benchmark used for planning.
- For Acute units, a standard assumption is that 1 FTE equals to 1,950 hours per year, plus a 30% uplift to cover benefit time. The percentage was determined by assessing average worked to earned ratios across acute care sites.

- For LTC units, a standard assumption is that 1 FTE equals to 1,950 hours per year, plus a 30% uplift to cover benefit time. The percentage was determined by assessing average worked to earned ratios across long-term care sites.

The calculations for recommended budgeted (FTE) positions results in a total required number of positions to meet the target nursing hours per patient (RN and LPN).

Calculating Recommended Skill-Mix

Using the recommended budgeted (FTE) positions calculated above, the results can be translated into a practical skill-mix and scheduling approach that outlines the recommended distribution of roles and the associated budget impact.

The calculations of recommended skill-mix used the following assumptions:

- For acute care units, the recommended RN/LPN skill mix is aligned to patient acuity and complexity – meaning:
 - RN hours are prioritized in higher-acuity patient populations, resulting in 70% - 100% of the skill mix on acute inpatient units.
 - LPN hours are applied where patient needs and unit context support safe, full-scope LPN practice (e.g., units with a higher proportion of Alternate Level of Care (ALC) patients).
 - PCA hours are treated as additional to the RN/LPN hours required to meet the target hours per patient day; a typical planning assumption is to add approximately 5% additional hours for PCAs to support personal care and non-nursing tasks.
- For long-term care (LTC) units, a target skill mix of 30% RN/LPN and 70% PCA, as documented in the Long-Term Care and Personal Care Home Review¹.

1.3 The Care Settings

We examined three distinct care settings to develop a comprehensive understanding of the current state of staffing across provincial services:

Long-Term Care (LTC)

LTC provides 24-hour residential support for individuals with high dependency, cognitive decline or complex chronic conditions who can no longer live independently. Care focuses on daily living assistance, medication management, mobility support and palliative care, delivered primarily by LPNs and PCAs with RN oversight. The environment is designed to be homelike, emphasizing safety, routine and dignity. Long-term care services were examined at the Western Long-Term Care Homes, Lions Manor (Placentia), and the LTC program at Labrador South Health Centre.

Acute Care

Acute care is focused on providing necessary treatment for diseases or severe episodes of illness or injury over a short period of time. Services are often provided in a hospital-based setting, with access to equipment and resources required to stabilize and treat acute patients. Care teams deliver triage, emergency interventions, diagnostics coordination, and continuous patient monitoring over the course of a

¹ Government of Newfoundland and Labrador, Department of Health and Community Services, Long-Term Care and Personal Care Home Program Review: Recommendations (January 20, 2025), <https://www.gov.nl.ca/hcs/files/Long-Term-Care-and-Personal-Care-Home-Review.pdf> (accessed April 17, 2026).

patient stay. In rural and remote settings, RNs often lead frontline assessment and stabilization with virtual physician support, with the primary goal to stabilize, treat, and transfer or discharge patients as appropriate. Across the six sites included in scope, acute care services were examined at the Health Science Centre (Units 4NA and 4NB), James Paton Memorial Regional Health Centre, Placentia Health Centre, Western Long-Term Care Rehab and Restorative Units and Labrador South Health Centre.

Community Care

Community care focuses on prevention, wellness, and the management of chronic diseases for people living at home. This support includes public health nursing, home care, mental health services, primary care follow-up, and education for chronic conditions. The goal is to help individuals remain safe and well in their communities by reducing unnecessary emergency visits and supporting daily functioning. Across the region, a diverse range of programs provides the supports needed to address barriers and enhance quality of life. The overall focus is helping individuals access the supports they need to overcome barriers, enhance independence, and improve their quality of life. Community-based services were examined at Mount Pearl Square Community Health and Community Health services at Labrador South Health Centre.

1.4 The Factors

The analysis outlines the client, staffing and organizational factors that impact current staffing and patient care. This approach provides a holistic view of the conditions shaping core staffing.

Organizational Factors

Organizational factors consider the broader system environment that enables or limits effective service delivery, including physical layout, workflow design, operational policies, leadership structures, scheduling practices, diagnostic availability, and administrative processes. These factors shape workload distribution, system capacity and the overall functioning of care teams.

In rural and remote sites, organizational design and access constraints (e.g., limited on-site diagnostics, fewer support services, and reliance on virtual/on-call coverage) can impact staffing flexibility and the time required to coordinate and deliver care, which should be reflected in staffing models and workload assumptions.

Client Factors

Client factors describe the characteristics and needs of the population served, including acuity, complexity, functional dependency, chronic disease burden and psychosocial requirements. These factors determine the intensity and type of care required and directly influence the demand for staffing.

Staffing Factors

Staffing factors examine the availability, skill mix, staffing levels, and deployment of NPs, RNs, LPNs and PCAs. These factors highlight current staffing ratios, scope of practice, cross-coverage capacity, shift patterns and ability to target hours of client care needs or adjust to variability in supply and demand.

These three factors create a structured framework for evaluating current state core staffing and provides a comprehensive view across the care settings. The following sections will be structured by factor type.

2. Current State Findings

This chapter is intended to document a shared understanding of existing staffing models, workload drivers, and care delivery conditions across selected NLHS sites. Drawing on quantitative data, qualitative insights, and comparative evidence from other jurisdictions, the current state captures the provincial themes across and within care setting through the following sections:

2.1 Organizational Factors

2.2 Client Factors

2.3 Staffing Factors

Site specific findings are detailed in Appendix A. The current state serves as the baseline to inform future state planning and the development of staffing recommendations. Rural and remote care settings can experience workforce availability constraints due to smaller local labour pools, longer recruitment timelines, and limited access to specialized roles.

The project team employed a multi-faceted engagement approach that integrated quantitative analysis with direct input from staff, leadership, and other interested parties. Key activities included:

- Data collection and analysis of quantitative data from multiple sources, including financial systems, scheduling tools, and operational reports.
- Interviews with site and provincial interest holders to gather insights on staffing, client and organizational factors.
- Distribution of a front-line survey to capture broad input on staff experiences and ideas.
- Physical site visits to observe workflows and physical environments.
- In-person and virtual open forums for front line staff to share experiences and ideas.
- Collaborative sessions with site working groups to validate findings and identify opportunities.

2.1 Organizational Factors

This section summarizes the organizational factors that shape staffing and delivery of care. These findings highlight system-level enablers and constraints that contribute to workload.

Participants across sites in scope of the review reported that organizational factors impact their day-to-day work. While these conditions vary by site and care setting, four common themes emerged:

2.1.1 System and organizational factors

2.1.2 Physical environment and supports

2.1.3 Tools and Digital Enablers

2.1.4 Education and Leadership

2.1.1 System and Organizational Factors

Collective agreements from the following professional unions provide the working conditions and staffing requirements for their members, including standard working hours, use of overtime, casual and other deployment related requirements:

- Registered Nurses' Union Newfoundland and Labrador (RNUNL)
- Newfoundland and Labrador Association of Public and Private Employees (NAPE)

- Canadian Union of Public Employees (CUPE)

Today, staffing operates differently across the zones. While the province is moving to a centralized model, this work is not yet complete, which adds complexity to staffing approaches in Eastern, Central and Labrador Grenfell Zones. The Western Zone has historically operated a centralized staffing and scheduling model.

To advance the intended centralized model, several provincial-level policies and procedures are undergoing changes. The following NLHS Standard Operating Procedures have been drafted to be implemented following the CorCare go-live:

- Centralized staffing and float pool.
 - Self-scheduling management.
 - Daily scheduling decisions.
 - Use of agency resources.
 - Sick and leave calls.
 - Unscheduled shifts and overtime.
- NLHS professional practice policies and clinical guidelines, including scope-of-practice frameworks for regulated nursing roles, intended to provide role clarity and workload distribution.
- Provincial LTC operational standards set by the Department of Health and Community Services.

NLHS continues to work through the merger of the former regional health authorities into a provincial operating model. As these changes are implemented, staffing and professional practice approaches continue to vary within and across zones, and further harmonization work remains underway.

As a result of ongoing development of professional practice guidelines and standard operating procedures, variability in interpretation and application exists across sites today. The review did not assess the effectiveness or compliance with agreements or policies.

2.1.2 Physical Environment and Supports

Participants identified the physical environment and access to supports as contributors to staffing workload. Summary of details provided in the site-level analyses in Appendix A include:

- Physical environment characteristics, including the distance staff must travel between patient areas, limited line of sight from nursing stations, and constrained or inefficient layouts, are perceived to increase workload demands.
- Variable access to modern, appropriate equipment (e.g., lifts, oxygen machines) are perceived to increase manual workload demands.
- Variable access to support staff (e.g., clerical, administrative, security, MSAs) is perceived as resulting in an inaccurate reflection of core staff workload.²
- Virtual access to primary care providers, particularly in rural and community settings, provides some, but not all, support to manage patient needs, resulting in perceived increase in workload.
- Differences in the realities of urban and rural sites impact the feasibility of addressing staff supply shortages.³

² Government of Newfoundland and Labrador and Newfoundland and Labrador Nurses' Union. Report of the Provincial Nursing Duties Working Group: July 2011

³ Newfoundland and Labrador. Department of Health and Community Services. *Health Human Resources Plan: Comprehensive Final Interim Report*. May 2025, <https://www.gov.nl.ca/hcs/files/HealthHumanResourcesPlanReportMay-2025.pdf>.

Staff Perspectives (sample)

"Another significant factor that affects our workload is the ongoing limitation of essential stock and supplies. Staff often struggle to access the basic products required to provide safe, effective, and dignified care."

"Update equipment to prevent having to [sic] sit nurses constantly [sic] with airvo patients."

"Even if we did have enough staff on shift, we desperately need more support staff throughout the hospital (i.e. 24-hour blood collection, portering, pharmacy) because these specialized tasks fall back on the RN."

"Health care is a 24-hour job, the idea that the hospital slows down in the nighttime is outdated and not reflective of how the hospital operates after hours. I would argue that nurses who work night shift have to do more with less."

"Addressing workload requires more than just adding nurses. We urgently need increased support staff, clerical, clinical, and auxiliary, to take on non-nursing tasks that continually pull nurses away from direct patient care. When support roles are properly staffed, nurses can focus on what they are trained to do, and patient outcomes improve."

"We have amazing staff who are engaged, enthusiastic, and want to be able to do more for their patients, but they can't because they have to do so many other things (portering, doing MSA tasks, ...). The tools we need are more people to help us. We need more help and more storage."

"Acuity has changed so much over my 29 years as a nurse on [unit]. At target staffing levels, I feel it is still not possible to provide the care that people deserve and expect. Lack of support staff, carrying out their roles, is a big part of the picture. Nurses are left to carry out many non nursing duties."

"Majority of my job has become completing non-nursing tasks. I've worked outside of NL where there was adequate support staff and it was life changing. We struggle to keep our singular PCA position staffed, their reason for leaving is always because they don't have enough help and they cannot complete their duties... We need PCAs, LPNs, porters, MSAs, cleaners, etc. You will continue to see mass staff exodus of RNs on [unit] if there is no improvement seen to our core staffing levels. Our staff and patients deserve much better than the bare minimum."

2.1.3 Tools, Systems and Digital Enablers

A range of provincial tools are in place to support staffing and capacity planning across NLHS. Current core systems, in various stages of implementation, include:

- ANSOS, used to develop and manage schedules across acute and long-term care, providing visibility into target staffing levels, scheduled staff, variances, and agency utilization. Participants noted that ANSOS as a user-friendly tool, supported by regional and provincial centralized staffing teams.
- Acuity Assignment Manager (AAM), used in inpatient and critical care settings to assign patient acuity scores. Participants noted that AAM currently requires manual data entry each shift, and its use and adoption vary across teams.
- Capacity Planner (CP), used to capture capacity data, such as occupancy and patient volumes, to project the future capacity utilization based on 5-year historical trends.
- HealthStream dashboards, used to integrate ANSOS, AAM, Capacity Planner and budgeted data, where available, to visualize current and projected target and actual staffing.
- Data available from RAI-MDS that can be used to access Resource Utilization Group data to inform resident acuity and resource allocation accordingly. The organization is in the process of implementing CorCare (Epic EHR), with go-live planned for April 2026. Participants described the intended integration of existing staffing and capacity tools with electronic patient charts to enhance acuity-based staffing decisions.

Digital and equipment maturity varies across sites. Some sites maintain legacy equipment, such as bedside call bells and alarm systems, that limit their ability to digitally enhance workflows.

Leadership in the community care settings report an untapped potential to leverage RAI assessment data and frailty scores to identify community-based patients at risk of decline. This would allow for system-level planning and patient risk prediction that could inform staffing decisions.

Staff Perspectives (sample)

"Staff spend a considerable amount of time charting when they could be caring for patients. A streamlined charting system would allow more patient care time."

"I am excited for CoreCare to be rolled out. I feel that ANSOS, if embraced by our charge nurses, would be helpful. Acuity based staffing."

"It is crucial to encourage RNs across the hospital to complete their AAM and for central staffing and the site coordinator to examine these numbers when considering who to float."

"Point of care access to charting in community would be ideal, such as via iPad or a secure app on a phone. We currently chart later in the day on all clients seen, which is inefficient, and increases the risk of incorrect charting. Our charting system itself is slow, cumbersome, and outdated. I am hoping that this will improve with epic."

"Double, triple documentation has to stop, the amount of time it takes to complete an admission on a resident for Longterm care is not acceptable. Every other day there is another form added to the list, with all the documentation it is taking us away from the people that need us, the resident. I know these forms are required for accreditation but, somethings need to be revised or dropped."

"All of time wasted double documenting - transcribing orders, documenting in computer, writing on shift reports. A lot of time wasted managing staffing for units could be resolved with access to staffing screens, rather than having to call and email."

2.1.4 Education and Leadership

Access to education, mentorship, and leadership support is critical to stabilize and optimize staff capability. NLHS is actively working to establish a provincial mentorship program, being driven through the Professional Practice team. However, participants indicate this support can be variable – namely,

- Participants report while relevant education opportunities are available, there can be insufficient capacity to backfill while staff attend educational sessions.
- Internationally educated nurses (IENs) have been recruited at higher rates over the last 3 years; however, participants reported that leadership capacity to onboard IENs has been limited, resulting in concerns over IEN integration and independence.
- At times across settings, clinical nurse educators and coordinators bridge gaps in shift vacancies by taking patient assignments, which impacts the ability to support mentorship and learning opportunities for staff and to enable nurses to work to their full scope of practice.

Staff Perspectives (sample)

"The role of educator is different from each zone. Some zones are more education focus, and some pull educators in to provide clinical care support."

"Adequate clinical educator support is essential for expansion of scope of practice for LPNs and RNs and all nursing staff for onboarding education and ongoing support."

"It is neither sustainable nor fair to expect already exhausted nurses to train IENs, especially when those IENs are entering the system without going through the Center for Nursing Studies.... Relying on burnt-out staff to fill the gaps in orientation or training only compounds the problem ..."

"Being senior leads to extra work."

"They [IENs] need support in getting their permanent residency, access to care, social services and overall well-being, not just training."

"The IEN are relying on each other more than relying on other staff within the site... the biggest concern is they don't have the same level of education."

"We need the additional support and training... There is a program for our IENs and we did support the new 300 new staff... there is room for improvement, but we need to highlight that there is onboarding."

"Some of them [IENs] are recruited as PCAs while they were licensed professionals where they come from... we need to encourage them to continue training and upskill, with an adapted pathway to have them get to LPN, etc."

"Safe ratios, adequate support staff, and proper, structured education pathways are not optional, they are the foundation of a safe, functional, and ethical healthcare system. Without them, we are setting everyone up to fail."

Summary of Key Organizational Findings

Across the six sites, the following organizational insights include:

- Variation in the local implementation of NLHS policies, together with evolving professional practice guidance, contributes to differences in staffing approaches at the site and unit level.
- Workflows and staffing efficiency are influenced by the physical environment and by the level of access to clinical and diagnostic supports. Differences in location, facility layout, and time-of-day availability of key supports contribute to variability in workload.
- Despite strong foundational systems and the anticipated benefits of CorCare and other provincial tools, fragmented digital tools, manual data entry, and varying levels of digital maturity continue to impede timely and consistent staffing decisions.
- Professional practice and operational leaders cannot consistently prioritize their respective oversight and support to nurses, when shift vacancies must be addressed

These organizational factors form a critical part of the current state context and must be considered alongside client and staffing factors when determining future core staffing requirements.

2.2 Client Factors

Client factors describe the characteristics, needs, and care requirements of the populations served, including acuity, complexity, functional dependency, psychosocial needs, and patterns of service use. This chapter reflects quantitative and qualitative insights related to demand factors shaping staffing.

Provincial Findings

Participants described changes in population health across all care settings. Clients were described as presenting with a perceived increase in clinical and functional needs, including presentation with multiple chronic conditions, cognitive impairments, mental health and substance-use challenges, and significant psychosocial complexity.

Recent provincial reports⁴ have highlighted:

- Today, the largest age cohorts across Eastern Rural, Central and Western Zone are ages 45-79.
- Population over 65 years of age will grow from 23.6% in 2022 to 29.1% by 2032.
- Prevalence of cognitive and neurological diseases are anticipated to increase 30-40% by 2032.

These changes in overall population health and care demand of patients have resulted in workloads that are perceived as driven by cumulative care time per patient, rather than solely measured through patient volume. Participants reported feeling that these workload drivers are not consistently reflected in traditional acuity tools and staffing metrics.

Limited system capacity and challenges with patient flow have resulted in patients receiving care in settings misaligned with their clinical needs. This has implications for required staffing and skill mix.

- Data analysis shows a high proportion of patient days were spent in acute settings, often on inpatient medicine units, despite long-term care being the clinically appropriate setting.
- Participants report there is limited access to primary care in different regions, which results in higher readmissions post acute discharge.
- Participants report that limited availability of community-based rehabilitation resources, particularly in rural regions, contribute to longer LOS in acute care.

Staff Perspectives (sample)

"The acuity of my inpatient unit has increased exponentially since I started working there 5 years ago. When we are fully staffed the nurses still struggle, especially when in double overcapacity and surge protocol."

"We are not staffed based on acuity or surgical or any changes in the unit. We often work short and the acuity and age of patients have increased."

"If there [sic] were PCAs to help dress and wash [sic] in the morning, to help patients mobilize more throughout the day for voiding or up for meals, it would lead to less stress on rehab services and decreased time admitted in hospital."

"We have some of the best care even with some of the stuff that happens... being a volunteer and being on the floor, I have only good things to say. Even if staff are tied up."

⁴ Health Accord NL. *Our Province. Our Health. Our Future: A 10-Year Health Transformation*. Feb. 2022, https://www.healthaccordnl.ca/wp-content/uploads/2022/02/HANL_Report_Document_Web_modFeb28-2022.pdf.

System Progress and Enablers

The province and NLHS have made efforts to adapt care delivery and workforce planning approaches to account for changes in population demographics and overall health. Through targeted investments in senior-friendly care and system-wide data and digital capabilities, the system is strengthening its ability to anticipate demand and align sustainable staffing models to patient needs. This includes,

- Development of plans and guidelines such as the Senior's Health and Well-Being Plan⁵ and the Senior Friendly Care Framework, identifying core senior-friendly care principles to be adopted across the province, such as early and frequent mobilization of seniors in acute care to reduce functional decline, falls, and length of stay.⁶
- Implementation of CorCare across acute care, long-term care, and community care, integrated with workforce scheduling tools, increases the provinces' ability to project shifts in population care needs over time and across care settings.

As Client Factors vary across care settings, the key current state themes in this sub-section are further described through acute care, long-term care, and community care categories.

Acute Care

While each acute site operates within a different scale and context, common client-driven pressures were observed, such as high occupancy rates, patient complexity, longer than expected lengths of stay and sustained patient flow constraints.

Staff Perspectives (sample)

"It would be nice to be staffed at the target level but also even when we are fully staffed a lot of the time we are at 130% capacity at the hospital and need even more staff that they think "target" is."

"The acuity of my inpatient unit has increased exponentially since I started working there 5 years ago. When we are fully staffed the nurses still struggle, especially when in double overcapacity and surge protocol. We need more RNs and PCAs to help with the increased workload."

"Patient and family needs have changed in acuity and frequency. An additional core position especially on days would ensure patient and family needs are met, nursing duties are complete, nurses are getting breaks thus improving morale and sick leave hopefully impacting retention. As well, a charge nurse is needed for each unit. An eight-hour day -5 days week position to piece together the patient story as there are always changing staff and sometimes pt stay details are unknown."

"We are working with such a vulnerable population and us as nurses are struggling to give them the care that they deserve. [Unit] is a unit where sometimes you need to sit with people and be there for them as they probably just got a terrible diagnosis or their family member is comfort care and they just need someone to talk to. How many patients' receiving [treatment] don't receive the proper education that they deserve because we're working 2 nurses short... It's impossible, our unit deserves better, our patients deserve better."

"We are a very acute unit but yet our patients deserve personal care. Often times we have patients that want their head shaved because they just started treatment or they just need some assistance with basic activities of daily living and that's put on the back burner because we're short staffed."

⁵ Government of Newfoundland and Labrador. *Health Care Action: Senior's Health and Well-Being Plan*. July 2024, <https://wellbeingnl.ca/wp-content/uploads/2024/07/24150-Seniors-Health-and-Well-Being-Plan-July-29-v2-1.pdf>

⁶ Health Accord NL. *Our Province. Our Health. Our Future: A 10-Year Health Transformation*. Feb. 2022, https://www.healthaccordnl.ca/wp-content/uploads/2022/02/HANL_Report_Document_Web_modFeb28-2022.pdf.

“Complex patients care needs are at an all time high. Each inpatient unit would benefit from PERMANENT PCAs positions days/nights. on top of the staff we are already have.”

“When we have an increased acuity, we have a really hard time to convince management that we need another RN to provide quality care and to actually get someone in to cover our increased acuity needs. When we have less acuity, we are able to distribute workloads amongst our RN's in order to provide quality care. However that isn't always the case.”

“When acuity is high and there are patients that also require a lot of physically demanding care, it's impossible to provide patients with the best care that they deserve when there is no extra help ever available.”

Occupancy and Baseline Demand

Participants described occupancy levels that are consistently at or exceed organizational capacity – with data showing 8 of 9 reported acute inpatient units exceeding 90% consistently. At JPMRHC and HSC, overcapacity beds were described as part of routine operations rather than exceptional surge measures; described in more detail on each unit in Appendix A.

Table 1: Occupancy Rate Trends by Hospital Unit Over Time

Data Highlights: While staff report that inpatient areas are regularly over capacity, overall, the data trends illustrate units operated at capacity over the last three years.

Site/Unit	2022/2023	2023/2024	2024/2025	Year Over Year Trend
JPMRHC				
Intensive Care	99.0%	95.6%	93.2%	Consistent
General Surgery Inpatient Unit	101.1%	98.0%	94.4%	Consistent
Medical Inpatient Unit	102.6%	101.4%	101.3%	Consistent
Obstetrics Unit	92.6%	90.0%	60.1%	Decreasing
Orthopedic Inpatient Unit	101.2%	97.3%	93.0%	Consistent
PHC				
Medical Inpatient Unit	51.6%	73.3%	62.9%	Variable
HSC				
4NA Hematology/Oncology Inpatient Unit	100.1%	98.9%	95.5%	Consistent
4NB General Surgery Inpatient Unit	99.4%	99.4%	97.6%	Consistent
4NB Special Care Inpatient Unit	92.9%	95.4%	94.7%	Consistent

Note: Source, Meditech Admissions Module. LSHC data is unavailable. PHC converted 2 Medical Unit beds to ED beds to meet demand. JPMRHC Obstetrics unit increased operational beds x10 in 2024.

Length of Stay (LOS) and Level of Care

LOS patterns can provide insight into patient needs and system pressures, including acute LOS trends, the proportion of Alternate Level of Care (ALC) days relative to total LOS, and patient flow by admission source.

- Participants reported that extended admissions are more commonly associated with patient complexity, frailty, and system-level discharge barriers rather than ongoing acute clinical instability.
- Consistent with these perspectives, Table 2 shows that medical inpatient units have longer average lengths of stay and a higher proportion of ALC days than surgical units, where LOS remains shorter and predominantly acute, this may indicate that prolonged admissions are more often driven by discharge constraints not sustained acute clinical need.

- ALC pressures were consistently described as contributing to increased staff workload, with patients awaiting placement often requiring continued care related to functional dependency, cognitive impairment, behavioural needs, and social complexity.
- The absence of outpatient rehabilitation services in the Western region was identified as a contributing factor to longer lengths of stay within the WLTC Rehabilitation and Restorative Care units.

Table 2: LOS and ALC Rates Over Time by Site

Data Highlights:

- Overall, the % ALC days in acute care were relatively consistent over the past three years, with notable exceptions for JPMRHC medical, obstetrics and surgical units.
- JPMRHC and PHC Medical Inpatient Units – the majority of a patient's LOS was ALC, however, the most recent year shows a decrease in % ALC days.
- JPMRHC Orthopedic Inpatient Unit – The average LOS has decreased over time. However, the total LOS days and proportional % ALC days have increased, which may reflect that a subset of patients could be managed at a lower level of care.
- HSC General Surgery Inpatient Unit – The total LOS increased year over year, with limited ALC days, which suggests this patient population was appropriate for this level of care.
- While qualitative staff consultations reported longer lengths of stay (LOS) for WLTC rehabilitation patients due to limited availability of community resources, the average LOS has slightly increased year-over-year compared to other rehabilitation sites across the province. This may reflect the absence of formal publicly available community resources locally. Additionally, the unit does not appear to track ALC-related days.

	2022/2023				2023/2024				2024/2025			
	Total LOS	Avg LOS	% Acute	% ALC	Total LOS	Avg LOS	% Acute	% ALC	Total LOS	Avg LOS	% Acute	% ALC
JPMRHC												
Intensive Care	1,656	5.6	100%	0%	1,777	5.9	100%	0%	1,356	5.3	100%	0%
General Surgery Inpatient Unit	8,710	11.6	90%	10%	8,007	10.1	87%	13%	8,328	11.4	81%	19%
Medical Inpatient Unit	12,583	34.9	29%	71%	12,735	38	27%	73%	12,450	32.7	35%	65%
Obstetrics Unit	356	9.4	94%	6%	605	8.8	85%	15%	2,730	4	97%	3%
Orthopedic Inpatient Unit	6,488	8.6	90%	10%	6,674	6.7	82%	18%	6,698	6.8	73%	27%
PHC												
Medical Inpatient Unit	1,867	20.1	75%	25%	2,682	27.4	48%	52%	2,206	21.2	62%	38%
HSC												
4NA Haematology/Oncology Inpatient Unit	13,829	12.4	88%	12%	13,838	12.1	90%	10%	13,682	11.7	91%	9%
4NB General Surgery Inpatient Unit	12,953	8.1	93%	7%	13,864	9.1	93%	7%	14,696	8.9	96%	4%
4NB Special Care Inpatient Unit	299	3.9	100%	0%	257	8.9	100%	0%	288	7.2	100%	0%
WLTC												
Rehab Inpatient Unit	3 882	62	100%	0%	3 163	60	99.80%	0.20%	3 700	55	100%	0%
Restorative Care Unit	4 938	41	96%	4%	5 713	45	95%	5%	5 039	39	94%	6%

Note: Source, Meditech Admissions Module.

Table 3: Reasons for Alternate Level of Care (ALC) Over Time

Data Highlights:

- The primary drivers of ALC have remained consistent over the past three years, with LTC, Other Services, Palliative, and Home Supports accounting for the largest share of ALC patient days
- Overall ALC volume has increased (+6%) over the last 3 years, with discharge reasons “Other” and Community Health–related ALC days driving recent growth.
- Discharge to LTC was the top reason for ALC designation for the past three years

Reason for ALC – waiting for:	2022/2023	2023/2024	2024/2025	Year Over Year Trend
LTC	6,241	6,623	6,331	Consistent
Other Services (e.g. OT, PT)	1,962	1,989	2,095	Consistent
Palliative	1,085	1,942	1,351	Consistent
Other (e.g., refused discharge)	723	1,165	1,300	Increasing
Home Supports	276	333	391	Consistent
Equipment	190	158	159	Consistent

Note: Figures reflect reported operational data and are presented to illustrate trends over time. They do not imply causality or performance assessment. Presented in this figure is data for ALC from JPMRHC and HSC and is not inclusive of all acute care sites.

Long Term Care

Participants consistently described perceived increase in complexity of resident population, with high functional dependency, and sustained care needs.

Staff Perspectives (sample)

“As well, MDs are often not available to participate in rounds leading to resident not being assessed in a timely manner, medications not being reassessed on time and residents becoming sicker or being required to be transferred to ER/acute care due to lack of assessment/treatment in LTC setting.”

“We have a patient with no family. We purchase clothes and other things out of our own money because we care for the residents. They are our family.”

Occupancy and Continuous Demand

Occupancy has remained consistently high, reflecting sustained demand. Participants and site documentation indicate that bed turnover occurs quickly, with available beds filled by waitlisted residents. Staffing demand is reportedly driven by resident complexity and dependency, not by fluctuations in volumes.

Table 4: Bed Days, Residents Days, and Occupancy Trends Over Time in LTC Setting

Data Highlights: Long-term care demand is sustained across sites, with resident days and occupancy trending toward consistently high levels.

	2022/2023			2023/2024			2024/2025		
	Bed Days	Resident Days	Occupancy	Bed Days	Resident Days	Occupancy	Bed Days	Resident Days	Occupancy
WLTC	38325	29284	76.40%	38430	36845	95.90%	38325	38170	99.60%
PHC/LM	24917	23598	-	21228	20863	-	21690	21303	-
LSHC LTC	-	5734	-	-	5754	-	-	5722	-

Note: Figures reflect reported operational data and are presented to illustrate trends over time. They do not imply causality or performance assessment. Lions Manor Unit 3 part of the review scope of Placentia & was closed for renovations in 2023-2024, which may impact Residents bed/days. Bed days data were unavailable for LSHC and Occupancy data were unavailable for Placentia & Lions Manor. There was a staggered opening at WLTC, where one of the houses did not open until 2023 and may explain the lower occupancy during this timeframe.

Resident Functional Needs

Participants consistently described residents as requiring moderate to total assistance with daily living (ADL), including mobility, transfers, feeding, toileting, and personal care. Mechanical lifts and additional resources are used for residents requiring movement; temporarily increasing the staff ratio appropriate for that individual resident.

Residents commonly present with the following care needs, which staff report can be labour intensive:

- Advanced cognitive impairment or dementia.
- Behavioural and safety needs requiring close monitoring.
- Significant mobility limitations and fall risk.
- High reliance on staff for basic daily care.

Clinical Needs

Participants consistently described an increase complexity of resident clinical requirements. Residents admitted directly from acute care frequently require ongoing clinical interventions that were historically less common in the LTC setting. Examples shared during the site engagement include:

- Complex medication management and monitoring, including residents discharged from acute care with multi-drug regimens requiring closer oversight.
- Advanced and chronic wound care, including pressure injuries and wounds requiring specialized treatments.
- Episodic medical interventions, such as intravenous therapies and blood transfusions, following acute discharge.
- Palliative and end-of-life care, supported through dedicated end-of-life suites and clinical pathways.
- An increased prevalence of bariatric care needs requiring mechanical lifts and minimum two-person assistance.

These observations reflect staff-reported perceptions and could not be quantitatively validated using available site-level data. Regardless, these insights are consistent with broader provincial trends captured

in the recent long-term care and personal care home report⁷, indicating high levels of functional dependency and cognitive impairment among long-term care residents.

Community Care

The community care sites represent urban and rural community care environments, including home visits, ambulatory clinics, public health services, and mixed service community programs. While service models, geography, and population profiles vary, common client factors were described by participants.

Staff Perspectives (sample)

"If we have full staff we can provide quality care, however the level of care of our clients has increased as hospital stays are shorter. This results in not being able to give quality care to clients if there is a sick call."

"I truly believe that the Palliative End of Life Program is an essential piece of Community Health care. However, the program has grown so very much in the last few years, that it can completely take over a CHNs workload. A palliative care team that includes dedicated CHNs, social workers and physicians in the community would be so very useful."

"My concern is not with staffing levels...I wanted to identify that an NP at each community health office would be ideal. We often identify concerns such as infection in clients, that require urgent assessment. Clients often do not have a family physician, cannot get an urgent appointment with a physician, and/or are too unwell to go to emergency to wait in the waiting room for hours."

Scope of Community Based Care

Participants described experiences with program scope expansion at their site, including perceived increase in intensity or complexity of care delivered. Community nurses report routinely caring for clients with higher medical, functional, and psychosocial complexity, such as:

- Chronic disease management for medically complex clients.
- Intravenous therapies and complex medication administration.
- Advanced and chronic wound care.
- Palliative and end-of-life care delivered in the home.
- Post discharge follow-up for clients discharged earlier from acute care.
- Care for newcomer populations, including immunizations and health education.
- Manual, lengthy assessment processes.

Participants report that these services, while clinically appropriate for community delivery, require more time, coordination, and clinical judgment per client than historically. Workload was consistently described as being driven by complexity and cumulative time required per client, rather than visit volume.

Participants reported increased time spent on assessment, education, monitoring, documentation, and follow-up.

⁷ Government of Newfoundland and Labrador, Department of Health, and Community Services. (2025). Long-term care and personal care home review. <https://www.gov.nl.ca/hcs/files/Long-Term-Care-and-Personal-Care-Home-Review.pdf>

Table 5: District and Clinic Visit Trends Across Community Care Setting

Data Highlights: - Total Community Care person visits increased 18.4% over the last three years, with district/home visits driving just over 50% of all activity. - Clinic visits increased 14.2% over the three-year period.									
	2022/2023			2023/2024			2024/2025		
	District Visits	Clinic Visits	Total Number of In Person Visits	District Visits	Clinic Visits	Total Number of In Person Visits	District Visits	Clinic Visits	Total Number of In Person Visits
MPS – Community Care	11147	9671	20818	11965	9815	21780	13597	11043	24640

Note: Source: CRMS.

Geography, Travel, and Access Factor

Participants in rural and mixed care settings consistently identified geography and access constraints as drivers of client related workload, noting that:

- Travel time may impact the number of home visits feasible in a day.
- Weather related disruptions introduce unpredictability in visit planning.
- Limited access to diagnostics and allied health supports.
- Limited access to primary care.
- Afterhours and on-call responsibilities intensify workload for small teams.

These factors reduce the ability to flex capacity in response to demand.

Cognitive, Behavioural, and Psychosocial Complexity in Community Care

As noted in the provincial findings above, cognitive, behavioural, and psychosocial complexities are increasing with clients in the community. These factors primarily affect visit duration, follow-up frequency, and workload predictability. Participants described increased workload related to:

- Mental health assessment and crisis support.
- Substance use related care and harm reduction activities.
- Support for clients experiencing housing insecurity or social isolation.
- Language barriers and supporting the needs of newcomer populations.

Participants emphasized that these factors extend visit times and contribute to unpredictable workload that may not be consistently reflected in visit counts or scheduling assumptions.

Summary of Key Client Factor Findings

Across the six sites, the following client themes were identified:

- Population demographics and overall health are shifting in the province, with projections indicating an aging and increasingly frail patient population.
- Care demand is primarily driven by complexity and cumulative care time, followed by patient or visit volume.
 - Acute care demand is variable, with high ALC volumes and prolonged lengths of stay.
 - LTC demand is stable and predictable but requires labour-intensive care delivery.

- Community care demand is stable but influenced by a mix of factors, including care coordination, travel, and access to other care providers.
- Care delivery is impacted by overall health system capacity and flow constraints, resulting in clients receiving care in environments not clinically aligned to their needs.
- Maturity of digital tools and data collection methods limit the system's ability to capture shifts in client factors and accurately project the shifts relevant for staffing.

These client factors form a critical part of the current state context and must be considered alongside organizational and staffing factors when determining future core staffing requirements.

2.3 Staffing Factors

This chapter summarizes the staffing factors including workforce availability, scope of practice and skill mix, deployment and scheduling practices that shape the function of staffing models across care settings.

Provincial Findings

Workforce Availability

Participants consistently described challenges to respond to day-to-day changes in staffing needs, including sick and leave coverage and short-term fluctuations in volumes or client-related workload. Shift vacancies are covered through overtime, redeployment/floating, and supplemental resources such as casual staff. While the organizational policies outline the requirements for casual positions, leaders and front-line staff reported it is difficult to monitor and enforce obligations, resulting in unpredictable coverage.

Participants reported increasing trends in absenteeism and sick time across sites and care settings, reducing short-notice staffing flexibility and placing additional strain on staffing continuity. Sample data provided for fiscal year 2024/2025 highlighted that 4,700 RNs collectively accounted for 61,500 sick leave days, averaging 13 sick days per nurse. In response to these pressures, the province has implemented several mitigation strategies, including regional float pool, fly-in/fly-out staffing models, and the use of nursing locums.

Staff Perspectives (sample)

"We have solved the 'vacancy gap' and returned to pre-covid levels. What we have now is an experience gap and specialty gap, and we need to shift our focus to that [continuous education, training, supports]."

"We have no float pool to cover sick calls, family leave, etc. So, if someone is off work, we work short. We had PCA positions which were taken away from our surgical units by senior admin. Unfortunately, even after continuous advocating for ourselves and advocacy from our manager, they have never been reinstated ... A PCA position for day shift on a busy surgical unit would make a world of a difference."

"There is no mandating because staff care about each other and do not want to see others stuck or suffer alone so they will pick up OT shift because they care for their colleagues and residents/patients."

"When applying for leave as an LPN months/weeks ahead of time it still may not be viewed, approved, or denied until sometimes the day before. I have worked here since May 2025 and have not been approved for any leave other than sick leave or family leave even if requested multiple weeks ahead of time."

"Unable to foster work life balance as there is no staff for vacation/sick relief. Currently we rely on agency nurses. There is no incentive for local hires to want a float pool position to provide such relief."

"There are no consequence for calling in sick and abusing leave."

"Inpatient surgical units are often working short due to sick calls, family reasons and vacation and have no PCAs staffed on the unit to assist in personal care that take a great deal of time. Nurses are getting burnt out caused by increased workload with decreased staff. I disagree quality care is being provided, we are often unable to effectively meet patients' needs due to lack of staffing mix on these units."

"There is such thing as an [sic] obligated casual but its not enforced, and there is no true way of tracking it [hours] and when you need a casual you will take the one available."

"We are currently losing 14 RNs on our floor that have accepted jobs elsewhere because no one can handle the unrealistic expectations placed upon us. We are all severely burnt out and spend days off trying to recover in time for the next shift."

Scope of Practice and Skill Mix

Participants reported higher proportion of non-nursing duties (e.g., administrative tasks, inventory stocking, patient transport, medication and supply reordering, and housekeeping duties) being undertaken by regulated clinical staff that could be managed by other support roles (e.g., clerical/operational supports). The non-nursing duties can reduce the time available for nurses to provide direct clinical care and limits all staff from working to their full scope. These realities were first formally identified in a 2011 provincial report that reinforces that support staff shortages were the primary driver for non-nursing duties.⁸

Leading practice shows education and mentorship-based support models can improve scope of practice utilization, increase staff independence, and improve integration of new hires and IENs. This model was demonstrated most recently at HSC.

There is variability in the deployment of NPs and advanced scopes of practice like RN-prescribing. Participants reported that limited provincial tools or resource support availability make it challenging to operationalize these roles, including:

- NP classifications (2) cover acute care and primary care settings, but are not generalizable to various types of units or inclusive of ambulatory, community care and other scopes.
- Limited availability of physicians to support admission and discharge pathways.
- RN prescribing has been implemented through a standardized provincial program; however, as a relatively new initiative, its integration into routine staffing and care delivery models continues to evolve across sites and units.

Staff Perspectives (sample)

"We need to have proper guiding documents to help with the overhaul needed to truly have a fully functioning RN prescribing role. The amount of work required is huge... and it will take a lot to educate once the guidelines are created and educators are already struggling [with workload]."

"There are policy red tapes that prevent professionals from doing things that they are trained to do (e.g., paramedics can do things on the floor). There is a need to understand the full scope and allow people to practice to scope. Need investment, education, and understanding."

⁸ Government of Newfoundland and Labrador and Newfoundland and Labrador Nurses' Union. Report of the Provincial Nursing Duties Working Group: July 2011

"We urgently need increased support staff - clerical, clinical, and auxiliary - to take on non-nursing tasks that continually pull nurses away from direct patient care. When support roles are properly staffed, nurses can focus on what they are trained to do, and patient outcomes improve."

"LPN scope of practice has evolved a lot, and it works really well when they are completely integrated within the team and given caseload and programs"

"Community health needs an NP. So much care is delayed due to waiting for simple orders that can be written by an NP. Clients would have less complications if an NP was able to see them in their home in the community."

"I really feel a NP would be a great addition to the community support program as many clients do not have access to a family doctor. I also feel the addition of a palliative team would decrease the workload of a registered nurse in community and would increase the quality of care given to our palliatives."

"There should be a PCA on each inpatient unit to allow for patients to receive the care they deserve that often nurses are just not able to give because of the demand for them. Patients should not have to wait to be washed, or go to the bathroom, or having accidents happen because a nurse can't get to them fast enough when there could be better staffing in place to prevent it, for example having a PCA on staff everyday to help assist with workload. Nurses have enough on their plates as it is. It's time for people to realize this and act on it instead of losing our nurses due to burn out."

"Our call bells are constantly ringing for tasks that PCAs can handle. Even if we had an LPN for workload it would make a significant change when people ring for things such as needing their IV unhooked so they can go to the bathroom or need PRN meds. These small tasks take up a significant amount of the RNs time and make it difficult to complete critical tasks...This leaves our call bells unanswered for long periods of time when we have a deteriorating patient. This is unbelievably unsafe, we NEED more PCAs or LPNs so our patients aren't abandoned during code blues and rapid response situations. I cannot emphasize this enough."

"Patients go days without being washed at times due to the fact that the nurse has to prioritize interventions and simply does not have the time or the extra set of hands to do this, the same goes for getting patients out of bed that require a lift."

"I feel that the staff on our unit always provide exceptional, quality and compassionate care. They truly are some of the best nurses I have ever worked with and met... Staffing strains, shortages and gaps have been ongoing for some time. Our unit has only recently started having a PCA as a part of our staff. Since having a PCA there has been somewhat of a better ability to meet levels of demand... It has been immensely helpful to work with such wonderful PCA's, however it is important to consider the workload of all nursing staff, not just that of the RN's."

Deployment and Scheduling Approaches

Scheduling practices and the application of collective agreement provisions were described as influencing staffing experience. The ICM tool is currently being used across several sites and has demonstrated positive outcomes; however, it has not yet been rolled out across all NLHS regions. Participants noted that self-scheduling policies are not applied consistently across acute care settings, and that access to casual staff varies by site and unit. As a result, the ability to address short-notice staffing gaps differs across settings, often increasing reliance on overtime where flexible staffing options are limited.

Staff Perspectives (sample)

"The importance of safe, fixed nurse-to-patient ratios cannot be overstated. Consistent staffing levels are essential to protecting patient safety, reducing preventable errors, and ensuring nurses can provide the quality of care our system demands."

"We have been unsuccessful in suggesting a change in language for shifts. [To cover busy time] 4 hour shifts could be helpful but we are not able to do it in previous negotiations."

"We do have self scheduling in some of the rural sites and you are putting a lot of reliance on staff to work as a team to optimize the scheduling and make sure that shifts are filled. It can work if you have all staff on board and no obligated casual."

"We are doing self scheduling now which has helped immensely."

"The shift work schedule/self scheduling allows nurses to swap shifts where they need to get time off without using leave."

"Having casual staff available for when core staff are sick or when annual leave is being granted would improve care delivery."

"I will attempt to fill vacant holes in the schedule weeks in advance but they are never filled unless I call scheduling myself. Many times I have had to call scheduling because my picked up shifts haven't been entered. I find often times our vacancies are continued to be filled by staff nurses and charge nurses organizing versus staffing filling holes."

"Our ability to self schedule around kids, spouses jobs and flexibility are gone. We are floated with burns and sick patients leaving the unit short staffed and decreased quality care for patients. Senior staff is leaving in masses leaving very junior staff with little to no experience to navigate these sick patients"

System Progress and Enablers

The province and NLHS have made efforts to adapt staffing approaches to manage variability in staffing requirements, changes in scope of practice, gaps in supply, and improving digitally enabled staffing processes.

- Establishment of a central staffing support function to support site planning and coordination of staffing requirements.
- Development of a rural float pool model in long-term care to provide targeted flexibility to smaller, geographically dispersed sites.
- Development of standard operating procedures for self-scheduling, use of agency nurses, sick and leave management, and casual staffing.
- Ongoing work to refresh scope of practice documentation that reflects advanced scopes, such as NP practice mandates and RN-prescribing, and modernized scopes for LPNs and unregulated roles.
- Increases in budgeted PCA roles across acute care settings to shift the non-nursing duty workload.

These approaches were described as helping to stabilize coverage, enhance role clarity and improve skill mix.

Acute Care

Patient Assignment

Participants reported high variability in staff to patient ratios and predictability of workload demands, often driven by changes in patient acuity, patient flow constraints, and short notice absences. This is most pronounced in acute inpatient units, where participants report working "short" due to shift vacancies, resulting in a higher number of patient care assignments per RN.

Scope of Practice and Skill Mix

Participants consistently described RNs as the role they most often rely on to maintain continuity of care and keep units functioning when conditions change. In practice, this was described as reprioritizing direct patient care to undertake coordinating escalations and transfers, supporting flow decisions, and addressing clinical and non-clinical gaps where other supports are limited. Delegation of duties and access to supports can also vary between rural and urban settings, where models of care and service delivery

often reflect expanded spans of control (e.g., units sharing managers), finite operational supports (e.g., 1-2 porting staff for full-service site), and limited opportunities to work to full scope based on patient population needs.

Participants reported overall lower average tenure on the inpatient units, leaving limited experienced staff to support novice nurses while balancing clinical workload. Participant reported examples include:

- Average tenure of 2-3 years on inpatient surgical and medicine units.
- IENs with < 1 year tenure working on intensive care units.
- Short-stay units staffed using only agency nurse contracts.

Scheduling Approach

Scheduling approaches in acute sites are often consistent, with some adaptations to meet flexibility requirements of unit-level staff. Participants reported:

- Consistent use of 12-hour shifts, on 6–8-week rotations.
- Variable use of structure and self-scheduling processes, dependent on staff preference.
- Centralized staffing support used to coordinate sick, leave and overtime calls.
- Unit-specific float and casual pools.
- Variable use of agency nursing, with higher reliance in rural settings due to vacancies and units' overcapacity.

Staff Perspectives (sample)

"It's hard to get leave or we're last-minute waiting to hear if we can have a day off. The shifts are extremely busy and most days we go without breaks. We can not keep up with the pace of triage and treatment. I would like more time to review my patients as a whole. It would be nice to have more hands on and time to review results to ensure we provide quality care. We often get behind on triage or can not do reassessments in a timely manner. I feel we need extra help in emerge most days."

"It's difficult to be responsible for 8 in patients and triage and assist in the Er. Getting breaks is challenging and there are days when I don't feel I have enough time to provide quality care to assigned patients."

"Overlap of schedules - One LPN 09-21 and one 08-20. May provide more relief when the major change of shift occurs."

Increased onboarding demands, elevated sick leave at select sites, and rising constant care pressures were observed to disrupt planned staffing models; sites often sustained operations through high overtime.

Table 6: Worked Hours Distribution by Role, Hours Category and Site

Data Highlights:

- RNs carry the highest workload pressure across all sites, indicating that staffing variability is largely absorbed by the RN workforce.
- Orientation demand is heavily concentrated on RNs, reflecting the reliance on experienced nurses to integrate new nurses.
- PCAs deliver most constant care hours, demonstrating the critical role of support staff in meeting enhanced-care needs.

	2022/2023							2023/2024							2024/2025						
	Total Worked Hours	Reg. Time	Overtime	Orientation	Sick Leave	Constant Care	Extra Workload	Total Worked Hours	Reg. Time	Overtime	Orientation	Sick Leave	Constant Care	Extra Workload	Total Worked Hours	Reg. Time	Overtime	Orientation	Sick Leave	Constant Care	Extra Workload
JPMRHC	293,510	80%	6%	2%	10%	1%	1%	273,828	78%	5%	5%	10%	1%	1%	305,496	76%	6%	8%	8%	1%	1%
NP	6,539	70%	1%	-	29%	-	-	4,733	93%	2%	1%	4%	-	-	5,015	95%	2%	-	3%	-	-
RN	199,286	80%	7%	2%	10%	0%	1%	195,315	78%	5%	7%	10%	0%	1%	226,253	76%	6%	10%	7%	0%	1%
LPN	67,385	80%	6%	2%	10%	1%	1%	54,120	78%	6%	2%	12%	2%	1%	53,834	77%	7%	2%	12%	1%	1%
PCA	20,302	74%	7%	1%	5%	10%	4%	19,663	75%	6%	1%	11%	7%	1%	18,652	82%	7%	-	11%	-	0%
PHC	18,929	75%	7%	3%	8%	6%	2%	15,345	70%	11%	2%	13%	3%	1%	23,619	59%	9%	24%	5%	3%	0%
NP	1,394	101%	-	-	-1%	-	-	1,629	92%	0%	-	8%	-	-	1,619	93%	0%	-	6%	-	-
RN	12,862	78%	6%	3%	10%	0%	2%	10,169	67%	11%	4%	17%	1%	1%	17,835	56%	7%	31%	5%	0%	-
LPN	3,996	68%	10%	3%	4%	14%	1%	3,236	77%	12%	1%	4%	6%	0%	3,253	73%	14%	3%	5%	4%	-
PCA	675	1%	20%	-	2%	77%	-	355	1%	40%	-	1%	57%	0%	913	6%	34%	-	-	56%	4%
HSC	154,194	81%	6%	5%	7%	0%	0%	152,175	84%	5%	3%	7%	0%	1%	168,698	78%	7%	5%	9%	0%	0%
NP	1,939	98%	0%	-	2%	-	-	2,537	95%	2%	-	3%	-	-	5,172	95%	3%	-	2%	-	-
RN	142,523	81%	7%	5%	7%	0%	0%	143,864	84%	5%	3%	7%	0%	1%	157,797	78%	7%	6%	9%	0%	0%
LPN	999	43%	10%	-	-	1%	46%	87	14%	25%	-	-	14%	47%	272	6%	6%	-	-	21%	67%
PCA	8,730	74%	2%	9%	11%	1%	3%	5,686	89%	3%	1%	6%	1%	1%	5,458	60%	8%	4%	17%	9%	3%
LSHC	13,023	66%	11%	3%	19%	0%	1%	10,487	75%	12%	8%	3%	-	2%	11,446	72%	18%	4%	3%	0%	2%
NP	307	36%	35%	7%	-	-	22%	97	45%	55%	-	-	-	-	0	-	-	-	-	-	-
RN	11,289	64%	11%	3%	21%	-	1%	8,824	72%	13%	10%	3%	-	2%	9,707	69%	21%	5%	3%	-	2%
LPN	1,428	92%	2%	-	3%	3%	0%	1,567	93%	2%	-	1%	-	3%	1,740	90%	3%	-	4%	2%	1%
Totals	479,656	79%	7%	3%	9%	1%	1%	451,835	80%	6%	4%	9%	1%	1%	509,259	76%	7%	8%	8%	1%	1%

Note: Figures reflect reported operational data and are presented to illustrate trends over time. They do not imply causality or performance assessment. Regular time, overtime, orientation, constant care, and extra workload was calculated using General Ledger data.

Long-Term Care

A key strength highlighted in the rural communities was the use of the established float pool model to support relief coverage where recruitment and short notice backfill are challenging. Staff also described targeted pockets of unregulated staff supporting delegated tasks under appropriate oversight as a practical enabler of workload distribution.

Despite these strengths, long-term care teams described a recurring gap in having a consistently available staffing supply model to cover sick and leave time, vacancies, and episodic increases in workload. When coverage gaps occur, staff reported relying on overtime – including mandated overtime, rebalancing assignments, and informal workarounds. Staff also described role compression during off-hours when access to support roles is reduced, resulting in licensed staff absorbing additional basic care and non-clinical tasks that could otherwise be supported through more consistent unregulated staffing capacity.

While sites are working towards aligning staffing models with the provincial 4.0 HPPD target, 2024–25 performance ranges from approximately 2.9 to 3.9 hours across units, indicating progress in some areas, but ongoing work is required to close the gap to target.

Staff Perspectives (sample)

- “When we don't have adequate staffing or they are mandated you can't provide good care.”*
- “Hire more PCAs , let LPNs work to their full scope. Do not expect the LPNs to provide daily hygiene care. They are needed in other capacities and should be working more directly with the RN. They cannot however do that in their current scope because they already have so many responsibilities on the floor.”*
- “There are many times we don't have support services like housekeeping to provide a safe and clean workplace.”*
- “The current scheduling approach does not adequately support staff well-being. Inconsistent assignments, limited flexibility, and short staffing levels have increased stress and reduced recovery time between shifts. The schedule often creates difficulty managing personal responsibilities and negatively impacts physical and mental health. As a result, work-life balance is significantly compromised, which also affects our morale & causes toxic work environment.”*
- “Recreation in LTC is already going through shift changes to ensure that more ‘non-business hours’ coverage is provided”*

Table (8) shows the distribution of worked hours by role, expressed as a percentage of total hours for each site, year, and workload category. For each column, the site-level total equals 100%, and the percentages below indicate which staff groups are carrying that portion of the workload.

Table 7: Nursing Hours Distribution by Category and Site

Data Highlights:

- Overall, the indicators related hours worked by staff remained relatively consistent over the past three years.
- The increase in constant care hours was driven by PCAs to care for patients needing more support.
- Sick leave time was variable across recent years at PHC LTC. However, overall overtime use trended downwards in that same time period.

	2022/2023							2023/2024							2024/2025						
	Total Worked Hours	Reg. Time	Overtime	Orientation	Sick Leave	Constant Care	Extra Workload	Total Worked Hours	Reg. Time	Overtime	Orientation	Sick Leave	Constant Care	Extra Workload	Total Worker Hours	Reg. Time	Overtime	Orientation	Sick Leave	Constant Care	Extra Workload
WLTC	169,512	80%	6%	2%	10%	0%	2%	194,328	77%	6%	3%	12%	1%	1%	229,211	72%	8%	4%	12%	3%	1%
NP	0	-	-	-	-	-	-	2	-	100%	-	-	-	-	0	-	-	-	-	-	-
RN	45,623	84%	6%	2%	4%	-	4%	43,855	84%	3%	2%	8%	0%	3%	46,481	82%	3%	3%	9%	0%	2%
LPN	55,569	82%	6%	1%	11%	0%	0%	63,441	78%	4%	2%	14%	0%	1%	78,467	79%	5%	2%	14%	0%	0%
PCA	68,321	77%	6%	2%	13%	0%	2%	87,029	73%	9%	3%	13%	1%	1%	104,266	63%	13%	6%	12%	6%	0%
PHC LTC	90,600	67%	12%	1%	19%	1%	0%	78,996	58%	12%	2%	25%	2%	1%	78,904	76%	10%	3%	9%	1%	1%
RN	12,370	66%	5%	2%	27%	0%	-	10,587	57%	5%	1%	38%	0%	0%	4,275	168%	11%	15%	-95%	0%	1%
LPN	39,642	69%	17%	0%	12%	2%	0%	30,601	57%	19%	0%	21%	2%	1%	30,995	69%	14%	2%	13%	0%	1%
PCA	38,590	66%	8%	1%	24%	1%	0%	37,809	60%	9%	3%	24%	3%	1%	43,633	72%	7%	3%	17%	1%	1%
LSHC	19,477	84%	3%	1%	11%	0%	0%	18,281	88%	1%	-1%	11%	0%	0%	20,258	83%	3%	1%	13%	0%	0%
RN	1,207	83%	1%	-	16%	-	-	1,150	96%	2%	-	2%	-	-	1,235	85%	1%	4%	9%	-	-
LPN	13,439	85%	4%	0%	11%	0%	1%	11,508	94%	1%	-1%	6%	0%	1%	12,848	88%	3%	-	8%	0%	1%
PCA	4,831	84%	2%	3%	10%	-	0%	5,624	76%	1%	-	23%	-	-	6,177	74%	3%	1%	22%	-	-
Totals	559180.99	76%	8%	1%	13%	1%	1%	583210.53	73%	7%	2%	16%	1%	1%	656750	74%	8%	4%	12%	2%	1%

Note: Figures reflect reported operational data and are presented to illustrate trends over time. They do not imply causality or performance assessment. Sick leave was calculated from Payroll data. Regular time, overtime, orientation, constant care, and extra workload was calculated using General Ledger data. Negative balances were observed in the data submitted by NLHS; therefore, while we recognize this may not accurately reflect the actual situation, it represents the information made available to us.

Community Care

Community care staffing models were described as sensitive to short-notice changes in demand, driven by caseload complexity, coordination needs, and travel requirements. Staff emphasized that limited access to casual staff reduces the ability to flex quickly in response to absences or workload surges. This has resulted in increased reliance on extended workdays or deferral of lower-urgency activities.

Staff also described role compression in community care as occurring through increased coordination, documentation, and system navigation tasks that accumulate when other supports are limited. As a result, it was challenging for clinicians to consistently operate to full scope of practice, particularly with the deployment of NP and RN advanced scopes of practice (e.g., RN prescribing). Improved access to an NP in community services was identified as an enabler to deliver timely intravenous assessments, and clinical assessments, reducing avoidable emergency department visits, minimizing care delays, alleviating system pressure, and improving patient outcomes.

The recent introduction of LPNs within community services in MPS was identified as a strength, demonstrating an opportunity to better distribute care delivery activities and support appropriate skill mix. This model can continue to be leveraged to support care delivery across community settings, where appropriate. In addition, staff have observed and acknowledged the benefits of the implementation of the evening pilot clinic at MPS, which was established to help alleviate workload and manage periods of increased demand.

Staff Perspectives (sample)

"Our biggest downfall here is not having a nurse practitioner to send our clients who need assessment. We see so many complex clients with complex needs. So many either have no GP or can't get in to see their GP for weeks, sending them to an already clogged emergency department."

"Social work duties become the nurse's role which can take up a lot of time from other nursing related duties and can cause increased stress levels for nursing staff to take on when not properly trained in this area of work."

"Nurses are expected to be apart of all the programs that encompass community health. As part of the nursing role, we are expected to assume case manager roles of home supports and palliative needs that takes away from our role with case managing our clients who require wound care and other nursing task. And unfortunately, there are not enough staff to help out with the everyday tasks of a registered nurse."

Table (8) shows the distribution of worked hours by role, expressed as a percentage of total hours for each site, year, and workload category. For each column, the site level total equals 100%, and the percentages below indicate which staff groups are carrying that portion of the workload (e.g., regular time, overtime, orientation, constant care, or extra workload).

Table 8: Nursing Hours Distribution by Category and Site

Data Highlights:

- Regular time hours increased overall, driven primarily by growth among RNs and NPs, while LPN regular time declined in 2024/2025 relative to the prior two years.
- Overtime hours were concentrated among RNs and increased year over year, while remaining minimal or negligible for NPs and PCAs.
- Sick leave decreased in 2023/2024 before rising again in 2024/2025, with RNs accounting for the highest sick leave hours.

	2022/2023				2023/2024				2024/2025				
	Total Worked Hours	Reg. Time	Overtime	Sick Leave	Total Worked Hours	Reg. Time	Overtime	Sick Leave	Total Worked Hours	Reg. Time	Overtime	Orien- tation	Sick Leave
MPS	16,815	42%	5%	53%	14,582	52%	7%	42%	18,568	37%	7%	0%	56%
NP	1,683	94%	0%	6%	1,732	93%	2%	5%	1,705	96%	0%		4%
RN	11,623	20%	7%	73%	9,432	29%	9%	61%	13,055	23%	9%		68%
LPN	3,510	91%	0%	8%	3,418	93%	1%	7%	3,809	59%	1%	2%	38%
LSHC	2,024	90%	2%	8%	2,185	91%	3%	5%	2,135	90%	2%	3%	5%
RN	2,024	90%	2%	8%	196	1%	38%	61%	2,135	90%	2%	3%	5%
Totals/ Average	18,839	74%	2%	24%	16,767	54%	13%	33%	5,176	67%	3%	2%	29%

Note: Figures reflect reported operational data and are presented to illustrate trends over time. They do not imply causality or performance assessment. Sick leave was calculated from Payroll data. Regular time, overtime, orientation, constant care, and extra workload was calculated using General Ledger data.

Community care staffing is sustained through a narrow RN-led model, with limited role diversification and minimal capacity to absorb variability without reliance on sick leave coverage and extended workload.

Summary of Key Staffing Factors Findings - Provincial

Across the six sites, the following staffing-related themes were identified:

- Urban and rural site context (e.g., access to local labour pools, recruitment and retention challenges, travel time, and access to specialized supports) can affect staffing availability and deployment.
- In rural settings, geography and limited workforce supply can require different coverage approaches (e.g., recruiting RNs into roles that could otherwise be delegated due to limited availability of other trained staff, and using cross-training so staff can perform multiple functions to maintain safe service coverage).
- The current staffing models, resource pools, and processes do not consistently address the gaps related to known and unknown vacancies. Continuity of service is frequently maintained through overtime, redeployment, and extra workload hours rather than through baseline staffing resilience.
- Across care settings regulated clinical staff routinely undertaking non-clinical and support tasks due to limited availability of unregulated, clerical, portering, or allied health supports.
- Scope of practice and skill mix are not consistently optimized, with variability in the deployment of NPs, RNs, LPNs, and PCAs across sites and care settings.
- Onboarding and integration of new hires generate significant workload in the current state, requiring mentorship, supervision, and shadowing that are largely absorbed by experienced RNs alongside their routine clinical demands.
- Scheduling practices and access to casual staff vary across sites and settings, limiting the ability to address short-notice gaps without increasing overtime or agency usage.
- Targeted staffing strengths demonstrate opportunities for scalability, including rural float pool models in long-term care, instances of unregulated staff supporting delegated tasks under appropriate oversight, and prior mentorship-based onboarding models that improved integration and workforce sustainability.

These staffing factors highlight a system that can maintain baseline service delivery but lacks consistent resilience to variability. Addressing staffing supply, scope optimization, role alignment, and onboarding capacity will be critical to improving workforce sustainability and aligning staffing models with evolving care demands.

3. Literature Review, Jurisdictional Scan and Gap Analysis

This chapter presents a structured gap analysis that compares the current state of core staffing across NLHS sites with leading practices observed in peer jurisdictions and emerging opportunities identified through interest holder engagement. The analysis is intended to support decision-making by identifying where current staffing approaches may be misaligned with evolving care demands, workforce realities, and system level objectives.

The gap analysis provides a fact-based foundation that:

- Surfaces challenges affecting care delivery, workforce sustainability, and operational performance;
- Highlights how other jurisdictions are addressing similar challenges; and
- Frames emerging opportunities that will be translated to recommendations and inform the implementation plan.

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
1 Scope of Practice		
Provincial and organizational policies and guidelines provide expectations for nursing scope of practice, including delegated acts for NPs and RN prescribing. However, operational application varies across sites, care settings, and regions. This variability contributes to differences in local decision-making on role capabilities in a staff model and provider capacity.	Scope of practice for clinical professionals continues to evolve driven by population demands, workforce availability, medical advancements and new technology changing ways of working. Jurisdictions have developed consistent and standardized approaches to support these changing roles: British Columbia defines the scope of practice for nurses through a regulatory framework that identifies what each nursing role is educated, competent, and legally authorized to do. This framework is guided by four controls on practice: legislation, BCCNM standards, organizational policies, and the nurse's individual competence.⁹	Establish provincial resource supports to regions to translate provincial policies locally, such as: - Standardize role definitions and job descriptions at scale; - Leverage available NLHS professional practice supports to co-design oversight and governance models required to establish guidance document, education and training requirements and mechanisms to monitor outcomes; and Determine the support model required to enable RNs to consistently practice to their full authorized scope - E.g., quality oversight, education and training, standardized medical directives, etc.
2 Care Delivery Models and Role Alignment		
Prior provincial work has documented the lack of role clarity as a key driver of inefficiency and role misalignment.¹⁰ While provincial scope of practice frameworks exist, NPs, RNs, LPNs, and unregulated staff are not consistently deployed or supported in ways that optimize interdisciplinary care delivery. Participants indicated they value the expertise that allied health staff bring to multidisciplinary teams to meet the targeted needs for patients, but the resource models for these practitioners vary across care settings and sites.	Team-based care enables patients to have their holistic needs met by providers that work to full scope of practice: - Ontario has funded NP roles in long-term care homes, embedding NPs as on-site primary care providers responsible for managing complex residents, leading care planning, and collaborating with interdisciplinary teams.¹¹ - Ireland has implemented APN-led cardiology chest pain services. Within the first year of this service, admissions to the ward reduced by 36% and to ED by 60%, contributing to system savings and timely diagnosis and treatment.¹² - The revisions to the Ontario Long-Term Care Act in 2021 allowed for Personal Support Workers (PSW's) to administer medication.	Advance skill mixes to fully optimize interdisciplinary care models by care setting to: - Increase physician capacity with NPs assuming appropriate provider functions to treat patients across care settings - Strengthen cross-training and role flexibility for LPNs and PCAs across mixed care settings (e.g., acute and LTC). - Free RN capacity in acute care for high complexity work. - Strengthen LPN/PCA utilization in LTC; and - Expand differentiated nursing and support roles in community care to better align with client need. Conduct an allied health staffing review to complement this current core staffing review.

⁹ British Columbia College of Nurses and Midwives. (n.d.). *Scope of practice*. <https://www.bccnm.ca/RN/learning/scope/Pages/Default.aspx>

¹⁰ Government of Newfoundland and Labrador and Newfoundland and Labrador Nurses' Union. Report of the Provincial Nursing Duties Working Group: July 2011

¹¹ Government of Ontario. (n.d.). *Attending nurse practitioners in long-term care homes initiative: Funding policy*. <https://www.ontario.ca/page/attending-nurse-practitioners-long-term-care-homes-initiative-funding-policy>

¹² International Council of Nurses. (2022). *Advanced practice nursing: Keynote address*. https://www.icn.ch/sites/default/files/inline-files/WS_26_APN%20Conference_Dublin_HCkeynote_V5_FINAL_0.pdf

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
	• In Nova Scotia, RNs supported by VON completed specialized RN prescribing education to expand their scope so they can prescribe medications and order diagnostic tests for clients, particularly those with limited access to primary care in home and community settings.¹³ • The UK The Social Care Institute for Excellence (SCIE) provides guidance on establishing a multidisciplinary team (MDT) model, including common elements and principles of MDTs as described by the World Health Organization, NHS England, and Health Education England.¹⁴	
3 Non-Clinical Duties		
Nurses across care settings are routinely required to perform non-clinical and administrative duties (e.g., clerical tasks, portering, supply management, coordination activities), which reduces time available for direct patient care, constrains the ability for nurses to consistently work to full scope of practice, and contributes to increased workload.	Many provinces have considered the impacts of non-clinical duties on the utilization of clinical staff, including physicians, nurses and allied health professionals. • Health Canada's Nursing Retention Toolkit has outlined reducing administrative burden as a goal to free up nurse capacity to focus on the tasks and care that they are uniquely skilled to provide. Health Canada urges healthcare organizations to identify opportunities to ease nurses' non-clinical and administrative duties as well as care duties that are more appropriate for other healthcare professionals.¹⁵ • Jordanian research has proposed solutions to reduce the challenges associated with non-nursing activities performed by nurses. Strategies proposed include establishing transparent task assignment, implementing feedback loop to hold individuals accountable for task outcomes, creating rotation-based task assignment	Assess operations to provide the most appropriate solution to support staffing models to manage non-clinical duties, such as additional support staff or digital enablers, with consideration for: • Urban and rural workload and recruitment variations. • Demand thresholds to address patient population needs.

¹³ Insights collected through interviews with VON Canada.

¹⁴ Social Care Institute for Excellence. (n.d.). *Multidisciplinary teams working for integrated care*. <https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams/>

¹⁵ Health Canada. (n.d.). *Nursing retention toolkit: Improving working lives of nurses*. <https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/health-human-resources/nursing-retention-toolkit-improving-working-lives-nurses/nursing-retention-toolkit-improving-working-lives-nurses.pdf>

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
	system, hiring additional non-nursing staff, establishing clear job description and strict adherence, addressing confusion and uncertainty around nurses' duties and responsibilities. ¹⁶	
4 Data-Driven Decision Making		
While multiple systems are in place to support staffing and workload management, reliance on inconsistent data sources and manual processes limits the timeliness, comparability, and reliability of information used to inform staffing decisions. This reduces the organization's ability to proactively align staffing with care demand.	Leading systems integrate acuity and workload indicators into routine clinical documentation and operational decision making, enabling near real time staffing adjustments that align with collective agreements and inform objective escalation protocols: Ontario Healthcare Indicator Tool (HIT) is an evidence-based benchmarking platform that uses standardized data from Ontario's Ontario Healthcare Reporting Standards (OHRS) and the Ontario Healthcare Financial and Statistical (OHFS) database to support peer benchmarking across the province.¹⁷ - NHS in the UK has a Model Hospital dataset, that provides benchmarked insights at a hospital and provider level across quality of care, productivity and staffing to identify opportunities for improvement, enhancing system efficiency, patient outcomes, and population health. Insights from this dataset support their acuity-based staffing model.¹⁸ - New Zealand's Care Capacity Demand Management (CCDM) programme, introduced in 2009, aimed to align	With the current digital initiatives underway provincially, explore: - Optimization of information systems, including ICM and CorCare post implementation, to inform staffing model decisions. - Standardized assessments and indicators that reflect patient/resident needs, including acuity and complexity. Embed objective and standardized methodology and targets into operational processes and provincial monitoring, including Identification of target hours per patient day or visit across select care settings (e.g., inpatient units, ambulatory clinics, emergency departments).

¹⁶ Al-Akash, H., Aldarawsheh, A., Elshatarat, R. et al. "We do others' Jobs": a qualitative study of non-nursing task challenges and proposed solutions. BMC Nurs 23, 478 (2024).

<https://doi.org/10.1186/s12912-024-02059-9>

¹⁷ Marin, M., & Arbour Gagnon, R. (2016). Improving data quality for evidence-based decision making using the Healthcare Indicator Tool (HIT).

https://www.allianceon.org/sites/default/files/documents/D9_Improving_data_quality_for_evidence-based_decision_making.pdf

¹⁸ NHS England. (n.d.). *Model Hospital*. <https://www.england.nhs.uk/applications/model-hospital/>

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
	staffing with patient demand using workload and acuity measurement rather than legislated ratios.¹⁹ Using this data, select jurisdictions have worked to identify appropriate hours per patient or hour per resident day to be shared across proportional nursing and support staff: • The NHS uses CHPPD for ward-level monitoring and national benchmarking, publishing guidance and dataset specifications that split hours by staff type (registered vs support) and explicit calculation methods so trusts can compare deployment over time and between similar wards.²⁰ • Ontario's Long Term Care Act requires facilities to achieve at least four (4) hours of direct care per resident day by 2025, with other provinces tracking similar HPPD measures and reporting regional variation, illustrating how daily hours based metrics are used to monitor workforce levels and equate staffing input with care expectations.²¹ • Nova Scotia set an operational goal and reporting framework to move facilities toward an average of 4.1 direct care hours per resident per day, with public reporting and quarterly submissions on hours worked to track progress.²²	
5 Digital Tools and Enablers		
Physical environments and geographic dispersion of patients impact care delivery models and workflow, which drives efficiency and workload. Unit layout, travel distances,	Service delivery models increasingly leverage digital and robotic assets to enhance workflows:	Explore the use of digital enablers that enhance workflows and ways of working, including those that:

¹⁹ Nursing Advisory Group. (2022). *Nursing Safe Staffing Review and Report on the Review of the Care Capacity Demand Management (CCDM) Programme*. Wellington: Ministry of Health.

https://www.health.govt.nz/system/files/2022-02/nursing-safe-staffing-review-final_report-feb22.pdf

²⁰ NHS England. (2018). *Care hours per patient day (CHPPD): Guidance for all inpatient trusts*. <https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-guidance-for-all-inpatient-trusts/>

²¹ Government of Ontario. (2021). *Fixing Long-Term Care Act, 2021*. <https://www.ontario.ca/laws/statute/21f39/v6>

²² Government of Nova Scotia. (2024). *Department of Seniors and Long-Term Care Accountability Report 2024–25*. [accountability-report-2024-25-department-seniors-and-long-term-care-en.pdf](https://www.novascotia.ca/healthcare/accountability-report-2024-25-department-seniors-and-long-term-care-en.pdf)

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
line-of-sight limitations, and the use of repurposed or constrained spaces increase time spent on indirect care activities.	- British Columbia Provincial Health Services Authority implements CIS and mobile EHR access for home health and chronic disease management programs, enabling nurses in the community to review labs, medication lists, and care plans on the go. This integration allows fewer in-person visits while maintaining safety and quality. - In 24 hospitals and six long-term care facilities across Canada, HALO uses remote observation technology to monitor high-risk patients (e.g., constant care, ED waiting rooms), reducing the need for continuous in-room observation by nurses and enabling redeployment of staff during peak demand.²³ - CHUM and Providence Living at The Views have integrated automated guided vehicles or robots into its daily operations respectively, such as transporting supplies, meal trays, and materials throughout their respective organizations. This reduces the need for clinical and support staff to perform administrative tasks and frees capacity for direct patient care.²⁴ - Partner's Community Health uses AI-driven interRAI assessments to measure resident care needs and calculate Case Mix Index (CMI), which informs staffing levels, hours of care, and resource allocation. Partner's Community Health is piloting specialized digital health applications to monitor skin integrity and wound progression, enabling earlier intervention and improved documentation.²⁵	- Reduce nursing and nurses support administrative burden. - Provide portable patient care supports, such as robotic lifts and diagnostic tools. - Automate inventory, supply and logistical tasks. Virtual care models have been adopted in different settings, particularly for access to primary care providers in rural areas, and there is opportunity to expand further.

²³ CanHealth. (2025). *Nurses' insight sparks Canadian patient safety innovation with Halo*. <https://www.canhealth.com/2025/10/01/nurses-insight-sparks-canadian-patient-safety-innovation-with-halo/>

²⁴ Innovation of the World. (n.d.). *The CHUM AI project*. <https://innovationsoftheworld.com/the-chum/>

²⁵ Insights gathered through interviews with Partner's Community Health.

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
6 Education and Mentorship		
The breadth of responsibility assigned to educators and clinical leaders has limited their capacity for orientation, mentorship, and professional development across care settings. Participants highlighted that PCA recruitment is currently constrained by the suspension of PCA education programs at Atlantic colleges, resulting in limited training capacity. Addressing PCA workforce shortages will require renewed collaboration between the health system and education providers to ensure sustainable education pipelines.	Provinces are enhancing their partnerships with academic and regulatory colleges to strengthen the delivery of professional development. - Ontario Health launched the Emergency Department Nursing Education, Retention, and Workforce Program to support and educate nurses entering emergency departments for the first time. This initiative helps hospitals deliver high-quality emergency care and aims to retain ED nurses to meet staffing needs.²⁶ - British Columbia announced investments to help retain nurses, including the expansion of the internationally educated nurse bridging program, and other training and program bursaries.²⁷ - Nova Scotia Health announced training and retention initiatives for nurses in EDs, including post-secondary programs focused on emergency care for nursing students, professional development opportunities, and a nursing innovation fund for practicing RNs and LPNs.²⁸	Assess the value of expanding the HSC 4NA Mentor Role (pilot role) or other similar initiatives across other units and sites to share the mentorship load of senior staff, nurse educators and managers. Explore the possibility of formally partnering with post-secondary institutions to support nursing student placements, internships, and early-career employment pathways, strengthening recruitment and retention following graduation.
7 New Hires and Internationally Educated Staff		
Staff report that onboarding demands have increased due to an influx of IENs and new graduates, but education pathways and capacity have not kept pace. The reported result includes variable orientation durations and reliance on informal supervision – impacting the integration of new hires and workload of unit staff.	Provinces have invested in the supply of various health roles through increase of seats in academic programming and recruitment of internationally trained professionals. Nova Scotia's Early Immersion Program (EIP) offers senior nursing students meaningful early clinical experience within the provincial health system, helping build	Explore enhancements to training and resource support for nurses onboarding to the NLHS system, including expansion of the Nursing Collegian program and opportunities to leverage local academic and regulatory partners to strengthen integration of IENs in communities and care settings.

²⁶ Ontario Health. (2024). *Innovative Program Bolsters Emergency Department Nursing Skills, Workforce at Rural Hospitals*. <https://www.ontariohealth.ca/news/emergency-department-nursing-workforce-program>

²⁷ Government of British Columbia. (2025). *Nurse in Practice Program*. <https://www2.gov.bc.ca/gov/content/health/nurse-in-practice-program>

²⁸ Nova Scotia Health. (2024). *Nova Scotia Health announces training and retention initiatives for nurses in EDs*. <https://innovationhub.nshealth.ca/news-and-updates/nova-scotia-health-announces-training-and-retention-initiatives-nurses-eds>

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
	familiarity with local practice environments, improving long-term retention.²⁹ • Nova Scotia has an Internationally Educated Nurses Network to support IENs with licensing challenges and integrate into the Nova Scotia workforce. Nova Scotia also committed to accelerate and support the integration of IENs, with specific actions such as working with the Nova Scotia Community College to position the Nursing Re-entry Program to meet the needs of internationally educated LPNs.³⁰ • The New Brunswick government has implemented a coordinated approach combining a Navigation Service for Internationally Educated Health Professionals with financial supports to offset licensure and relocation costs.³¹ • Ontario has worked with the College of Nurses of Ontario (CNO) to implement programs such as the Enhanced Extern Program and Supervised Practice Experience Partnership to provide IENs and students opportunity to gain practical experience.³² • A comparative study based on a systematic review has found that Australia is more successful than Canada in integrating IENs into the workforce, with higher rates of employment, utilization of knowledge and expertise, and access to leadership positions.³³	

²⁹ Nova Scotia Health. (2023). "We want to make sure nurses remain in health care": How an early immersion program sets up nursing students for success. <https://www.nshealth.ca/news-and-noticees/we-want-make-sure-nurses-remain-health-care-how-early-immersion-program-sets>

³⁰ Nova Scotia Internationally Educated Nurses Network. (n.d.). Home. <https://nsienn.ca/>

³¹ Government of New Brunswick. (n.d.). Internationally educated nurses. <https://nbhealthjobs.ca/internationally-educated-health-professionals/nurses/>

³² Government of Ontario. (2024). Ontario Continuing to Support and Grow its Nursing Workforce. [Ontario Continuing to Support and Grow its Nursing Workforce | Ontario Newsroom](https://news.ontario.ca/ontario-newsroom/2024/05/ontario-continuing-to-support-and-grow-its-nursing-workforce/)

³³ Alostaz, N. (2024). Integration trends of internationally educated nurses in Canada and Australia: A scoping review. <https://journals.library.torontomu.ca/index.php/http/article/view/1958/1816>

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
8 Flow Constraints and Levels of Care		
High Alternate Level of Care (ALC) volumes and prolonged lengths of stay result in patients receiving care in settings that are not clinically aligned to their needs. Participants report that care needs are associated with physical declines, cognitive impairment, and psychosocial factors. The province has recognized the need to establish specialized programs, such as frailty units in hospitals, to allow for the efficient deployment of care models that meet demands³⁴.	Aiming at relieving bed pressures means jurisdictions are considering innovative ways to ensure patients receive the right care in the right place. • Nova Scotia's 2022-2026 Action for Health strategic plan details the province's commitment to expand access to homecare. The goal is to help more patients return home with increased levels of supports rather than wait in hospital for admission to long-term care.³⁵ • Through the Bayshore @ Home program, Bayshore has partnered with 13 hospitals across Ontario to save more than 240,000 ALC hospital bed days in 4 years. More than 80% of patients have been diverted from long-term care, with 40% of those patients continuing to live independently in their home.³⁶	Continue to explore opportunities across care settings to co-locate patient populations with 'like' needs and leverage principles found in the NL Health Accord – ALC Framework, the Seniors' Health and Well-Being Plan, and Home First Philosophy.
9 Availability of Staff		
Sites across care settings report increased challenges with covering shift vacancies driven by sick time, vacation, position vacancies, and changes in patient acuity and demand in each day. Coverage is maintained through redeployment of staff to areas of need, use of agency staff, and overtime. Participants perceive there are several factors that contribute: • Limited casual availability for shifts • Reduced resilience to sustain these strategies • Growing reliance on reactive staffing measures vs proactive management	Other jurisdictions have explored innovative strategies to mitigate disruptions in services due to staff supply shortages. • Shared Health Manitoba employs a team of Provincial Travel Nurses, who are contracted directly by the province, and may be full-time, part-time, or casual. From urban centers in Winnipeg to remote northern communities, incentives of per-hour pay premium, travel support, and flexible scheduling has brought nurses back to the public sector.³⁸ • Nova Scotia provides \$10,000 financial incentives to nurses who have left the publicly funded system if they	Build upon the current initiatives in place for staff recruitment and retention, as well as mechanisms to monitor impact of staffing strategies, such as: Assess current performance monitoring and attendance management programs to identify opportunities to strengthen accountability and enable informed decision-making in alignment with collective agreements. • Additional support to improve monitoring and enforcement of programs aimed at reducing operational and staffing disruptions

³⁴ ³⁴ Health Accord NL. *Our Province. Our Health. Our Future: A 10-Year Health Transformation*. Feb. 2022, https://www.healthaccordnl.ca/wp-content/uploads/2022/02/HANL_Report_Document_Web_modFeb28-2022.pdf.

³⁵ Gov of Nova Scotia. (2023). *Action for Health: Strategic plan for Nova Scotia*. <https://actionforhealth.novascotia.ca/sites/default/files/2023-09/action-for-health-strategic-plan-for-nova-scotia.pdf>

³⁶ Bayshore HealthCare. (2025). *@Home impact report 2023*. <https://www.bayshore.ca/wp-content/uploads/2025/02/2023@home-Impact-Report.pdf>

³⁸ Shared Health Manitoba. (2025). *Provincial Travel Nurse Team*. [Manitoba Travel Nursing - Health Careers Manitoba](https://www.shm.mb.ca/manitoba-travel-nursing)

Current State Challenge (NLHS)	Peer Insights from Jurisdictional Scan	Emerging Opportunities for NLHS
In 2025, provincial RNs and PCAs vacancy rates were between 4–5%, and LPN vacancy rates were 7-8%. NP vacancy rates of 22–23% are reflective of the creation and funding of new positions³⁷. Several targeted initiatives are underway to further reduce vacancies. These rates are within historical operating norms and trending downward from their peak during COVID-19 pandemic - indicating a stabilization of workforce capacity. NLHS has been deploying strategies to manage staffing shortages, including implementing the Locum Program Pilot, and provincial performance and absentee management programs. Effectiveness of these programs are reported as variable, with little capacity to operationalize in current state. Casual vacancy rates as of January 2026 were approximately 11% for RNs and 3% NPs.	agree to come back and sign a two-year return of service agreement.³⁹	• Explore policy and other levers to strengthen the supply and predictability of casual coverage, to align with the collective agreements

³⁷ As reported by the Department of Health and Community Services.

³⁹ Gov of Nova Scotia. (2023, March 20). *Retention bonuses and incentives for nurses and healthcare workers*. <https://news.novascotia.ca/en/2023/03/20/retention-bonuses-incentives-nurses-healthcare-workers>

4. Future State Recommendations

This chapter presents the future state recommendations from the NLHS Core Staffing Review. The recommendations set out system level directions to strengthen core staffing models across NL Health Services, supporting sustainable workforce planning, improved alignment between staffing and patient or client needs, and consistent, high-quality care across care settings.

These recommendations are not intended to duplicate work already underway. Rather, they identify where existing NLHS initiatives – mentorship programs, provincial digital tools, and others where noted – can be aligned, scaled, standardized, or further resourced to support sustainable core staffing across care settings. Many activities are already in progress at provincial, zonal, and site levels; the implementation focus should therefore be on sequencing, integration, and continuous improvement.

Health system sustainability depends on improving productivity and optimizing the use of existing resources. Many of the recommendations in this report are therefore intended to reduce wasteful practices and better align our valuable human resources with the health needs of the population.

The recommendations are organized across 4 strategic buckets with eight interrelated domains. Together, these recommendations form a coherent framework for strengthening core staffing models by addressing both workforce availability and the systems, processes, and care delivery models that shape how staff capacity is utilized.

The implementation plans for each domain provide preliminary guidance on the sequencing, interdependencies, and anticipated duration of initiatives. The Core Staffing Review Steering Committee, in consultation with respective organizational executive leadership, is responsible for reviewing, prioritizing, and planning the implementation of the recommendations it elects to advance.

4.1 Enable staff to work to full value

Domain A: Scope of Practice and Care Delivery Model Alignment seeks to ensure that nurses and other in-scope providers are consistently able to work to full scope within care delivery models that are appropriately aligned to patient and client needs – more explicitly, moving towards a team-based model of care delivery.

Domain B: Non-Nursing Duties addresses the extent to which nurses are required to perform tasks that could be reassigned or redesigned, with the aim of preserving nursing capacity for direct patient care.

4.2 Stabilize and sustain core staffing

Domain C: Education and Mentorship emphasize the need for sustainable education and mentorship structures that support competency development, safe practice, and workload balance, particularly in environments with high turnover or onboarding demands.

Domain D: New Hires and Internationally Educated Staff focuses on strengthening onboarding, integration, and support models to better absorb new graduates and internationally educated nurses while minimizing workload impacts on existing staff.

Domain E: Availability of Staff focuses on improving baseline staffing resilience and flexibility to reduce reliance on reactive staffing measures and support more consistent alignment between staffing and demand.

4.3 Move from reactive to defensible staffing

Domain F: Data-Driven Decision-Making highlights the importance of consistent, objective data and standardized indicators to inform staffing, workload assessment, and ongoing monitoring across care settings.

4.4 Reduce structural load on staffing

Domain G: Digital Tools and Enablers consider how digital systems and tools can be optimized and better leveraged to support staffing decisions, workload management, and operational efficiency.

Domain H: Flow Constraints and Levels of Care addresses systemic factors that impede patient and client flow, recognizing downstream impacts on workload, staffing utilization, and care delivery.

Each domain presents:

1. Select current-state highlights; and,
2. A distinct set of future-state recommendations.

For each recommendation, the reader will find a clear description of the proposed action and practical implementation insights, such as key dependencies, change management considerations, and identification of the responsible, accountable, consulted, and informed (RACI) stakeholders to support coordinated delivery and sequencing. The implementation insights will be used to inform the development of the Implementation Roadmap (deliverable D6).

4.4 Recommended Budgeted FTE Adjustments

As part of the Core Staffing Review conducted across the six sites, each department and service was assessed using the agreed-upon methodology to determine recommended core staffing levels for NPs, RNs, LPNs, PCAs. The detailed results of these assessments are provided in Appendix A and should be reviewed in full before considering any adjustments to budgeted FTEs. Where relevant, the recommended changes to staffing budgets are also dependent on key recommendations to be adopted. Overall, the recommendations for inclusion of more PCAs to support the team-based model and meet the fulsome patient needs comprise the largest change to budgets relative to other roles. To support a holistic understanding of the potential budget impact, a summary table has been included in this section.

4.1 Enable staff to work to full value

Domain A: Scope of Practice and Care Delivery Model Alignment

This recommendation domain addresses inconsistent application of scope of practice across NLHS. Although provincial and organizational policies define expected nursing roles, implementation varies by site, care setting, and zone. This inconsistency limits the system's ability to align staffing models with patient or resident needs and to deploy interdisciplinary teams as intended.

Select Highlights from the Current State

- Scope of practice for all roles within their respective care settings are inconsistent, resulting in variable role deployment and misalignment between staffing models and care needs.
- In scope providers are not consistently enabled to work to full scope.
- Local context and historical practice drive role interpretation more than standardized system level direction, contributing to variation across zones and care settings, particularly in long-term care as resident complexity increases.
- Population needs and case mix (e.g., high ALC volumes) are changing, yet a proportion of sites and departments have not adjusted staffing models or skill-mix assumptions accordingly.
- Variable access to other clinical roles (e.g., allied health) and non-clinical support roles (e.g., administrative/clerical support) results in nurses absorbing non-nursing tasks, limiting full-scope practice and weakening team-based care to address patients' holistic needs.

"LPNs are not even close to top of scope and there is a long way to go & in the city, it feels like an impenetrable forest."

"I did some work on the floor and I watched an LPN, and all I can say is that we are paying this lady a lot of dollars and she is basically the physician clerk... she was writing what he was saying, and she didn't even do the discharge of patients. We are not using them to their full scope."

Recommendation #1: Establish consistent frameworks, tools, and care models to enable nurses and PCAs to work to full scope of practice

Description Rationale

Update provincial staffing standards of practice and unit-level skill-mix accountabilities to maximize full-scope utilization of NPs, RNs, LPNs, and PCAs across care settings, ensuring work is consistently performed by the most appropriate provider. This includes:

- Developing province-wide, standardized role expectations (informed through job validation) for each in-scope role by care setting, to confirm responsibilities reflect full scope of practice; include guidance for rural and remote sites where patient census, case mix, and workforce availability may differ from other areas
 - Establishing dedicated regional support to aid site operations in making decisions on appropriate skill mix and staffing approach to meeting targeted skill mix
 - Systematically reviewing population needs and data-driven decision-making tools to inform skill mix for acute care, long-term care, and community care settings
-

Description Rationale

Establishing clear staffing models that combine required baseline staffing to maintain continuity of operations with responsive, acuity-based adjustments based on patient acuity, complexity, and care needs (*see Domain E for more information*)

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Ensuring alignment with collective agreements, licensing bodies, and professional practice requirements - Updated staffing standards and workload assumptions through job validation that explicitly reflect full-scope role utilization (incl. rural/remote adaptations) and collective agreement alignment - Unit-level change management and workflow redesign capacity	- Provincial support for change management and workflow redesign capacity to translate updated skill-mix assumptions into daily practice at the unit-level - Clear communication of revised role expectations and operational tools to support safe, consistent task allocation - Visible organizational and clinical leadership reinforcement to prevent uneven application across sites and settings	R: Human Resources and Workforce Planning; Operational leaders (Managers, Directors) A: NLHS Executive and Senior Leadership C: Professional Practice; Union Partners; Clinical teams (NPs, RNs, LPNs, PCAs); Education and training teams (e.g., Learning and Development) I: Education and training teams (e.g., Learning and Development)

Recommendation #2: Strengthen governance and visibility of professional practice

Description Rationale

Enable consistent application of scope of practice expectations across NLHS by increasing understanding and visibility of available Professional Practice support to provide timely operational consultation.

This includes:

- Reviewing and enhancing escalation pathways to ensure they are clear, consistent and visible to staff to enable them to make appropriate use of those pathways.
- Reconciling and standardizing professional practice documentation, as per regulatory bodies across the province aligned with work completed to date for CorCare go-live
- Standardizing core processes at sites and departments (e.g., medical directives, delegation decision supports, escalation pathways for scope related issues)
- Educate staff and communicate how best to access existing provincial repository for professional practice guidance
- Advancing integration of the NP role, with enhanced directives and formalized supports (e.g., medical directive supports, escalation pathways, and role-specific decision support), in partnership with Professional Practice

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Sustained access to education, standardized medical directives (where required), and quality monitoring to detect and address practice variation over time - Defined and published escalation pathways for scope-of-practice inquiries - Ongoing audit and feedback through CorCare functionalities to identify and address practice drift	- Sustained access to education, standardized directives, and decision supports to reinforce scope-of-practice expectations - Clear accountability and escalation pathways to address scope-related inquiries consistently - Ongoing monitoring and feedback to ensure practice consistency and address variation as care models evolve over time (e.g., with CorCare implementation)	R: Professional Practice; Education and training teams A: NLHS Executive and Senior Leadership C: Operational leaders (Managers, Directors); Union Partners; Clinical teams (NPs, RNs, LPNs, PCAs); Human Resources and Workforce Planning I: Human Resources and Workforce Planning

Recommendation #3: Maximize the role of PCAs

Description Rationale

Establish province-wide role definitions for PCAs that clearly articulate scope aligned responsibilities, delegation parameters, and expected contributions within interdisciplinary care teams across care settings.

This includes:

Strengthening provincial PCA role guidelines in consultation with educational institutions to reflect best practices to maximize the roles of nurses and unregulated PCAs that are applicable for acute care, long-term care, and community care settings

- Build on the existing provincial PCA curriculum and standardized training by setting enhanced provincial minimum education and training requirements for regions to adopt, with oversight, examinations, and certification processes to maximize PCA abilities; consider add-on modules/micro-credentials and a standardized delivery model (e.g., Nova Scotia)
- Consider appropriate delegated tasks for PCAs within a site or care setting and establish the oversight model required support and monitor.
- Collaboration between operations leaders and Professional Practice to assess care models, informed by industry-leading practices and jurisdictional best-practice reviews, to recommend the most appropriate PCA scope within the care team, with consideration for regulatory and operational guidelines already established, including potential delegated acts expansion (e.g., topical medications, basic wound/skin care)
- Explore the development of career pathways, in consultation with CNA, for PCAs to use this continuing education towards a pathway for LPN's or RN designation

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- System-wide agreement on role definitions and delegation parameters - Align PCA tasks and delegation processes with relevant regulatory requirements and professional standards (as applicable) - Standardized implementation tools (e.g., role cards, job aids, decision supports) and an exceptions process (e.g., rural/remote adaptations)	- Translation of provincial PCA role definitions into practical local tools (e.g., role cards, delegation aids, job supports) - Leadership reinforcement to embed role expectations into daily workflows, not just documentation - Clear communication to managers and frontline teams on PCA role expectations, delegated tasks, and local implementation supports - Clear guidance on rural/remote adaptations and further elaborate on process to support consistent uptake	R: Human Resources and Workforce Planning A: NLHS Executive and Senior Leadership C: GNL leadership – including Seniors and Education departments; Professional Practice; Union Partners; Operational leaders (Managers, Directors); Clinical teams (NPs, RNs, LPNs, PCAs) I: Education and training teams

Recommendation #4: Enhance team-based care model

Description Rationale

Support care delivery model redesign that embeds scope aligned roles within team-based workflows, ensuring staffing models are designed around patient and resident needs, acuity, and service context rather than historical role deployment and staffing approaches.

This includes:

Evaluating the current model of nursing care across all NLHS sites to establish a baseline of current unit-level patient/resident needs and acuity profile, using agreed indicators and a consistent assessment cadence, aligned with the Data Driven Decision-making.

- Update staffing models reflected in deployed tools to reflect target FTEs and target skill mix⁴⁰ by unit, clinic or community service, to align with current and projected patient/resident needs and acuity profile
- Mapping the required interdisciplinary supports and embedding their role accountabilities within the unit, clinic or community service care team model with safe staffing

⁴⁰ See Appendix A for suggested amendments for in scope sites of this Core Staffing Review.

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Interdisciplinary service design capability (process mapping, co-design, facilitation) - Defined measures and monitoring (role clarity, skill mix, quality/safety) - Availability of enabling infrastructure (including technology and virtual care delivery) and support roles to sustain team-based models	- Local capacity for interdisciplinary codesign, facilitation, and change leadership - Flexibility to adapt team-based models to rural and remote operating realities - Clear measures (e.g., role clarity, skill mix, quality/safety) to monitor and sustain redesigned models - Communicate the future-state team model in plain language (e.g., who does what, when, and why) and reinforce that redesign is based on acuity/needs, not historical staffing patterns	R: Operational leaders (Managers, Directors); Clinical teams (NPs, RNs, LPNs, PCAs) A: NLHS Executive and Senior Leadership C: Professional Practice; Human Resources and Workforce Planning; Union Partners; Education and training teams (e.g., Learning and Development) I: Human Resources and Workforce Planning

Recommendation #5: Review the role of Allied Health in interdisciplinary care teams

Description Rationale

Review and clarify the role of allied health professionals within interdisciplinary care teams to ensure their deployment is aligned with population, patient and resident needs and reduces unnecessary task shifting to nursing staff.

This includes:

- Conducting a third-party review of selected allied health staffing to complement the Core Staffing Review
- Clarifying allied health role accountabilities within team-based care models across care settings
- Assessing whether core allied health staffing levels and coverage (by discipline) are aligned to patient/resident acuity, demand, and the intended care delivery model, and identify gaps requiring adjustment through stakeholder engagement

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Defined review scope - what care settings/units, allied health disciplines, and roles - coverage, accountability, pathways - Baseline data pack (current allied health staffing/coverage, demand/consult volumes, wait times, and evidence of tasks shifting to nursing). - Defined service standards to assess against (e.g., expected	- Early engagement of allied health leadership to define role expectations within care models - Clear communication to interdisciplinary teams on revised accountabilities and interfaces with nursing roles - Monitoring of task shifting, flow, and workload impacts to reinforce credibility and uptake	R: Operational leaders (Managers, Directors); Professional Practice A: NLHS Executive and Senior Leadership C: Clinical teams (NPs, RNs, LPNs, PCAs); Human Resources and Workforce Planning; Union Partners I: Education and training teams (e.g., Learning and Development)

Key dependencies

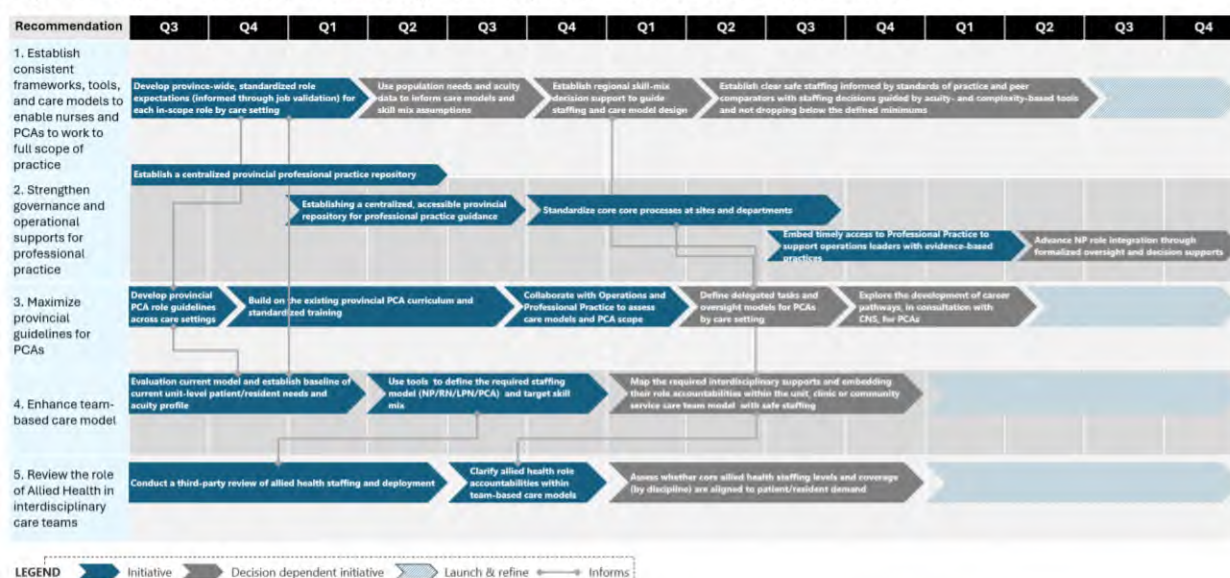
- coverage/response times/referral pathways by setting/acuity)
- Agreed interdisciplinary role accountabilities and escalation mechanisms to resolve gaps in coverage and prevent work from defaulting to nursing
- Clarified operating model and decision rights to enable resources to flex with demand (e.g., program vs discipline vs provincial model), including defined authority to move resources and an accountable executive sponsor to arbitrate cross-program trade-offs, particularly where staff are embedded within programs (vs discipline departments), reporting lines are mixed (e.g., NPs reporting to non-NPs), and positions are not easily redeployed across services

Change Management Considerations

Responsible, Accountable, Consulted, Informed Stakeholders

Domain A: Implementation Roadmap

Sequencing assumes that role clarity, professional practice governance, and delegation frameworks are established before staffing models are formalized. Care models and interdisciplinary roles are refined iteratively as scope, skill mix, and acuity assumptions are tested in practice.



Domain B: Non-Nursing Duties

This recommendation domain addresses the routine assignment of nonclinical and administrative duties to nurses across acute care, long-term care, and community care settings. Current state findings show that these duties are not episodic but structural, diverting nursing capacity away from direct care and limiting the system's ability to deploy staff to full scope.

Select Highlights from the Current State

- Nurses routinely perform non-nursing duties (e.g., clerical work, portering, supply management, coordination), reducing time for direct patient care and limiting full scope practice.
- Inconsistent access to support roles forces nurses to absorb non-clinical tasks, particularly in rural and smaller sites where dedicated support is limited, increasing workload and operational inefficiency.

"When RNs have to do extra ward clerk duties, they are doing more paperwork than patient care. When we don't have physiotherapists, people don't progress and go home as quick as they should. When we don't have supplies and linen, it takes time away from the patients to look for these things."

Recommendation #6: Assess and standardize support roles

Description Rationale

Review support role (e.g., clerk, MSA, portering, EVS) requirements across care settings and redesign workflows to systematically reduce non-clinical tasks currently performed by nurses and protect nursing time for direct patient care.

This includes:

- Conducting a systematic assessment of non-nursing tasks performed by nurses across acute care, long-term care, and community care settings to inform the need for support roles in addition to current nursing staff numbers
- Using the assessment to formally reassign identified non-nursing tasks to defined support roles and embed these accountabilities and coverage requirements into staffing standards, so the work does not default back to nursing
- Embedding reduced non-nursing duties into staffing standards and workforce planning models
- Applying these standards consistently across sites to support comparability and transparency
- Defining appropriate levels of clerical, portering, diagnostic, and other supports, with consideration for job validation in rural and remote operating contexts

Recommendations in other domains may also support the reduction of non-nursing duties delivered by nursing staff (e.g., Digital Enablers). Benefits could be quantified through a systematic assessment of non-nursing duties.

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
• Reliable task/time data to identify priority non-nursing duties, plus recruitment and scheduling capacity for support staff (with rural-specific coverage approaches) • Project Sponsors to decide if the review of non-nursing duties should be completed before	• Phased implementation aligned with staffing feasibility, particularly in rural and remote contexts • Use of context-specific solutions (e.g., role bundling, shared services), where standalone support roles are not viable • Clear communication plan to explain what tasks are being	R: Operational Efficiency; Human Resources; Support Staff; Clinical Teams A: NLHS Executive and Senior Leadership C: Professional Practice; Unions; Workforce Planning I: Clinical Teams

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
staffing level adjustments are made.	reassigned, to whom, and when, including escalation pathways • Clear articulation of how redesigned support roles will reliably remove non-nursing work from nurses • Consider establishing a model/team and a formal process to capture feedback and solutions from frontline staff, to inform implementation	

Domain B: Implementation Roadmap

Sequencing assumes that non-nursing workload must be measured and standardized before support roles and staffing adjustments are implemented. Ongoing refinement reflects differences in care setting, operating context, and rural or remote service delivery.



4.2 Stabilize and sustain core staffing

Domain C: Education and Mentorship

This recommendation domain addresses variability in the education and mentorship models to support staff across NL Health Services. Building on the successful Nurse Mentorship Program pilot and ongoing provincial expansion efforts, NL Health Services has an opportunity to establish a consistent, sustainable mentorship approach across classifications and practice settings. While the pilot demonstrated positive outcomes for participant confidence, communication, and retention intent, current state findings indicate variability in access to education and mentorship supports across zones and care settings, highlighting the need for broader implementation and continued program refinement.

Select Highlights from the Current State

- NL Health Services successfully piloted the Nurse Mentorship Program from June 2024 to May 2025, supporting 71 mentor-mentee relationships across 11 sites. Preliminary evaluation findings demonstrated improvements in nursing skill confidence, interdisciplinary communication confidence, and intent to stay, with 77% of participants indicating they would recommend the program to others.
- Clinical educator capacity is inconsistent and diluted by competing demands, including shift coverage, onboarding new team members, and system initiatives, reducing focus on core education functions.
- Education and mentorship support are uneven across care settings, with rural sites particularly affected by limited educator capacity (i.e., zonal), resulting in delayed competency development.
- While the Nurse Mentorship Program has demonstrated positive outcomes, access to structured mentorship opportunities remains inconsistent across zones, professions, and care settings. Where formal mentorship supports are unavailable, mentorship responsibilities continue to rely on informal frontline support models, increasing workload pressures and limiting scalability.

“We need training sessions before complex residents arrive (e.g., bowel regimes, Coban dressings, behavioural changes due to illness).”

“Training for complex residents’ needs to be provided BEFORE the residents show up so they do not have to go without or wait for their basic needs to be met until we get someone who can teach us.”

Recommendation #7: Standardize the Clinical Educator role

Description Rationale

Standardize the clinical educator role across zones and care settings by clearly defining responsibilities and expected on unit presence. A standardized and protected education and mentorship model is expected to accelerate safe independence for new and transitioning staff, reducing the duration and intensity of informal supervision required from frontline teams and clinical leaders.

This includes:

- Defining standardized role expectations and scope for clinical educators
- Establishing clear, Professional Practice accountable guidelines for educator deployment and coverage models (including CE structure, program, and outcome measures)
- Aligning educator capacity with onboarding, competency development, and ongoing practice support needs

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
Advancing this opportunity will depend on sustained resourcing to support protected educator and mentorship capacity, including alignment of funding, staffing models, and operational expectations to prevent routine redeployment of these roles to cover short-term staffing gaps, with consideration given for sustaining optimal patient care as per standard of practice.	- Clear operational expectations and leadership reinforcement to protect educator capacity - Consistent role definitions, spans of control, and deployment guidelines across zones - Alignment of educator capacity with onboarding, transition, and competency development needs - Clear communication of educator and mentorship role expectations, access pathways, and how units request/support coverage	R: Operational Site Leads (Managers, Site Leads and Clinical Leaders) A: NLHS Executive and Senior Leadership C: NLHS Human Resources; Union Partners; Scheduling and Workforce Planning I: Occupational Health and Safety (Disability Case Managers)

Recommendation #8: Scale and embed the existing Nurse Mentorship Program as a core component of professional practice support programs

Description Rationale

Build on the existing Nurse Mentorship Program by making mentorship a standard part of onboarding and role transitions, especially in high-turnover and rural areas, and roles with expanded or changing scope of practice. As the program expands, strengthen consistency in pairing, expectations, and delivery, and consider virtual options to support remote sites.

Scaling this program presents a near-term opportunity to strengthen workforce capability and retention, particularly for nurses entering, re-entering, or transitioning in practice. As the program expands, addressing identified improvement areas, such as mentor accessibility, pairing consistency, and role clarity, will be important to ensure consistent impact at scale. This includes:

Identifying priority units, sites, and/or roles based on turnover, onboarding volume, scope of practice and alignment with system priorities (e.g., advanced scopes and rural retention).

- Developing learning plans and/or other guidelines to support the mentor/mentee relationship and promote consistency in experience.

Developing pairing processes that take into account the needs of mentees and the knowledge and experience of mentors.

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
Continued funding to incentivize the participation of Mentors in the formal mentorship program delivered through Professional Practice.	- Funded backfill to protect mentorship roles from absorption into baseline staffing - Clear governance to reinforce program intent and prevent routine redeployment	R: Operational Site Leads (Managers, Site Leads and Clinical Leaders) A: NLHS Executive and Senior Leadership

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
	- Transparent criteria for prioritizing units and sites to support fairness and sustainability - Communicate the mentorship program intent, eligibility/priority criteria, and how backfill will protect the mentor role so units see it as reliable support (not a temporary initiative)	C: NLHS Human Resources; Union Partners; Scheduling and Workforce Planning I: Occupational Health and Safety (Disability Case Managers)

Recommendation #9: Strengthen education system partnerships

Description Rationale

Strengthen partnerships with post-secondary institutions and education providers to rebuild sustainable education pipelines aligned with system demand.

This includes:

- Strengthening PCA education pipeline by improving seat-fill (recruitment, selection, and supports) where training capacity exists
- Aligning nursing and PCA training volumes with projected workforce demand
- Coordinating placement capacity and preceptor availability across sites

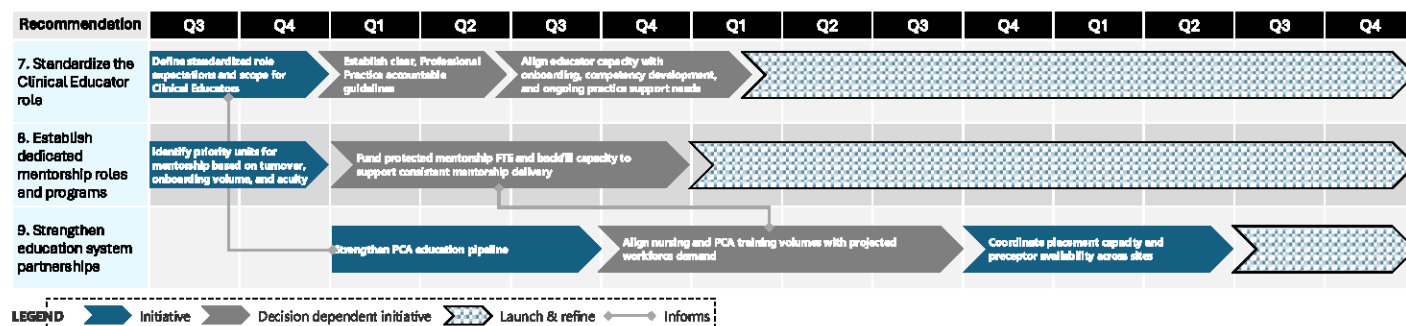
Recommendations provided in the NL Provincial HR Plan may also support the strengthening of education system partnerships

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
Continued and coordinated engagement with post-secondary institutions and education partners will be required to rebuild PCA and strengthen nursing education pipelines, address training capacity constraints, and align education supply with projected workforce demand across urban and rural settings.	- Continue to engage and coordinate planning with education partners to align training volumes and capacity - Proactive management of preceptor availability and clinical placement constraints - Joint governance to ensure education pipelines scale without increasing unit workload - Communicate shared planning assumptions with education partners (volumes, placements, preceptor supports) and keep sites informed on what will change for placement scheduling and supervision load	R: NLHS Human Resources A: NLHS Executive and Senior Leadership C: Operational Site Leads (Managers, Site Leads, and Clinical Leaders); Union Partners; Scheduling and Workforce Planning; post-secondary institutions; Dept. Education and Early Childhood Development; Dept. of Jobs, Growth and Rural Development. I: Occupational Health and Safety (Disability Case Managers)

Domain C: Implementation Roadmap

Sequencing assumes that education capacity and training volumes drive onboarding demand, which in turn informs Clinical Educator and mentorship capacity requirements. Education, mentorship, and partnership models are refined over time to respond to workforce supply and practice-level needs.



Domain D: New Hires

This recommendation domain addresses increasing onboarding and integration pressures across NL Health Services driven by workforce turnover and growth in newly graduated nurses and internationally educated nurses (IENs). Current state findings indicate that onboarding, integration, and support models have not scaled consistently to meet growing volume and complexity, placing strain on teams and limiting readiness for independent practice.

Select Highlights from the Current State

- Onboarding and integration demands have increased significantly with [more than 1,300 nurses hired between 2023 to 2025](#), while existing programs and supports have not scaled to meet system-wide volume and complexity.
- Readiness for independent practice among IENs is uneven, with variable confidence and preparedness across settings and reliance on formal peer support rather than structured interdisciplinary integration.
- High concentrations of early tenure staff increase supervision and mentorship demands, elevating workload pressure on experienced teams and increasing risks of delayed readiness, burnout, and early attrition.
- Locally grounded integration approaches show promise in some rural settings, but these practices are not consistently supported or scaled across the system.

"Safe staffing, adequate support staff, and proper, structured education pathways are not optional—they are the foundation of a safe, functional, and ethical healthcare system. Without them, we are setting everyone up to fail."

Recommendation #10: Strengthen pre-hire and early-hire assessment processes

Description Rationale

Strengthen early hire assessment processes to better align education, experience, and support needs, to enable earlier identification of targeted training, supervision, and mentorship requirements.

This includes:

- Standardizing assessment approaches across roles and care settings
- Using assessment results to inform differentiated onboarding and support pathways

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Province-wide alignment on onboarding standards and role expectations appropriate for each care setting - Protected educator and mentorship capacity to operationalize differentiated supports - Timely access to standardized assessment results to inform onboarding and support decisions	- Pairing standardized assessments with protected education, mentorship, and supervision supports - Timely access to assessment results to inform differentiated onboarding pathways - Clear guidance on how assessment outputs are used operationally - Develop a communication plan for staff, managers, and educators to outline the purpose of assessments, how results will be used, and any required changes	R: NLHS Human Resources; Professional Practice A: NLHS Executive and Senior Leadership C: Operational Site Leads; Education and Training; Union Partners I: Scheduling and Workforce Planning

Recommendation #11: Strengthen community partnerships to support IEN integration

Description Rationale

Strengthen community-based integration to support retention, enhance social and professional integration of IENs, and reduce early attrition, particularly in rural and remote settings.

This includes:

- Sustaining coordination with academic, regulatory, and community partners specifically regarding newcomer integration

Integrating workplace onboarding with existing community tool kit to support with housing and transportation

- Supporting locally grounded integration approaches led by site and community leadership

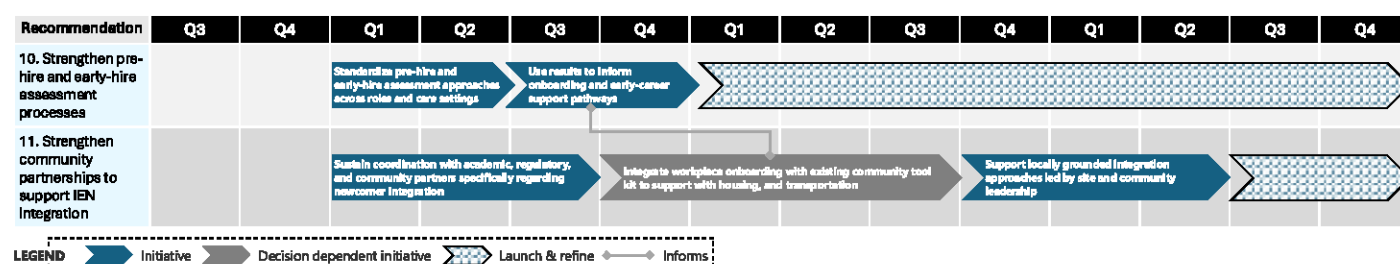
Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Sustained collaboration with regulators, educators, and community partners - Alignment with housing, transportation, and settlement supports - Local leadership capacity	- Formal agreement among stakeholders to collaborate on the initiative - Alignment of workplace onboarding with existing community tool kit, to support with housing, and transportation - Clear local leadership ownership and tailored approaches for rural and remote settings - Communicate how community supports connect to workplace onboarding (who coordinates what) so IENs and managers have	R: NLHS Human Resources; Community and Rural Health Leadership A: NLHS Executive and Senior Leadership C: Academic Partners; Regulatory Bodies; Community Organizations (Municipalities NL: MNL) I: Operational Site Leads

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
	a clear, single pathway to access support	

Domain D: Implementation Roadmap

Sequencing assumes that standardized assessment and early-hire insights enable more targeted onboarding and integration supports, particularly for internationally educated nurses. Community-based integration approaches are strengthened as assessment data improves segmentation and support planning.



Domain E: Availability of Staff

This recommendation domain addresses persistent challenges related to staff availability that continue to place systemic pressure on core staffing models across acute care, long-term care, and community care settings. Current state findings indicate that variability in baseline staffing, attendance management, and coverage practices limits staffing stability and drives ongoing reliance on reactive measures.

Select Highlights from the Current State

- The defined baseline staffing assumptions are inconsistently applied, contributing to variable coverage expectations and avoidable gaps that escalate to overtime, redeployment, and agency use.
- Attendance management practices are applied unevenly, limiting the system's ability to address avoidable absenteeism and stabilize baseline staffing.
- Inconsistent application of baseline staffing assumptions results in fluctuating staff availability, leading to coverage gaps that ultimately require overtime, redeployment, or agency resources to address.
- Ongoing reliance on reactive coverage and unpredictable schedules contributes to burnout, negatively affecting staff well-being, retention, and overall workforce stability.
- Approximately 20% of the RN workforce is employed on a casual basis. Casual workers are categorized as those with an annual availability commitment (e.g., 900 hours) under the most recent bargaining agreements and those without availability commitments that have been grandfathered in from past bargaining agreements. Casual staff are not obligated to accept shifts when offered, which can reduce the reliability of casual pools as a coverage strategy.

"If there is a sick call they are not getting replaced. There is a float pool, but they are currently filling in for vacant positions. Therefore, casuals are not available."

"A huge problem—there is no consequence for calling in sick and abusing leave. Management is not respected the same because they are not on-site."

Recommendation #12: Develop proactive processes for management of short-term staffing needs (e.g., casual / flexible staffing)

Description Rationale

Implement standardized tracking and monitoring of casual/float staffing to improve the predictability of casual/float coverage and reduce overtime and agency use. Monitoring improves reliability by identifying recurring coverage gaps and low fill rates, enabling proactive management of flexible staffing (e.g., availability updates and right-sizing), and supporting targeted engagement and recruitment where needed to preserve staffing levels to meet quality patient care.

This includes:

Monitoring casual/float staff hours worked, shift acceptance rates, and site coverage patterns

- Using utilization data to inform workforce planning, highlight cases where targeted casual staff are not meeting contract commitments, and targeted recruitment strategies
- Targeting areas with sustained agency use to shift coverage toward more effective and reliable flexible staffing approaches
- Identify strategies to encourage casual staff to increase their participation in the workforce

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
• Policy and collective agreement alignment related to how casual staff are scheduled/used • Timely integration of attendance, scheduling, and HRIS systems to reduce manual reconciliations and errors	• Clear governance, definitions, and accountability for how casual utilization data is interpreted and applied • Manager capacity and tools to actively monitor and act on utilization insights • Integration of scheduling, attendance, and HR systems to improve data quality and reduce manual reconciliation • Communicate the definitions and expectations behind “casual utilization” metrics (what is being tracked and why) so managers and staff trust the data and the actions taken from it	R: Scheduling and Workforce Planning; NLHS Human Resources A: NLHS Executive and Senior Leadership C: Operational Site Leads (Managers, Site Leads and Clinical Leaders); Union Partners I: Occupational Health and Safety (Disability Case Managers)

Recommendation #13: Strengthen attendance management accountability

Description Rationale

Implement a provincially standardized attendance management framework to reduce avoidable absenteeism, improve schedule predictability, and stabilize baseline staffing. This reduces avoidable absenteeism and last-minute call-ins, improving schedule stability and lowering the volume of shifts escalated to agency staffing.

This includes:

- Review current attendance management program and approaches and identifying opportunities to enhance protocols and escalation pathways
- Aligning attendance management practices with performance management frameworks
- Strengthen the early assistance and support programs for employees returning from short- and long-term disability and explore industry-leading practices such as Early Assistance and Support for Employees (EASE) programs, which provide confidential, voluntary early intervention funded through partial long-term disability premiums, enabling proactive outreach following unexplained absences and facilitating timely, supported return-to-work through coordinated clinical, ergonomic, and workplace accommodation services
- Exploring incentives to improve attendance at work, such as mechanisms that recognize or reward limited use of sick time banks, e.g., payout options for hours accrued above defined bankable thresholds at specific service or anniversary milestones

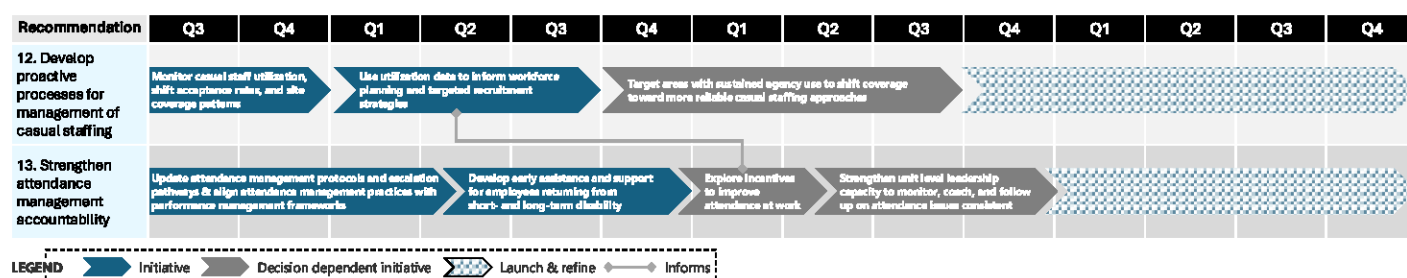
Strengthening leadership capacity to monitor, coach, and follow up on attendance issues consistently

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
Consistent application of attendance-related policies and practices across all sites/departments (especially across like collective agreements), dependent on provincially refreshed, clarified, and standardized policy language (e.g., clear expectations for planned vs. unplanned absences, including notice requirements that support predictive staffing). • Clear escalation pathways for chronic absenteeism supported by labour relations expertise • Sufficient leadership capacity at the unit level to monitor, coach and follow up on attendance issues	• Consistent application of attendance management practices across sites and collective agreements • Clear escalation pathways supported by labour relations expertise • Sufficient leadership capacity to monitor attendance, provide coaching, and follow up consistently • Communicate the attendance framework as consistent and fair (what triggers coaching/escalation, timelines, and supports available) to reduce perceptions of uneven enforcement	R: NLHS Human Resources; Operational Site Leads (Managers, Site Leads and Clinical Leaders) A: NLHS Executive and Senior Leadership C: Union Partners; Occupational Health and Safety (Disability Case Managers) I: Scheduling and Workforce Planning

Domain E: Implementation Roadmap

Sequencing assumes that attendance accountability stabilizes workforce availability, enabling more proactive and data-driven management of casual staffing. Casual staffing approaches are refined over time as reliability improves and demand variability is reduced.



4.3 Move from reactive to defensible staffing

Domain F: Data-Driven Decision-Making

This recommendation domain addresses inconsistent use of standardized, timely, and comparable data to inform staffing decisions across NL Health Services. Current state findings indicate that gaps in data integration, tool usability, and governance limit the system's ability to make proactive, transparent, and defensible staffing decisions aligned to acuity and care complexity.

Select Highlights from the Current State

- NLHS has made strong progress in advancing acuity-informed staffing through the evolution of data-driven decision-making tools; however, implementation has been targeted to select zones and care settings, limiting system-wide visibility into acuity, care complexity, and local operational realities.
- Where implemented, these tools have improved understanding of workload and acuity; however, they are not yet consistently integrated across care settings or fully leveraged to distinguish demand from capacity, contributing to continued reliance on reactive staffing decisions in some areas.
- Acuity-based staffing tools rely on consistent and efficient data entry; in some settings, current workflows increase documentation burden, with certain digital systems adding workload rather than consistently enabling timely, effective decision-making.
- The absence of a system-wide data governance approach limits NLHS's ability to scale leading practices such as data-driven decision-making tools, proactively anticipate staffing pressures, compare performance across sites, and support transparent, defensible staffing decisions at a provincial level.

"As an extremely busy unit covering general surgery, plastic surgery, burns, and traumas, I believe that our high acuity should be considered when being considered to float. I truly believe that the impact we feel by being short of an RN is far greater than any other unit. It is crucial to encourage RNs across the hospital to complete their AAM and for central staffing and the site coordinator to examine these numbers when considering whom to float."

Recommendation #14: Establish standard staffing workload, and acuity indicators

Description Rationale

Establish a core set of standardized staffing, workload, and acuity indicators with clear definitions and consistent application across acute care, long-term care, and community care settings to support transparent, defensible, and data driven staffing decisions.

This includes:

- Establishing standardized indicator definitions and minimum data standards applied consistently across programs and zones using available data (e.g., CorCare capabilities)
 - Using standardized indicators to inform both baseline staffing assumptions and real-time staffing adjustments
 - Defining how qualitative and contextual inputs (e.g., non-nursing workload, skill mix, local operating context) are incorporated alongside quantitative data
 - Applying indicators to support flexible staffing responses to changing patient mix, ALC volumes, cohorting decisions, and flow pressures
-

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Alignment among Workforce Planning, Data and Analytics, clinical leaders, and operational leaders on indicator definitions and minimum data standards - Availability of reliable workload, acuity, and flow data across care settings - Alignment with centralized scheduling processes and workforce planning models - Clear provincial governance for indicator oversight and use	- Frontline and leadership engagement to ensure indicators reflect operational realities and are trusted - Clear guidance on how indicators are applied in both baseline planning and real-time decision making - Leadership capability development to translate data insights into timely staffing actions - Ongoing monitoring to ensure consistent interpretation and application across sites - Communicate indicator definitions and how they will be used in decisions (baseline and real-time) so frontline teams understand and trust the logic	R: Workforce Planning; Data and Analytics A: NLHS Executive and Senior Leadership C: Clinical Leaders; Professional Practice; Scheduling and Workforce Planning; Union Partners I: Operational Site Leads

Recommendation #15: Standardize, capture, and automate staffing and workload data

Description Rationale

Standardize, capture, and automate staffing, workload, and acuity data across care settings to ensure timely, consistent, and comparable inputs are available to support staffing and workforce planning decisions.

This includes:

- Standardizing data definitions, indicators, and minimum data standards across programs and zones
- Automating data capture where possible to reduce manual entry and documentation burden
- Integrating staffing, workload, and acuity data across clinical, scheduling, and workforce systems
- Establishing data governance to support data quality, consistency, and appropriate use

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Alignment among Data and Analytics, Workforce Planning, Digital Health and IT, clinical leaders, and union partners on indicator definitions and minimum data standards - Integration between clinical, scheduling, and HR systems	- Leadership commitment to data standardization and automation as a foundation for decision-making - Frontline engagement to ensure data capture workflows are practical and reduce burden - Ongoing monitoring to confirm automation improves efficiency	R: Data and Analytics; Workforce Planning A: NLHS Executive and Senior Leadership C: Digital Health and IT; Clinical Leaders; Professional Practice; Union Partners

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
Clear data governance structures and ownership	- rather than introducing duplication - Communicate how automation will reduce documentation burden (what will be removed/streamlined) and provide quick training/support	I: Operational Site Leads

Recommendation #16: Standardize data inputs used to inform staffing and scheduling exceptions

Description Rationale

Standardize the data inputs used to inform staffing and scheduling exceptions to support consistent, transparent, and defensible decisions across sites and care settings.

This includes:

- Defining the objective data inputs required to justify staffing and scheduling exceptions (e.g., floating exemptions, redeployment decisions, escalation thresholds)
- Clarifying how quantitative and qualitative inputs are weighted and applied in decision making
- Aligning decision rules with centralized scheduling practices, labour relations frameworks, and collective agreements
- Leveraging the data-driven decision-making tools to understand staffing impacts and develop scenario planning
- Establishing governance and oversight to ensure consistent application across sites

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Agreed decision criteria and thresholds for staffing and scheduling exceptions - Alignment with centralized scheduling processes and labour relations frameworks - data-driven decision-making tools platform to develop scenario-based staffing models - Governance to oversee interpretation and application	- Clear communication of standardized decision rules to managers, schedulers, and clinical leaders - Leadership reinforcement to ensure consistent application across sites and settings - Oversight mechanisms to build trust and reduce perceived subjectivity in decisions	R: Scheduling and Workforce Planning; Operational Leaders A: NLHS Executive and Senior Leadership C: Human Resources; Labour Relations; Union Partners; Data and Analytics I: Clinical Teams

Recommendation #17: Build analytical capabilities and data literacy to support operational decision-making

Description Rationale

Build analytical capability and data literacy among managers and clinical leaders to support confident, consistent use of staffing and acuity data in operational decision making. This improves consistency and confidence in staffing decisions, reduces reliance on anecdotal evidence, and strengthens the organization's ability to proactively manage emerging workload pressures.

This includes:

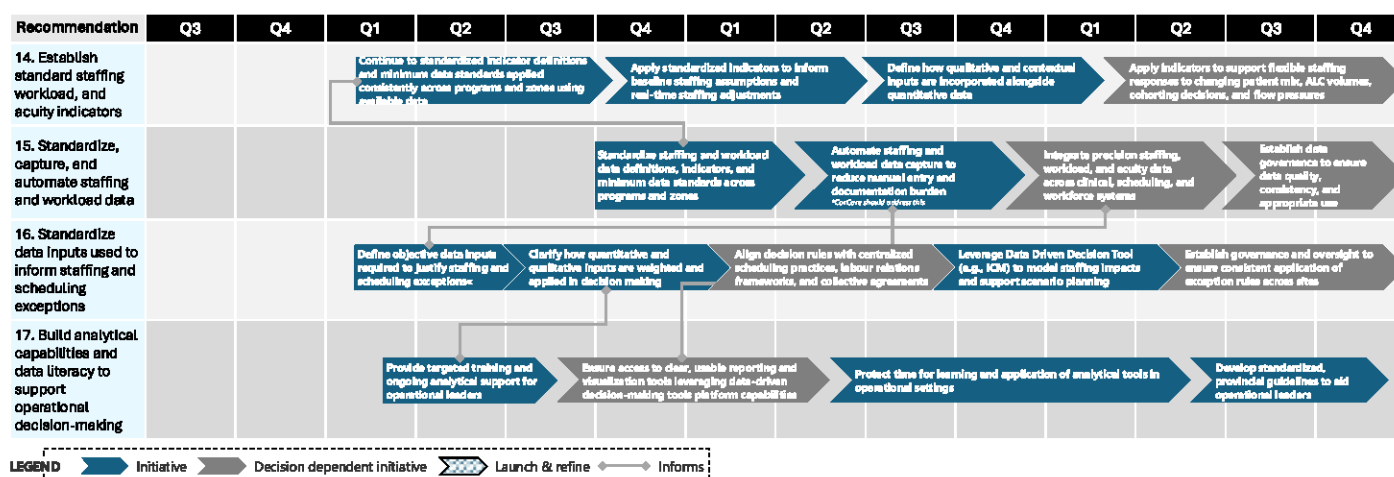
- Providing targeted training and ongoing analytical support
- Ensuring access to clear, usable reporting and visualization tools leveraging data-driven decision-making tools platform capabilities
- Protecting time for learning and application in operational settings
- Develop standardized, provincial guidelines to aid operational leaders in leveraging the data and tools available to support staffing decisions

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
• Targeted training and ongoing support • Accessible reporting and visualization tools • Protected time for learning and application • Build on the Deloitte "How-to-Guide"	• Targeted training and ongoing analytical support tailored to operational leaders • Access to clear, usable reports and visualizations that support day-to-day decision-making • Protected time for managers and leaders to build and apply data literacy skills	R: Data and Analytics; Learning and Development A: NLHS Executive and Senior Leadership C: Operational Leaders; Workforce Planning; Central Staffing; Data-Driven Decision-Making Tools Team I: Professional Practice

Domain F: Implementation Roadmap

Sequencing assumes a maturity progression from defining indicators, to building data infrastructure, to standardizing decision rules, and finally to building analytical capability. Analytical tools and training are most effective once data inputs and decision logic are consistent and trusted.



4.4 Reduce structural load on staffing

Domain G: Digital Tools and Enablers

This recommendation domain addresses variability in the availability, maturity, and integration of digital tools and enabling infrastructure across NL Health Services. Current state findings indicate that uneven digital adoption, workflow misalignment, and infrastructure constraints contribute to inefficiencies, increased indirect care time, and inconsistent support for care delivery and staffing decisions.

Select Highlights from the Current State

- NLHS has established a strong digital foundation, including the evolution of data-driven decision-making tools and targeted use of virtual and remote care solutions; however, availability, maturity, and integration vary across zones and care settings.
- Existing platforms have improved access, coordination, and visibility in some areas, while continued reliance on legacy and non-integrated systems elsewhere drives workflow inefficiencies and administrative burden.
- The upcoming implementation of CorCare presents a significant opportunity to strengthen system integration, standardize workflows, and improve real-time access to clinical and operational information to support both patient care and staffing decisions.
- Inconsistent deployment and workflow alignment of digital tools contribute to workload variability, with some processes increasing documentation burden rather than consistently enabling timely, effective decision-making.
- Geographic dispersion, particularly in rural and remote settings, increases indirect care time, reinforcing the importance of digital and virtual solutions to support equitable access and efficient care delivery.

“Halo patient monitoring—it’s difficult finding a person to sit constant with our patients, this could be utilized when that occurs”

“Schedule is manually entered into excel document by team lead and takes significant nursing hours to complete. Scheduling software across all zones would be significantly less time consuming. Having access to iPads or equivalent when on the road would make the day go smoother as we could chart on the go instead of waiting to get back to the office.”

Recommendation #18: Address gaps in available digital tools

Description Rationale

Assess and address gaps in digital tools and integrations required to support efficient care delivery and reduce manual workarounds that increase workload. This reduces manual workarounds and delays, improves reliability of care delivery, and enables frontline staff to spend more time on direct patient care.

This includes:

- Prioritizing investments based on operational and workforce impact by using baseline and post implementation data to assess impact
 - Aligning equipment and digital tool decisions with staffing models and care delivery needs
 - Ensuring equitable access across urban, rural, and remote settings
-

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Sustained capital investment prioritization based on operational impact - Access to baseline and post-implementation performance data - Alignment with staffing models and care delivery needs across urban and rural settings	- Transparent prioritization of investments based on operational and workforce impact - Alignment of infrastructure decisions with staffing models and care delivery needs - Equitable deployment strategies across urban, rural, and remote settings - Communicate the prioritization rationale for digital infrastructure investments and timelines so sites understand sequencing and equity considerations	R: Digital Health and IT; Biomedical Engineering A: NLHS Executive and Senior Leadership C: Operational Leaders; Clinical Teams; Finance I: Workforce Planning

Recommendation #19: Ensure Digital Tools Reduce Administrative Burden

Description Rationale

Ensure that digital tools supporting staffing, scheduling, and workload management are implemented with clear operational intent and workflow alignment to reduce administrative burden.

This includes:

- Engaging frontline staff in design and implementation of future-state care and staffing models
- Mapping workflows to enable task automation and eliminate duplication and unnecessary steps
- Aligning clinical, operational, and digital teams throughout deployment

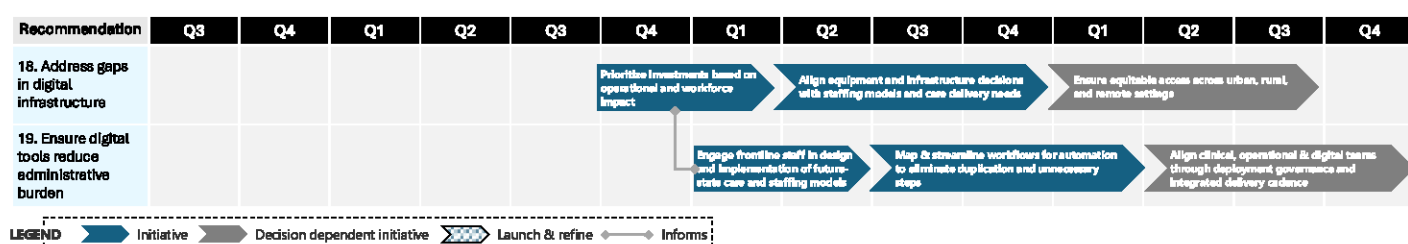
Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
- Frontline engagement in design and implementation - Workflow mapping - Clear articulation of future-state care models - Alignment between clinical, operational, and digital teams	- Frontline engagement throughout design and implementation to ensure usability - Workflow mapping to eliminate duplication and unnecessary steps - Clear articulation of future-state staffing and care delivery models to guide tool deployment - Ongoing monitoring of administrative burden and rapid refinement based on user feedback - Communicate workflow changes alongside the tool (what steps are	R: Digital Health and IT; Operational Efficiency A: NLHS Executive and Senior Leadership C: Clinical Teams; Workforce Planning; Union Partners I: Professional Practice

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
	removed, what is simplified) and set up a rapid feedback loop to address challenges	

Domain G: Implementation Roadmap

Sequencing assumes that future-state care models and workflows must be clearly defined before digital tools are deployed at scale. Clinical, operational, and digital alignment is sustained over time to support iterative deployment and continuous improvement.



Domain H: Flow Constraints and Levels of Care

This recommendation domain addresses persistent patient flow constraints across NL Health Services that continue to place downstream pressure on staffing models, workload sustainability, and care delivery across acute care, long-term care, and community care settings. Current state findings indicate that flow challenges are systemic, extending beyond individual sites and requiring coordinated, system level responses alongside flexible staffing models.

Select Highlights from the Current State

- Persistent flow constraints, driven by high alternate level of care (ALC) volumes and prolonged lengths of stay, limit bed availability and create sustained pressure on staffing models and workload.
- Flow challenges extend beyond hospital operations, with constrained long term care capacity, limited community and allied health supports, and transportation barriers—particularly in rural and remote areas—delaying discharges and transfers.
- Staffing adjustments and cohorting are being used as interim mitigation measures rather than solutions to underlying flow issues and require careful application and appropriate staffing and environmental supports.
- Provincial flow initiatives (e.g., ICM, IOC, Home First) have improved predictability where mature, but uneven implementation across zones results in variable flow performance and inconsistent workload impacts.
- Increasing staffing levels alone is insufficient to resolve flow challenges, underscoring the need for staffing models that are flexible and responsive to acuity, delayed discharges, and patient mix while broader system-level flow solutions continue to mature.

"If we had physician support from a constant on-site physician, proper community health support, mental health support, many of the issues that make care delivery so frustrating would be alleviated."

Recommendation #20: Standardize patient flow processes provincially

Description Rationale

Ensure that digital tools supporting staffing, scheduling, and workload management are implemented with clear operational intent and workflow alignment to reduce administrative burden.

This includes:

- Engaging frontline staff in design and implementation of future-state care and staffing models
- Mapping workflows to enable task automation and eliminate duplication and unnecessary steps
- Aligning clinical, operational, and digital teams throughout deployment

Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
• Province-wide agreement on principles • Clear escalation and override criteria • Alignment with transportation and environmental capacity	• Province-wide agreement on principles and decision criteria • Clear escalation and override pathways to support safety and flexibility • Alignment of patient placement decisions with staffing and environmental capacity	R: Provincial Flow Leadership; Zonal Flow Directors A: NLHS Executive and Senior Leadership C: Operational Leaders; Clinical Teams; Long Term Care Leadership I: Workforce Planning

Recommendation #21: Strengthen cross system patient flow coordination

Description Rationale

Strengthen coordination across provincial flow leadership, zonal teams, long term care, and community and allied health programs to ensure staffing decisions reflect real time flow dynamics. This improves alignment between flow decisions and frontline capacity, supports more equitable workload distribution, and reduces downstream staffing pressure across the continuum.

This includes:

- Clarifying roles and accountability across flow partners
- Improving shared data and communication mechanisms
- Sustaining cross sector engagement to reduce downstream workload impacts

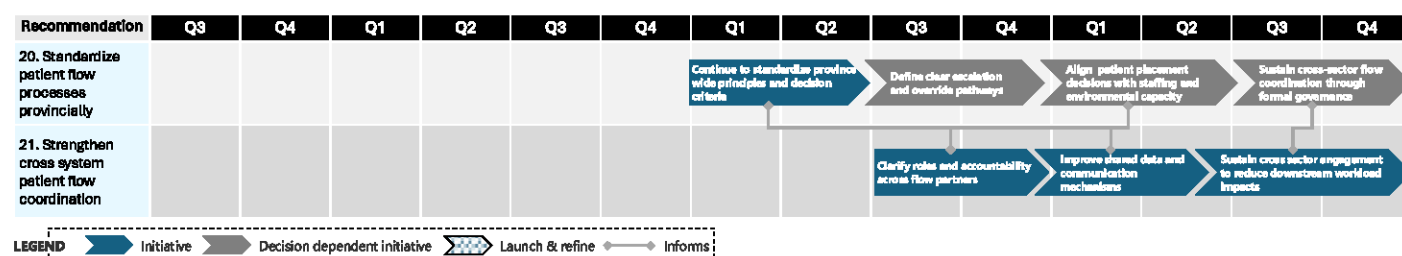
Implementation Planning

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
• Clear roles and accountability across flow partners • Shared data and communication mechanisms	• Clear roles and accountability across flow partners • Shared data and communication mechanisms across the continuum	R: Provincial Flow Leadership; Zonal Flow Directors A: NLHS Executive and Senior Leadership

Key dependencies	Change Management Considerations	Responsible, Accountable, Consulted, Informed Stakeholders
Sustained cross-sector engagement	Sustained cross-sector engagement to reduce downstream workload impacts	C: Long Term Care Leadership; Community and Allied Health Programs; Workforce Planning I: Operational Site Leads

Domain H: Implementation Roadmap

Sequencing assumes that patient flow processes and accountability are standardized before shared data, escalation mechanisms, and cross-sector coordination are implemented. Sustained flow performance depends on clear governance, shared information, and embedded engagement forums that mature over time rather than one-time implementation.



4.4 Implement Recommended Budgeted FTE Adjustments

Table 9 summarizes the budgeted, actual, and recommended core staffing FTEs across the six sites included in the review. It provides a high-level view of the overall staffing impacts identified through the Core Staffing Review and should be read alongside the detailed departmental assessments in Appendix A, which outline the rationale for each recommended adjustment. Variances between budgeted, actual, and recommended staffing levels reflect site-specific workload, acuity, and operational considerations identified through the review methodology.

Overall, the review identifies a net increase of approximately 56.6 FTEs across the six sites, with most additions focused on PCA positions to better support direct care delivery and enable nurses to work to full scope. Recommended increases are concentrated at larger acute-care sites, particularly HSC and JPMRHC, while rural and mixed-care sites primarily require targeted skill-mix adjustments. The analysis also highlights that several sites are already operating above budgeted staffing levels, suggesting that the recommendations largely align budgeted staffing with actual operational demand rather than representing entirely new staffing requirements.

Table 9: Summary of Recommended Budgeted FTE Adjustments

Site/Department	NP Budget (2024-25)	NP Actuals (2024-25)	NP Recomm ended	Budget Impact	RN Budget (2024-25)	RN Actuals (2024-25)	RN Recomm ended	Budget Impact	LPN Budget (2024-25)	LPN Actuals (2024-25)	LPN Recomm ended	Budget Impact	PCA Budget (2024-25)	PCA Actuals (2024-25)	PCA Recomm ended	Budget Impact
Health Science Centre																
4NA Hematology/Oncology Inpatient Unit	0.50	1.08	1.25	0.75	47.37	49.18	49.90	2.53	0.38	0.10	-	-0.38	1.35	0.12	2.50	1.15
4NB General Surgery Inpatient and Special Care Unit	1.00	2.00	2.00	1.00	57.48	56.99	61.00	3.52	0.14	0.22	-	-0.14	3.39	2.76	3.39	-0.00
James Paton Memorial Hospital																
Medicine Inpatient Unit	-	1.01	1.25	1.25	15.27	17.31	14.10	-1.17	13.56	12.79	17.20	3.64	3.36	4.25	3.10	-0.26
Emergency Depart and Overflow Unit***	2.25	0.02	1.25	-1.00	29.22	37.16	39.77	10.55	-	0.75	2.21	2.21	-	2.94	2.21	2.21
Intensive Care Unit	-	-	1.25	1.25	22.23	24.05	20.29	-1.94	-	-	-	-	-	-	1.40	1.40
Surgical Inpatient	-	-	1.25	1.25	20.58	21.56	20.60	0.02	5.43	4.79	6.70	1.27	-	2.49	2.70	2.70
Day Surgery	-	-	-	-	5.20	5.46	5.20	-	-	-	-	-	-	-	-	-
OR/PARR	-	-	-	-	15.73	14.90	17.25	1.52	-	0.18	-	-	-	-	0.83	0.83
Obstetrics Unit	-	-	-	-	23.23	20.49	16.60	-6.63	-	-	-	-	-	-	-	-
Orthopaedics Inpatient Unit	-	-	-	-	20.08	21.62	18.20	-1.88	5.43	5.75	7.80	2.37	-	2.11	2.60	2.60
Dialysis Unit	1.00	0.94	1.25	0.25	7.82	7.94	8.75	0.93	2.28	2.48	2.75	0.47	-	-	-	-
Cancer Clinic	-	-	-	-	1.14	1.35	1.40	0.26	4.00	4.33	4.20	0.20	-	-	-	-
Endoscopy	-	-	-	-	6.14	5.73	5.10	-1.04	-	-	-	-	-	-	-	-
Labrador South Health Center																
Ambulatory*	-	-	-	-	-	6.50	1.30	Unknown	-	1.19	0.30	Unknown	-	-	-	Unknown
LTC*	-	-	-	-	-	0.70	-	Unknown	-	9.18	4.20	Unknown	-	3.15	4.20	Unknown
Emergency Dept*	-	-	-	-	-	6.52	5.10	Unknown	-	1.19	0.60	Unknown	-	-	-	Unknown
Community Care**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Public Health**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Western Long-term Care																
Rehabilitation	-	-	-	-	4.40	6.82	4.20	-0.20	4.20	3.96	4.70	0.50	-	1.46	2.60	2.60
Restorative	-	-	-	-	1.85	6.82	4.73	2.88	4.20	3.96	5.40	1.20	4.72	1.46	3.30	-1.42
Birchview	-	-	-	-	0.30	0.95	0.44	0.14	4.20	4.35	4.20	-	6.30	9.74	9.90	3.60
Shoreview	-	-	-	-	0.30	2.97	0.44	0.14	4.20	3.79	4.20	-	6.30	8.31	9.90	3.60
Bayside*	-	-	-	-	-	2.94	0.44	Unknown	-	4.98	4.20	Unknown	-	8.23	9.90	Unknown
Natures Heaven*	-	-	-	-	-	2.43	0.44	Unknown	-	4.15	4.20	Unknown	-	8.69	9.90	Unknown
Still Waters*	-	-	-	-	-	2.07	0.44	Unknown	-	3.46	4.20	Unknown	-	7.67	9.90	Unknown
Valleyside*	-	-	-	-	-	1.97	0.44	Unknown	-	4.64	4.20	Unknown	-	8.08	9.90	Unknown
Balsamview*	-	-	-	-	-	1.98	0.44	Unknown	-	4.41	4.20	Unknown	-	6.38	9.90	Unknown

Placentia Long-term Care (Incl. Lions Manor)																
Unit I	-	-	-	-	6.82	11.07	4.38	-2.44	8.63	10.02	8.63	-	13.43	13.74	16.10	2.67
Unit II	-	-	-	-	2.71	1.54	4.10	1.39	8.33	8.78	8.33	-	11.10	13.44	15.00	3.90
Unit III	-	-	-	-	-	0.01	2.20	2.20	6.00	2.44	5.00	-1.00	7.60	2.64	9.40	1.80
Emergency Dept.	-	-	-	-	6.16	6.16	6.70	0.54	-	-	1.43	1.43	-	-	1.40	1.40
Medicine	-	-	-	-	6.24	7.36	6.24	-	1.20	2.15	1.20	-	-	-	-	-
Family Medicine	1.00	1.01	2.00	1.00	-	-	-	-	0.64	0.57	0.64	-	-	-	-	-
Ambulatory	-	-	-	-	1.36	1.24	1.36	-	-	-	-	-	-	-	-	-
Mount Pearl Square																
Home Care and Clinic	-	-	1.00	1.00	14.97	21.04	13.53	-1.44	1.89	1.63	4.06	2.17	-	-	-	-
Public Health**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MH&A**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Totals	5.75	6.06	12.50	6.75	316.60	374.83	335.06	9.87	74.72	106.24	114.75	13.93	57.56	107.66	140.03	28.78

* Budget Unavailable/Impact Unknown

** No Recommended FTEs due to missing data

*** No current budget for overflow unit

Total Budget Variance 59.32

Appendix A – Contents

James Paton Memorial Regional Health Centre

Site Overview

James Paton Memorial Regional Health Centre (JPMRHC), located in Gander, serves as a critical regional referral centre, supporting a broad catchment area encompassing numerous rural communities within the Central Region. The facility operates approximately 85 acute care beds.

- Emergency Department (24/7)
- 8 bed intensive care unit
- 20 bed inpatient surgical unit
- 32 bed inpatient medicine unit
- 20 bed inpatient orthopaedic unit
- 10 bed obstetrics unit and prenatal clinic
- 5 room combined OR and recovery
- Outpatient renal dialysis services
- Outpatient cancer care clinic
- Ambulatory endoscopy services
- Ambulatory day surgery

JPMRHC also hosts several small, often rotational ambulatory clinics, such as Speech Pathology, Nutrition Services, and other allied health or outreach programs – with limited support from nursing. These clinics operate with stable, consistent rosters and are driven by scheduled appointments rather than variable daily demand. Given their size, predictable activity, and limited nursing involvement, they were not examined in detail as part of this review. Staffing for these services is best guided by ambulatory activity measures, service performance indicators, and local operational decisions.

There are limited casual staff available for the units, with a float pool that is shared between James Paton site and nearby long-term care facilities, a reality under current assessment by provincial leadership. Approach to scheduling varies across the site, with units like Medicine relying on a consistent 12-week rotation, and others like surgery undertaking self-scheduling.

Strengths:

- Demonstrated ability to maintain service delivery and patient flow under sustained bed capacity and discharge pressures.
- Clearly defined, acuity-aligned staffing models in specialty areas (e.g., Emergency Department, ICU, Obstetrics), including RN-led models and suggested nurse-to-patient ratios aligned to leading practice.
- Improved role differentiation in the recent fiscal year, with integration of LPNs and PCAs where appropriate to support routine and indirect care and preserve RN capacity for higher-acuity needs.
- Approved Emergency Department Patient Navigator role is anticipated to enhance patient experience and flow once onboarded.

Key Observations by Role:

Nurse Practitioner

- NP roles present in select programs (e.g., Medicine, Renal Dialysis)
- NP coverage primarily weekday-based where included
- NP roles often shared across programs or sites

Registered Nurse

- RNs provide primary clinical oversight across all inpatient and acute care settings
- RN-only staffing models used in high-acuity areas (e.g., ICU, Obstetrics, ED, Overflow)
- Defined RN roles and ratios established in multiple units
- [REDACTED]
- Ongoing use of overtime and agency RNs to maintain coverage in some units

Licensed Practical Nurse

- LPN roles integrated across some inpatient and ambulatory units
- LPN staffing exceeds budget in some programs
- LPNs used to support medication administration and routine care
- LPN role is not included in select high-acuity or specialized units

Patient Care Assistant

- PCA roles included in some inpatient and surgical units
- PCA staffing exceeds budget in some areas
- Additional PCA positions approved in at least one program but not yet implemented
- PCA role is not included in multiple acute and procedural units

Emergency Department (ED) and Overflow Unit

Unit Overview and Organizational Factors

Emergency Department (ED)

The ED consists of defined clinical and functional care areas that support emergency assessment, treatment, and patient flow.

The ED includes:

- An ambulance offload and registration area adjacent to the main entrance.
- A trauma/resuscitation area with two functional resuscitation beds (additional spaces are used for non-trauma emergency care).
- Emergency treatment rooms arranged along corridors on either side of a single enclosed nursing station, supporting both monitored and non-monitored care.
- A triage area with stretcher and ECG capability.
- An emergency waiting room shared with the hospital's main public entrance.
- A psychiatric assessment room accessed from the waiting room and located near offload registration.

Staffing in the ED is allocated across these distinct areas, including,

- 1 RN for trauma/resuscitation,
- 2–3 RNs allocated to either assessment spaces, assigned with physician oversight, or ED inpatient,

- 1 RN for triage,
- 1 RN for float, ambulance offloads and psychiatric assessment.

The physical layout of the ED is fragmented and confined, reducing visibility across the unit. The configuration and distribution of care spaces inform staff deployment and coverage across the department.

Overflow Unit

The overflow unit opened in 2023 to support ED patients awaiting admission to inpatient units. The unit consists of 10 bed spaces and is physically separate from the ED. The unit does not include a dedicated waiting or registration area and operates with limited fixed infrastructure, including the absence of permanently installed oxygen and suction. Patient bathing and some basic care activities require transport to other areas of the hospital by nursing staff as the unit does not have clerical, MSA, and portering support.

The physical separation of the unit from core inpatient services influences communication, access to immediate clinical support, and coordination with other in-hospital services. Staffing and care delivery is impacted by the need for staff to leave the unit to access equipment, supplies, and support services.

Client Factors

Emergency Department (ED)

Increasing use of ED overflow and short-stay beds are reflective of ongoing flow pressures within the site, with the department frequently holding patients awaiting inpatient admission—in ED assessment spaces for those deemed higher acuity, and ED overflow (described below) for those deemed lower acuity.

Overall demand is stable over the last 3 years, with a range of patient presentations. Over half of the ED presentations are CTAS 4–5 (less urgent), which reflects lower acuity patient population and potentially primary care appropriate.

Table 10: ED Indicators at JPMRHC

Indicator	2022-23	2023-24	2024-25
ED Visit Volume	21,384	20,851	22,767
ED Unique Patients	11,789	11,312	12,072
ED Admissions	2,000	2,062	2,078
ED Patient Days	2,898	3,098	3,617
CTAS 1–2 (Emergent)	837 (4%)	1,311 (6%)	2,121 (9%)
CTAS 3 (Urgent)	6,489 (30%)	7,946 (38%)	8,269 (36%)
CTAS 4–5 (Less-Urgent)	13,841 (68%)	11,363 (54%)	12,158 (53%)
CTAS Unavailable	217	231	219
Average LOS (hours)	2.7 hours	2.5 hours	2.3 hours
Average PIA	2.9 hours	2.9 hours	2.8 hours

Note: Source, Meditech Meditech Emergency Department Database.

Overflow Unit

The unit supports a mixed patient population, including ED offloads, ICU step-downs, palliative patients, and individuals designated as an alternative level of care (ALC). Patient acuity and care needs fluctuate as a

result. Recent data for the unit reflects 63 discharged patients and 35.5% ALC. Detailed patient data may be captured by the most responsible unit (e.g., ED, Medicine) making it difficult to separate for analysis.

Staffing Factors

Budget for 2 NP roles has existed for the last 3 years. However, the site has been unable to fill the roles – resulting in vacancies. The ED attempted to use teledoc virtual services, with dedicated space, to avail of remote NP supports for the fast-track (CTAS 4-5) program. [REDACTED]

The actual RN resourcing has exceeded budget year-over-year – with an average variance of 10 FTE. This is due in part to the need to staff overcapacity beds (e.g., stretchers in hallways, overflow).

Self-scheduling is used to produce 12-hour rotating schedules.

Table 11: Actual Versus Budgeted FTEs in JPMRHC ED (including virtual)

	2022–2023		2023–2024		2024–2025		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
EMERGENCY	25.8	34.2	25.8	39.6	25.8	40.9	12.4
LPN	0.00	0.50	0.00	0.66	0.00	0.75	0.6
NP	2.25	2.19	2.25	0.60	2.25	0.02	-1.3
PCA	0.00	3.07	0.00	2.72	0.00	2.94	2.9
RN	29.22	28.45	23.59	35.62	23.58	37.16	10.2

Note: Source, NLHS General Ledger.

Table 12: Shift Rotation Schedule for JPMRHC ED

Shift	RN (Facilitator)	RN (Educator)	RN	PCA
07:30-19:30	1	0	6	2
08:00-16:00	0	1	0	0
19:30-07:30	0	0	5	0

Note: Information collected from site engagement. The clinical nursing educator and nursing facilitator is shared between the ICU and ED. On days, 1 RN is used for swing shift from 10:00-22:00.

Overflow Unit

Staffing in the overflow unit faces several challenges. There is a sole reliance on agency nurses to run the unit, resulting in unstable and unpredictable availability of unit staffing as agency nurses are contracted by the month. Based on agency hours reported provincially, the JPM ED has some of the highest rates across all sites and units in scope – greater than 40% of total worked hours in 2024-2025 were covered by agency. While the unit has access to a Care Facilitator role shared between Obstetrics and the Overflow unit, [REDACTED]

While at least 2 dedicated RNs were observed on the floor during site visits, the financial data reflects 0 FTE. Staff on the unit report that typical staffing is up to 3 RNs on days and nights – filled by agency nurses.

Detailed staffing data may be captured by the most responsible unit, making it difficult to separate for analysis.

Workload Analysis - HPPV

The unit's HPPV is in line with comparable sites. *Workload calculations for the Overflow Unit could not be completed because the worked-hours data lacked sufficient detail to discern deployment to ED or Overflow – ideally, this data would be separated for future evaluations.*

Table 13: HPPV for JPMRHC ED

Hours Per Patient Visit (HPPV)			
EMERGENCY	2022-23	2023-24	2024-25
Nursing UPP	2.1	3.0	2.9
Peer Benchmark (HPPV)	2022-23	2023-24	2024-25
Average based on Unit Producing Hours		0.5 – 2.2	

Note: JPM calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT 'AC Emergency' unit data of at least 10 comparable sites – based on the number of beds, volume of ED visits, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Emergency Department and Overflow Unit

This section summarizes the recommended future-state staffing for JPMRHC combined ED and overflow unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC ED and overflow unit.

- Target HPPV is based on a blended workload measure (ED visit volumes and total ED and overflow unit patient days), reflecting the combined service delivery realities.
- For inpatient visits, target HPPD is aligned with the Medicine Unit to reflect the most appropriate patient population needs.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are outlined below:

1. Consider reducing the number of NPs budgeted for the ED fast-track program if JPMRHC is unable to recruit for the role with the intended care model.
2. Increase RN budget to formalize current staffing of additional beds associated with overflow, which aligns closely with actual hours worked.
3. Increase LPN budget and add a role to support care for boarded CTAS 4–5 patients.
4. Increase PCA budget to formalize current staffing and consider adjustments to schedule to provide coverage for 1 PCA on days and 1 PCA on the swing shift.

Table 14: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Combined ED and Overflow Unit

Future State

Target Calculations			
Target HPPX	Total Patient Visits/Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
2.2 (ED visits)	22,797	50,153	33.4
4.46 (Inpatients)	3,617	16,132	10.8

Target Calculations			
Target HPPX	Total Patient Visits/Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
			Total: 44.2

Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	1.25	2.25	-1
RN	90-95%	39.77	23.58	10.55
LPN	5-10%	2.21	-	2.21
PCA	5-10%	2.21	-	2.21

Intensive Care Unit

Unit Overview and Organizational Factors

The Intensive Care Unit (ICU) is an 8-bed inpatient unit located on the second floor, adjacent to the ED and OR. The unit includes three open beds positioned at the nursing station for constant observation and five private, telemetry-enabled rooms, including designated cardiac and treatment spaces. In addition to providing direct critical care services, the ICU is responsible for monitoring telemetry for the entire site on a 24/7 basis.

The ICU coordinator role is shared with the ED, and Respiratory Therapy support is available on site for eight hours daily, with on-call coverage outside of these hours.

Client Factors

Care complexity in the ICU is driven by the presence of multiple, interacting medical conditions and the need for specialized treatments. Patient status can be unpredictable and change rapidly. Below describes the defined acuity levels for the unit:

Table 15: AAM Definitions for JPMRHC ICU

Acuity Level	Patient Condition	Typical Care Needs	Illustrative Ratio Implications
Level 1 – Highest Acuity	Critically unstable patients	Continuous monitoring, life support therapies, frequent interventions	1:1 nurse assignment required
Level 2 – Very High Acuity	Unstable or potentially unstable patients	Complex monitoring, multiple IV infusions, frequent assessments	1:1 or 1:2 depending on workload
Level 3 – High Acuity	Stable but critically ill patients	Ongoing ICU level care, regular interventions	1:2 nurse assignment
Level 4 – Moderate Acuity	Stable patients requiring ICU monitoring	Less frequent interventions, monitoring and support	1:2 to 1:3 assignment
Level 5 – Lower Acuity	Stable, recovering, or transfer ready patients	Minimal ICU interventions	1:3 or greater assignment

Note: Source, ICM – Acuity Assignment Manager definitions.

Patient acuity and complexity data were unavailable for the unit. Through interviews, participants reported the unit typically has 1–2 short-term ventilated post-operative patients. Postoperative surgical patients are sometimes admitted to ICU for short term ventilation (<24 hours) and are clinically ready for transfer or discharge shortly thereafter. Limited availability of inpatient beds and postoperative recovery capacity contributes to these patients remaining in ICU rather than transferring directly to an inpatient unit.

Given ongoing bed capacity pressures across the site, high occupancy and prolonged length of stay is likely attributable to limited inpatient bed availability. In addition, patients requiring telemetry observation are moved to the ICU – managed by the central ICU nursing station.

Table 16: Patient Activity Data in JPMRHC ICU

Patient Activity

MED/SURG ICU	2022-23	2023-24	2024-25
Bed Staffed	8	8	8
% Occupancy	99%	96%	93%
Total LOS	1,656	1,777	1,356
Avg LOS	6	6	5
Discharges	294	302	254

Note: Source, Meditech Admissions Module.

Staffing Factors

Staffing in the ICU is RN-only, with nurse-to-patient ratios ranging from 1:1 to 4:1 based on patient acuity.

Shifts are 12-hours with 4 RNs on day and night, and the ability to request additional nursing support for ventilated patients or special populations, including paediatrics, to meet the recommended ratios above. Self-scheduling is used to produce 12-hour rotating schedules.

Table 17: Actual Versus Budgeted FTEs in JPMRHC Med/Surg ICU

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
MED/SURG ICU	22.23	24.06	22.23	22.56	22.23	24.05	1.3
RN	22.23	24.06	22.23	22.56	22.23	24.05	1.3

Note: Source, NLHS General Ledger.

Table 18: Shift Rotation Schedule for ICU

Shift	RN (Facilitator)	RN (Educator)	RN
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07:30-19:30	1	0	4
08:00-16:00	0	1	0
19:30-07:30	0	0	4

Note: Information collected from site engagement. The clinical nursing educator and nursing facilitator is shared between the ICU and ED.

Workload Analysis - HPPD

The unit's HPPD is in line with comparable sites.

Table 19: HPPD for JPMRHC Med/Surg ICU

Hours Per Patient Day (HPPD)				
MED/SURG ICU	2022-23	2023-24	2024-25	2025-26
Nursing UPP	12.5	12.5	13.9	13.1
Peer Benchmarks (HPPD)	2022-23	2023-24	2024-25	2025-26
Range based on Unit Producing Hours	10.8 – 24.5			

Note: JPM 2022-23, 2023-24, 2024-25 calculated using NLHS General Ledger and discharge data. JPM 2025-26 actuals provided by ANSOS Productivity Reports. Peer Benchmarks were calculated using Ontario HIT 'IP ICU Combined Med/Surg' unit data of at least 10 comparable sites – based on the number of beds, total patient days, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Intensive Care Unit

This section summarizes the recommended future-state staffing for JPMRHC ICU unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter the following assumptions apply to calculations for JPMRHC ICU unit:

- Target HPPD is based on peer benchmarking and with consideration for patient complexity indicators documented above.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

- Adjust night schedule to reflect 3 RNs and 1 PCA.
- Maintain RN coverage for 100% of direct patient care assignments.
- Increase the PCA budget and add a role to support patient needs on night shift.

Table 20: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC ICU Unit

Future State

Target Calculations				
Target HPPD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
10.8	2,818	30,437.9	20.3	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	Current Budget 2024-2025	Budget Impact
NP	-	1.25	-	1.25
RN	100%	20.29	22.23	-1.94

LPN	-	-	-	-
PCA	5% additional	1.40	-	1.40

Additional recommendations:

Further assess the acuity of the patient population to inform the classification of the unit based on patient needs, to determine if any changes should be considered.

Surgical Inpatient

Unit Overview and Organizational Factors

The JPM Surgery unit is a 20-bed inpatient surgical unit with overflow capacity to accommodate one additional patient, operating 24/7 with a consistent staffing model across days, nights, and weekends. The unit is staffed primarily by RNs and LPNs, supported by weekday ancillary roles.

Client Factors

The inpatient surgery unit supports post-operative patients requiring monitoring, pain management, wound care, and mobilization. Health needs are recovery-focused. However, a proportion of patients are reported to require enhanced care due to chronic conditions, functional limitations, and concurrent mental health and addictions concerns; data to support this was unavailable.

Patient volumes are predictable and closely aligned to scheduled surgical activity. Turnover is relatively high, and occupancy fluctuates based on operating room throughput and downstream bed availability.

The unit routinely cares for off service patients, for whom care delivery and discharge planning may be less clear, contributing to longer lengths of stay. Social complexity, including homelessness, substance use, and limited access to community supports, contributes to barriers to discharge and impacts patient flow and bed availability. As reflected in the patient activity data, these factors are associated with variable length of stay trends, a year over year increase in ALC days driven primarily by discharge to LTC, and a concurrent decline in discharges, indicative of lower acuity trends year over year.

Table 21: Patient Activity Data for JPMRHC Surgical Inpatient

Patient Activity

GENERAL SURGERY	2022-23	2023-24	2024-25
Bed Staffed	20	20	20
% Occupancy	101%	98%	94%
Total LOS	8,710	8,007	8,328
Avg LOS	12	10	11
ALC Days	698	926	1,326
% ALC	9.8%	12.9%	19.2%
Discharges	750	796	674

Reason for ALC – Patient Days - waiting for:

GENERAL SURGERY	2022-23	2023-24	2024-25
LTC	284	288	479
Palliative	20	51	
Home Supports	41	17	40

Other Services (e.g., OT/PT, Rehab)	253	439	486
Other (e.g., patient refusing discharge, other assessment)	53	43	212
Equipment	47	9	15

Note: Source, Meditech Admissions Module.

Staffing Factors

Staffing includes RNs, LPNs, and PCAs working together to provide care and address patients daily living needs. Staffing levels appear stable for LPN and RN, with an average variance of 1 FTE between the roles. Participants report that nurse-to-patient ratios are maintained across shifts, with adjustments implemented during infrequent periods of overcapacity (occupancy > 100%).

Participants report that indirect care demands, surveillance, and care coordination frequently exceed what is captured in standard staffing ratios, resulting in limited coverage for breaks and variance in workloads. The unit has utilized approximately 2 unfunded PCAs year over year to relieve the workload pressures.

Table 22: Actual versus budgeted FTEs for JPMRHC Surgery Inpatient Unit

	2022/2023		2023/2024		2024/2025		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
SURGERY	26.0	28.4	26.0	29.4	26.0	28.8	2.9
LPN	5.43	5.62	5.43	4.70	5.43	4.79	-0.4
PCA	0.00	1.66	0.00	1.50	0.00	2.49	1.9
RN	20.58	21.17	20.59	23.16	20.58	21.56	1.4

Note: Source, NLHS General Ledger.

Table 23: Shift Rotation Schedule for JPMRHC Surgical Inpatient Unit

Shift	RN (Facilitator)	RN (Educator)	RN	LPN
07:30-19:30	0	0	4	1
08:00-16:00	1	1	0	0
19:30-07:30	0	0	3	1

Note: Information collected from site engagement. NP is shared between all inpatient surgery units at JPMRHC. PCA FTEs were previously trialed as unfunded positions on Inpatient Surgical and Ortho units but have since been discontinued; although not reflected in current data, there has been ongoing but unsuccessful effort to reinstate them.

Workload Analysis – HPPD

The unit's HPPD is in line with comparable sites.

Table 24: HPPD for JPMRHC Surgery Inpatient Unit

Hours Per Patient Day (HPPD)				
SURGERY	2022-23	2023-24	2024-25	2025-26
Nursing UPP	5.4	5.7	5.3	5.8
Peer Benchmarks (HPPD)	2022-23	2023-24	2024-25	2025-26
Range based on Unit Producing Hours	5.0 – 7.9			

Note: JPM 2022-23, 2023-24, 2024-25 calculated using NLHS General Ledger and discharge data. JPM 2025-26 actuals provided by ANSOS Productivity Reports. Peer Benchmarks were calculated using Ontario HIT “IP Surgical Inpatient Services” and “IP Combined Medical/Surgical” unit data of at least 10 comparable sites – based on the number of beds, total patient days, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Surgical Inpatient Unit

This section summarizes the recommended future-state staffing for JPMRHC Surgical Inpatient unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Surgical Inpatient unit.

- Actual HPPD for FY2025–2026, as reported in ANSOS, is used as the representative baseline and is aligned with available benchmarks.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Maintain the current skill-mix approach, with a modest increase in LPN staffing to support a growing proportion of predictable patients.
2. Increase the NP budget and establish a NP role to support the patient populations with complex conditions and discharge needs, improving quality of care and efficient patient flow.
3. Increase the PCA budget to formalize current staffing approach.

Table 25: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC ICU Surgical Inpatient

Future State

Target Calculations				
Target HPPD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
5.8	7,072	41,019.5	27.3	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	1.25	-	1.25
RN	75-80%	20.58	20.58	-
LPN	15-20%	6.70	5.43	1.27
PCA	5-10%	2.70	-	2.70

Combined Surgical OR/PARR

Unit Overview and Organizational Factors

The Combined Operating Room (OR) and Post-Aesthetic Recovery Room (PARR) supports both inpatient surgical procedures (e.g., obstetrics, orthopaedics, and general surgery) and elective surgeries (ophthalmology, endoscopy, and minor day procedures) with 5 shared OR spaces. Surgical activity is managed through physician block scheduling. Every Tuesday, there are two orthopedic surgeons scheduled in the OR, and patient volumes are heaviest on this day, resulting in concentrated demand for nursing and support resources.

The physician complement includes four orthopedic surgeons and four general surgeons, with general surgery coverage spanning day surgery, inpatient procedures, and endoscopy. Endoscopy activity occurs primarily on Mondays and Tuesdays. Physician schedules were described as generally consistent, with locum coverage used when physicians are unavailable.

Client Factors

The OR/PARR supports a diverse surgical case mix, including elective procedures and inpatient surgeries across multiple specialties. Participants report that:

- Ophthalmology is performed daily. Average volumes were not provided.
- General surgery is largely urgent or emergent, with a high proportion of cancer-related cases.
- Orthopaedic volumes average 3–4 cases per day, scheduled 4 days a week, with seasonal increases.
- Gynecology/Obstetric volumes average 1-2 scheduled days a week.
- Increasing inpatient surgical demand, combined with unplanned cases and limited inpatient bed capacity, contributes to variability in recovery needs and reduced scheduling reliability.

Further detail on patient acuity, recovery length, and specialty-specific demand was unavailable.

Table 26: Patient Activity in the JPMRHC OR/PARR

Patient Activity

COMB OR/PARR	2022-23	2023-24	2024-25
Inpatient	672.00	780.00	1,018.00
Clinic/Elective	3,104.00	2,908.00	2,648.00
Cancellations due to inpatient bed unavailable	-	1	33
Cancellations due to OR nursing unavailability	-	-	13

Note: Source, NLHS General Ledger.

Staffing Factors

Physician coverage is organized through block scheduling, which interacts with nursing availability and inpatient bed capacity. Porter support is available within the OR, while ward clerk support is limited to daytime hours (12-hour day shifts only). There is no PCA coverage overnight.

The following scheduling approach was reported by the unit:

- OR is staffed Monday to Friday from 07:45 to 15:45.
 - Staff start the day with set up for morning cases.
 - Cases are scheduled up to 15:45.

- PACU is staffed Monday to Friday from 09:00 to 17:00.
- All after hours coverage is done through on call shifts, with up to 3 staff on call.
- Weekend call shifts start Friday 09:00 to Monday 07:45.

Sequencing of RN start-end shift times across operating hours was unavailable.

Table 27: Actual versus budgeted FTEs for JPMRHC OR/PARR

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
COMB OR/PARR	15.7	15.0	15.7	15.5	15.7	15.1	-0.5
LPN	0.00	0.18	0.00	0.09	0.00	0.18	0.15
PCA	0.00	0.03					0.03
RN	15.73	14.84	15.74	15.46	15.73	14.90	-0.6

Note: Source, NLHS General Ledger.

Table 28: Shift Rotation Schedule for JPMRHC Combination OR/PARR Unit

Shift	RN (Facilitator)	RN	LPN	PCA
07:45 – 15:45	1 (dual role as educator)	16	2	2

Note: Information collected from site engagement.

Workload Analysis – HPPV

The unit's observed HPPV is in line with comparable sites.

Table 29: HPPV for JPMRHC OR/PARR

Hours Per Patient Day (HPPV)			
COMB OR/PARR	2022-23	2023-24	2024-25
Nursing UPP	5.9	6.1	6.1
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Range based on Unit Producing Hours		0.9 - 7.7	

Note: JPM calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT "Day Surgery Combined OR&PARR" and "Day Surgery Pre and Post Operative Care" unit data of at least 10 comparable sites – based on the number of procedures, total patient days, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – OR/PARR Unit

This section summarizes the recommended future-state staffing for JPMRHC OR/PARR unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC OR/PARR unit.

- The target HPPV from ANSOS was used, which aligns with the peer sites.
- Highest actual volume in last 3 years was used to account for variability.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Increase the RN budget and add a role to support appropriate coverage for expected/unexpected leaves and outages.
2. Increase the PCA budget and add a part-time role to support patient movement.

Table 30: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC OR/PARR Unit

Future State**Target Calculations**

Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
5.9	3,710	21,889.0	17.2

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	100%	17.25	15.73	1.52
LPN	-	-	-	-
PCA	5% additional	0.83	-	0.83

Medicine Unit**Unit Overview and Organizational Factors**

The Medicine Unit is a 30-bed inpatient unit, with capacity to flex to 32 beds during periods of overcapacity (> 100%). The unit includes the highest number of private rooms on site, often used for immunocompromised, infectious or palliative patients.

The unit operates as a locked unit to support patient safety for individuals at risk of wandering. Specialized infrastructure, including a bariatric room with ceiling lifts, supports safe care delivery for patients with complex mobility needs. The unit's single-corridor layout (15 beds per side) limits visual oversight and the absence of integrated overhead call bells limits audibility in end-of-corridor rooms, increasing reliance on staff presence and informal monitoring. The nursing unit placed at the end of one of the 15 bed wings was used for supply storage due to limited space.

Client Factors

The medicine unit serves patients with complex, chronic, and often multi-system conditions. Patients are frequently older and highly dependent, with prolonged lengths of stay and proportion awaiting alternative levels of care driven primarily by discharge barriers.

Patient census on the unit can be characterized as moderately predictable. Lengths of stay are significantly longer than other inpatient areas – averaging > 30 days - and ALC days represent > 65% of total patient days. Fluctuations are driven largely by emergency admissions and inpatient flow constraints. Patient cohorts of like illness are not established.

Table 31: Patient Activity Data for JPMRHC Medicine Unit

Patient Activity

MEDICINE UNIT	2022-23	2023-24	2024-25
Bed Staffed	25.00	25.00	31.00

MEDICINE UNIT	2022-23	2023-24	2024-25
% Occupancy	102.6%	101.4%	101.3%
Total LOS	12,583	12,735	12,450
Avg LOS	35	38	33
ALC Days	6,662	7,897	7,156
% ALC	70.8%	72.7%	65.0%
Discharges	361	335	381

Reason for ALC – Patient Days – waiting for:

MEDICINE UNIT	2022-23	2023-24	2024-25
LTC	4,295	4,551	4,228
Palliative	680	1,314	1,070
Home Supports	87	62	89
Other Services (e.g., OT/PT, Rehab)	1,069	826	726
Other (e.g., patient refusing discharge, other assessment)	431	779	548
Equipment	77	122	95

Note: Source, Meditech Admissions Module.

Staffing Factors

Staffing on the Medicine unit includes NPs, RNs, LPNs, and PCAs working together to provide care and support for daily living. Scheduling is a consistent 12-week rotation.

[REDACTED] orientation hours increased by more than 60% between 2024-2025 and the preceding year⁴¹. The unit has the second highest rates of agency nursing across all units in scope – greater than 30% of total worked hours in 2024-2025 were covered by agency⁴².

Participants report that indirect care demands, surveillance, and care coordination frequently exceed what is captured in staffing data or scheduling, resulting in limited coverage for breaks and variance in workloads. The unit has utilized unfunded PCAs to relieve the workload pressures, with staff reporting successful integration of the roles, and recently secured a budget to make 2 of those positions permanent.

Similarly, the unit has integrated a NP role to provide continuity of clinical care for patient management activities, with increasing utilization over the last 3 years to 1 FTE. This role is unfunded with no recent budget commitment to secure the position.

Table 32: Actual versus budgeted FTEs for JPMRHC Medicine Unit

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
MEDICINE UNIT	28.8	30.2	28.8	40.4	28.8	35.4	6.5

⁴¹ NLHS General Ledger

⁴² NLHS Provincial Agency Nursing Data

LPN	13.56	21.38	13.56	14.91	13.56	12.79	2.8
NP	0.00	0.52	0.00	1.01	0.00	1.01	0.8
PCA	0.00	4.50	0.00	4.22	0.00	4.25	4.3
RN	15.27	3.77	15.27	20.22	15.27	17.31	-1.5

Note: Source, NLHS General Ledger.

Table 33: Shift Rotation Schedule for JPMRHC Medicine Unit

Shift	RN (Facilitator)	NP	RN	LPN	PCA
07:30-19:30	0	0	4	3	2
08:00-16:00	1	1	0	0	0
19:30-07:30	0	0	3	2	2

Note: Information collected from site engagement. Clinical facilitator works weekdays only.

Workload Analysis – HPPD

The unit's HPPD falls below comparable sites. The variance may reflect differences in the acuity of the patient population, including ALC percentages. Provincial target of 4.0 for complex long-term care populations may be used as an alternative benchmark.

Table 34: HPPD for JPMRHC Medicine Unit

Hours Per Patient Day (HPPD)				
MEDICINE UNIT	2022-23	2023-24	2024-25	2025-26
Nursing UPP	4.1	5.2	4.1	4.7
Peer Benchmarks (HPPD)	2022-23	2023-24	2024-25	2025-26
Range based on Unit Producing Hours	5.3 – 5.8			

Note: JPM 2022-23, 2023-24, 2024-25 calculated using NLHS General Ledger and discharge data. JPM 2025-26 actuals provided by ANSOS Productivity Reports. Peer Benchmarks were calculated using Ontario HIT "IP Medical Inpatient Services" unit data of at least 10 comparable sites – based on the number of beds, total patient days, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Medicine Unit

This section summarizes the recommended future-state staffing for JPMRHC Medicine unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Medicine unit.

- The target HPPD from ANSOS was used, which aligns with the peer sites.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Formally incorporate the NP role into the budget to cover the effective use of current staffed role.
2. Replace 1 RN with 1 LPN on the day shift schedule and add an additional 1 LPN role on days and 1 LPN role on nights to achieve the target skill mix that meets the patient population needs.
3. Increase the PCA budget to formalize current staffing on both days and nights.

Table 35: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Medicine Unit

Future State

Target Calculations				
Target HPPD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
4.46	10,418	46,464.2	30.9	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	1.25	-	1.25
RN	45-50%	14.10	15.27	-1.17
LPN	30-40%	17.20	13.56	3.64
PCA	15-20%	3.10	-	3.10

Obstetrics Unit**Unit Overview and Organizational Factors**

The Obstetrics unit includes 10 inpatient beds and capacity for 10 newborn bassinets, supporting both maternal and newborn care, including obstetrical and neonatal patients. Clinical spaces include two birthing rooms and a designated high-risk nursery. Located within the inpatient birthing unit, the prenatal clinics pull on the unit's nursing staff to support the delivery of outpatient prenatal services. The unit does not provide postnatal services, but midwifery capacity exists in the community for postpartum patients.

The unit's location on the third floor necessitates nurse-escorted transfers to the operating rooms on the second floor. During caesarean sections, nurses may be off the unit for extended periods, reducing on-unit staffing capacity and increasing risk during obstetric emergencies.

Support roles include one clerical staff member and one Care Facilitator/Clinical Educator available weekdays from 8:00–4:00, with the Care Facilitator role shared between Obstetrics and the overflow unit. A Program Educator, shared between JPMRHC and CNRHC, is also available weekdays. Outside of these hours, nursing staff assume responsibility for coordination and operational tasks, further increasing workload.

Weekly rounds are completed every Wednesday, to align staffing with anticipated patient needs.

Client Factors

The unit provides care for a mixed population of labouring patients, prenatal mothers, post-operative gynaecology patients, newborns and paediatrics. The unit also provides prenatal outpatient clinic appointments in a dedicated assessment room, staffed by a physician 3x a week.

While overall patient volumes are relatively low, demand is unpredictable, with rapid shifts driven by urgent presentations and procedural needs.

Table 36: Patient Activity Data for JPMRHC Obstetrics Unit

Patient Activity

OBSTETRICS	2024-25 <i>*unit reopens*</i>
Bed Staffed	10
% Occupancy	60.1%
Total LOS	2,730.0
Avg LOS	4
ALC Days	76
% ALC	3.2%
Patient Deaths Adult	1
Live Births	54 C-section; 137 Vaginal Birth
Admissions Adult	250
Obstetric Visits Client	754
Obstetric Visits Inpatient	189
Discharge Adult	487
Discharge Newborns	175

Reason for ALC – waiting for:

OBSTETRICS	2024-25
LTC	46
Palliative	2
Community Health	2
Other Services (e.g., OT/PT, Rehab)	2
Other (e.g., patient refusing discharge, other assessment)	17
Transportation	16

Note: Source, Meditech Admissions Module. The unit was closed, due to staffing availability, for fiscal years 2022-23 and 2023-24.

Staffing Factors

Staffing on the Obstetrics unit is RN-only, with current staffing levels below budget. Care delivery is highly specialized and acuity-driven, with a 2:1 nursing ratio required for active labour, caesarean deliveries, and high-risk newborns, which can result in rapid shifts in staffing demand. If an RN is required to leave the unit to support emergency surgery, they may be absent for up to three hours, reducing on-unit capacity and increasing risk during emergent obstetric events.

Clinic schedules vary from week to week, leading to inconsistencies in physician presence and limiting the unit's ability to maintain predictable staffing patterns. Nurses also absorb responsibilities related to outreach coordination and discharge planning. The unit is staffed with 3 RNs on day and night shifts, increasing to 4 RNs on days when prenatal clinics are running. The unit is trending towards a decreased use of agency hours, with the first 6 months of 2025-2026 showing at least a 50% decrease over the previous 6 months⁴³.

⁴³ NLHS Provincial Agency Nursing Data

Table 37: Actual versus budgeted FTEs for JPMRHC Obstetrics Unit

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
OBSTETRICS	23.23	3.77	23.23	4.96	23.23	20.49	-13.5
RN	23.23	3.77	23.23	4.96	23.23	20.49	-13.5

Note: Source, NLHS General Ledger. Budgeted roles were held from 2022 – 2024 in anticipation of unit reopening.

Table 38: Shift Rotation Schedule for JPMRHC Obstetrics Unit

Shift	RN (Facilitator)	RN (Educator)	RN
07:30-19:30	0	0	3
08:00-16:00	1	1	0
19:30-07:30	0	0	3

Note: Information collected from site engagement. Clinical Facilitator and Educator work weekdays only with the educator shared with another site. On clinic days, staffing increases to 4 RNs on the day.

Workload Analysis – HPPD

The unit's observed HPPD is in line with comparable sites.

Table 39: HPPD for JPMRHC Obstetrics Unit

Hours Per Patient Day (HPPD)	
MEDICINE UNIT	2025-26
Nursing UPP	12.4
Peer Benchmarks (HPPD)	
Range based on Unit Producing Hours	10.6 – 25.1

Note: JPM 2025-26 actuals provided by ANSOS Productivity Reports. Peer Benchmarks were calculated using Ontario HIT "IP Obstetrics" unit data of at least 10 comparable sites – based on the number of beds, total patient days, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Obstetric Unit

This section summarizes the recommended future-state staffing for JPMRHC Obstetrics unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Obstetrics unit.

- Target HPPX was calculated as a blended mix of peer benchmark targets for birth events, clinic visits (excluding prenatal), and adult inpatient days.
- Uplift of 30% in resources to cover the variability of birth visits.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Reduce 1 RN FTE coverage of prenatal and physician-led clinics, leveraging administrative supports where required. Further, the unit should explore relocating the clinic with other ambulatory services to minimize IPAC risks on the inpatient unit and leverage potential shared administrative supports in ambulatory services.

2. RN budget to better align with realized patient population needs following a year of full operation of services.

Table 40: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Obstetrics Unit

Note that the assessment of recommended FTEs is based on a single year of patient data and should be validated with recent fiscal year reports. Overall, the low number of births recorded have a material impact on the number of recommended FTE for the unit.

Future State

Target Calculations			
Target HPPX	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
10.6 Births (all)	192	2,035.2	1.3
2.0 Clinic Visits (OBS, NST, OBO, Observation)	1,707.00	3,414.0	2.2
5.4 Inpatient Days (all)	2,553	13,786.2	9.1
<i>with contingency resources in event of spike in births</i>			Total: 16.6

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	100%	16.6	23.23	-6.63
LPN	-	-	-	-
PCA	-	-	-	-

Orthopaedic Unit

Unit Overview and Organizational Factors

The Orthopaedics unit is a 20-bed inpatient unit that supports both elective and non-elective orthopaedic care. The unit manages approximately 4 elective surgical cases per day, alongside urgent admissions.

The Pre-Admission Clinic supports surgical preparation, including screening for behavioural and addictions-related risks, providing predictability in discharge for service patients.

Client Factors

The Orthopaedics unit manages a mixed population of surgical and medical patients, including fractures, joint replacements, and patients awaiting or recovering from operative intervention. Overall patient acuity is moderate; however, discharge complexity is increasing. Participants report that patients present with

multiple comorbidities, including obesity, diabetes, mental health and addictions concerns, and functional limitations.

Discharge planning is frequently challenged by limited access to occupational therapy and physiotherapy resources, as well as gaps in community and social supports. As a result, the unit has experienced an increase in ALC over the last 3 years, particularly for patients awaiting post-acute placement to LTC and other services. While pre-admission discharge planning is prepared for orthopaedic patients, resulting in an overall decline in average length of stay, discharge of off-service patients can often be unclear.

Table 23: Patient Activity and Reason for ALC in JPMRHC Orthopaedic Unit

Patient Activity

ORTHOPEDIC UNIT	2022-23	2023-24	2024-25
Bed Staffed	-	-	-
% Occupancy	101.2%	97.3%	93.0%
Total LOS	6,488	6,674	6,698
Avg LOS	8.6	6.7	6.8
ALC Days	760	1,307	1,800
%ALC	10.1%	18.3%	26.9%
Discharges	755	1,000	987

Reason for ALC - Patient Days – waiting for:

ORTHOPEDIC UNIT	2022-23	2023-24	2024-25
LTC	151	466	499
Palliative	28	36	16
Home Supports	18	12	52
Other Services (e.g., OT/PT, Rehab)	404	523	646
Other (e.g., patient refusing discharge, other assessment)	120	254	431
Equipment	39	5	1
Personal	-	-	23

Note: Source, Meditech Admissions Module.

Staffing Factors

The model of care mirrors that of inpatient surgery, with standardized nurse-to-patient ratios and team-based assignments. Staffing includes RN, LPN, and PCAs, with actual staffing levels exceeding budget to meet workload demands. [REDACTED] Self-scheduling is used to produce 12-hour, 2-week rotation schedules.

The unit has floated unfunded PCAs to support non-nursing duties. The intake clinic has integrated a NP role to improve patient follow ups and reduce cancellations due to lack of discharge pathways.

The unit is trending towards a decreased use of agency hours, with the first 6 months of 2025-2026 showing at least a 30% decrease over the previous 6 months.⁴⁴

⁴⁴ NLHS Provincial Agency Nursing Data

Table 41: Actual versus budgeted FTEs for JPMRHC Orthopaedic Unit

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
ORTHO INTAKE CL	0.5	0.5	0.5	0.8	0.5	1.0	0.3
NP			0.00	0.46	0.00	0.96	0.5
RN	0.50	0.53	0.50	0.29	0.50	0.02	-0.2
ORTHOPEDICS	25.0	26.5	25.0	28.5	25.0	29.5	3.2
LPN	5.43	5.29	5.43	4.87	5.43	5.75	-0.1
PCA	0.00	1.67	0.00	1.69	0.00	2.11	1.8
RN	19.58	19.50	19.59	21.98	19.58	21.62	1.4

Note: Source, NLHS General Ledger.

Table 42: Shift Rotation Schedule for JPMRHC Orthopaedic Unit

Shift	RN (Facilitator)	RN (Educator)	RN	LPN
07:30-19:30	0	0	4	1
08:00-16:00	1	1	0	0
19:30-07:30	0	0	3	1

Note: Information collected from site engagement. NP is shared between all inpatient surgery units at JPMRHC.

Workload Analysis – HPPD

The unit's observed HPPD is in line with comparable sites. The variance may reflect differences in the acuity of the patient population, including ALC percentages.

Table 43: HPPD for JPMRHC Orthopaedic Unit

Hours Per Patient Day (HPPD)				
ORTHOPEDICS	2022-23	2023-24	2024-25	2025-26
Nursing UPP	5.2	5.5	5.8	5.9
Peer Benchmarks (HPPD)	2022-23	2023-24	2024-25	2025-26
Range based on Unit Producing Hours	5.0 – 7.9			

Note: JPM calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT "IP Combined Medical/Surgical" unit data of at least 10 comparable sites – based on the number of beds, total patient days, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Orthopaedic Unit

This section summarizes the recommended future-state staffing for JPMRHC Orthopaedic unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Orthopaedic unit.

- Target HPPD is based on average over the last 3 years.

Based on the recommended budgeted (FTE) positions, and as the team moves to integrated team-based care model, it is recommended that the night staffing skill mix be adjusted to consider:

1. Days: 3 RN; 2 LPN
2. Nights: 3 RN; 1 LPN
3. Additional PCA coverage of 1 PCA on days and 1 PCA on nights.

Table 44: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Orthopaedic Unit

Future State**Target Calculations**

Target HPPD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
5.5	7,099	39,042.7	25.0

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	70%	18.20	20.08	-1.88
LPN	30%	7.80	5.43	2.37
PCA	10%	2.60	-	2.60

Day Surgery Units**Unit Overview and Organizational Factors**

The Day Surgery unit operates Monday to Friday from 06:30 to 18:00, it does not operate after hours. The unit is located on the second floor, sharing a corridor with the ED. The unit is small and configured with open-concept stretchers separated by curtains, supporting efficient patient throughput.

The unit is highly dependent on operating room scheduling, including urgent admissions, and downstream recovery capacity. Cancellations in procedures or staffing shortages in OR/PARR can disrupt otherwise predictable volumes on the unit.

Client Factors

Day Surgery provides care for patients undergoing planned same-day surgical procedures, as well as minor procedures, infusions, and pre-operative assessments. Health needs are low-acuity and time-limited, with a strong emphasis on discharge readiness. Post-operative and post-procedure care pathways are typically known in advance of the scheduled visit, and there is typically < 24-hour stay.

Patient volumes are predictable and closely tied to scheduled operating room and clinic activity, allowing for advance planning of care delivery. The patient population is generally stable, with limited complexity compared to inpatient units, supporting a high-throughput ambulatory model.

Table 45: Visits in Person for JPMRHC Day Surgery Unit

Visits in Person		
2022-23	2023-24	2024-25
4,118	4,303	3,850

Note: Source, Meditech Admissions Module.

Staffing Factors

The Day Surgery unit is staffed by 4 RNs - 3 permanent full-time (PFT) and 1 permanent part-time (PPT); however, the unit budget has provided for 5.2 RNs over the last 3 years.

The PPT role follows a biweekly rotation, working three days one week (Monday to Wednesday) and two days the following week (Thursday and Friday), resulting in daily staffing fluctuations between 3 and 4 staff.

On days when three staff are scheduled, shift patterns typically include 06:30–14:30, 08:00–16:00, and either 09:00–17:00 or 10:00–18:00, depending on operating room schedules and departmental needs. When four staff are scheduled, coverage is extended through staggered shifts, most commonly 06:30–14:30, 07:00–15:00, 09:00–17:00, and 10:00–18:00, to support patient flow across the day.

[REDACTED] the unit has not exceeded budgeted FTE by more than 0.3 FTE over the last 3 years.

Table 46: Actual versus Budgeted FTEs for JPMRHC Day Surgery

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
DAY SURGERY	5.2	5.3	5.2	5.4	5.2	5.5	0.1
RN	5.24	5.28	5.24	5.39	5.24	5.46	0.1

Note: Source, NLHS General Ledger.

Table 47: Shift Rotation Schedule for JPMRHC Day Surgery Unit

Shift	RN
06:30-14:30	1
07:00-15:00	1
09:00-17:00	1
10:00-18:00	1 (PPT)

Note: Information collected from site engagement.

Workload Analysis – HPPV

The unit's observed HPPD falls in line with comparable sites.

Table 48: HPPV for JPMRHC Day Surgery

Hours Per Patient Day (HPPV)			
DAY SURGERY	2022-23	2023-24	2024-25
Nursing UPP	1.6	1.3	1.6
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Range based on Unit Producing Hours	0.4 – 3.28		

Note: JPM calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT "AC Clinic Surgical", "Day Surgery Pre and Post Operative Care" and "Day Surgery Combined OR&PARR" unit data of at least 10 comparable sites – based on the number of visits and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPV.

Future State Recommendations – Day Surgery Unit

This section summarizes the recommended future-state staffing for JPMRHC Day Surgery unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Day Surgery unit.

- Target HPPV was obtained through ICM reporting modules.
- Highest volume in last 3 years used to account for variability

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. No change to RN budget; reflecting minimum staffing required for continuity of scheduling.

Table 49: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Day Surgery Unit

Future State

Target Calculations				
Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
1.6	4,303	6,884.8	4.6	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	100%	5.20	5.20	-
LPN	-	-	-	-
PCA	-	-	-	-

Cancer Care Clinic

Unit Overview and Organizational Factors

The Cancer Care Clinic delivers outpatient oncology, operating services under a provincial cancer program mandate. The mandate provides the clinic with access to leadership at both the regional and provincial levels, shaping service scope, clinical standards, and care delivery expectations.

The clinic utilizes telehealth for physician consultations and provides chemotherapy on an outpatient basis, with RNs responsible for treatment administration and patient monitoring. Radiation therapy and inpatient oncology services are not available on site, requiring coordination with external centres as needed.

At the time of this report, the clinic is located at the back end of the second floor, with direct access from the main patient entrance. The clinic anticipates redevelopment and expansion of its physical space in the near term to better align with service demands.

The clinic is organized into distinct administrative and clinical zones, with office-based work and patient registration separated from patient care spaces. The clinical area includes,

- Central nursing station that can accommodate two staff charting simultaneously.
- Direct oversight of patient treatment areas.
- 8 patient chairs and 1 stretcher used for intervention administration.

Given the ambulatory nature of care and planned scheduling, clinic operations do not appear to be impacted by limited access to support services such as portering and laboratory.

Client Factors

The Cancer Care Clinic serves a stable outpatient population receiving chemotherapy and oncology follow-up care. Physician presence is limited to Monday through Wednesday, with no physician on site on Thursdays and Fridays, shaping the type of patients and services that can be safely supported on those days. Patient needs are focused on treatment administration, symptom monitoring, education, and coordination of follow-up care. Total number of visits has declined over the last 3 years, while staffing has remained consistent.

Table 50: Visits to JPMRHC Cancer Care Clinic

Visits in Person		
2022-23	2023-24	2024-25
18,042	18,793	13,375

Note: Source, Meditech Admissions Module.

Staffing Factors

Services in the clinic are RN-led, with support from 2 ward clerks and 1 facilitator responsible for appointment scheduling, coordination and flow. Staffing is driven by scheduled appointments, resulting in stable and predictable rotations.

Table 51: Actual versus budgeted FTEs for JPMRHC Cancer Care Unit

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
SPECIALIST CLIN	5.1	5.8	5.1	5.7	5.1	5.7	0.5
LPN	4.00	4.57	4.00	4.42	4.00	4.33	0.4
RN	1.14	1.21	1.14	1.26	1.14	1.35	0.1

Note: Source, NLHS General Ledger.

Table 52: Shift Rotation Schedule for JPMRHC Cancer Care Clinic

Shift	RN (Facilitator)	RN
07:30-19:30	1	2

Note: Information collected from site engagement.

Workload Analysis – HPPV

The unit's HPPV is in line with comparable sites.

Table 53: HPPV for JPM Specialist Clinics

Hours Per Patient Day (HPPV)			
SPECIALIST CLIN	2022-23	2023-24	2024-25
Nursing UPP	0.5	0.4	0.6
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25

Range based on Unit Producing Hours

0.45 – 1.48

Note: JPM calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT “AC Clinic – Medical” unit data of at least 10 comparable sites – based on the number of visits and nature of services delivered on site.

Future State Recommendations – Cancer Care Clinic

This section summarizes the recommended future-state staffing for JPMRHC Cancer Care Clinic. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Cancer Care Clinic.

- Target HPPV reflects the average HPPD over the last 3 years, and aligned to peer benchmarking.

Based on the recommended budgeted (FTE) positions:

- No adjustments to recommended FTES are required.

Table 54: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Cancer Care Clinic

Future State

Target Calculations

Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
0.5	16,737	8,368.3	5.1

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	25%	1.40	1.14	0.26
LPN	75%	4.00	4.20	0.20
PCA	-	-	-	-

Renal Dialysis Unit

Unit Overview and Organizational Factors

The Renal Dialysis Clinic is a dedicated, self-contained unit with 12 recline chairs, located on the second floor of the hospital. The unit operates as a satellite dialysis site in partnership with the Eastern Zone, providing only outpatient treatments. Treatments run Monday to Saturday from 7:00 AM to 7:00 PM. The unit is supported by 1 ward clerk for administration and appointment scheduling.

As an isolated outpatient unit, the clinic operates physically distant from all other services.

Client Factors

Renal Dialysis supports patients requiring ongoing haemodialysis treatments. Patient health needs are chronic, technology-dependent, and protocol-driven, with clearly defined treatment plans and schedules.

The unit exclusively cares for clinically stable patients. It does not provide dialysis services for ED or ICU patients, does not manage unstable or high-risk patients, and does not perform dialysis line insertions. This defined scope supports predictable volumes and consistent care delivery.

At the time of this review, there were 42 patients actively receiving dialysis at JPMRHC. Typical operations are 2 blocks of appointments ('runs') a day – morning run and afternoon run. The number of total visits has been increasing over the last 3 years.

Table 55: Visits in Person for JPMRHC Renal Dialysis Unit

Visits in Person		
2022-23	2023-24	2024-25
5,085	5,569	6,865

Note: Source, Meditech Admissions Module.

Staffing Factors

Staffing on the Renal Dialysis unit includes a mix of RN and LPNs, with a typical complement of two RNs and one LPN, supported by a Care Facilitator/Clinical Educator and a NP. This staffing model supports protocol-based care delivery and continuity for scheduled dialysis runs.

- RNs typically oversee 3 patients per run (6 per day).
- RN would take new dialysis patients or unstable patients.
- Once stable, care delivery shifts to LPNs.

The unit began using agency staffing in 2024–2025, representing approximately 18% of total worked hours. Reliance on agency hours is trending downward in the first 6 months of 2025–2026.⁴⁵

Table 56: Actual versus budgeted FTEs for JPMRHC Renal Dialysis Unit

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
RENAL DIALYSIS	11.1	11.0	11.1	10.8	11.1	11.4	-0.1
LPN	2.28	2.82	2.28	2.91	2.28	2.48	0.5
NP	1.00	0.48	1.00	0.96	1.00	0.94	-0.2
RN	7.82	7.67	7.82	6.93	7.82	7.94	-0.3

Note: Source, NLHS General Ledger.

Table 57: Shift Rotation Schedule for Renal Dialysis Unit

Shift	RN (Facilitator)	RN	LPN
07:30-19:30	1	2	1

Note: Information collected from site engagement.

⁴⁵ NLHS Provincial Agency Nursing Data

Workload Analysis – HPPV

The unit's HPPV is in line with comparable sites.

Table 58: HPPV Trends for JPMRHC Renal Dialysis Unit

Hours Per Patient Day (HPPV)			
RENAL DIALYSIS	2022-23	2023-24	2024-25
Nursing UPP	2.7	2.5	2.2
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Range based on Unit Producing Hours		2.62 – 4.15	

Note: JPM calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT “AC Renal Dialysis” unit data of at least 10 comparable sites – based on the number of visits and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPV.

Future State Recommendations – Renal Dialysis Unit

This section summarizes the recommended future-state staffing for JPMRHC Renal Dialysis unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Renal Dialysis unit.

- Target HPPV reflects the average HPPD over the last 3 years and aligns with peer benchmark.

Based on the recommended budgeted (FTE) positions consider:

- Minimal adjustments to RN and LPN FTEs to cover hours of care, and expected and unexpected shift vacancies.

Table 59: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Renal Dialysis Unit

Future State

Target Calculations				
Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
2.6	6,865	17,986.3	11.2	

Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	1.25	1.0	0.25
RN	75%	8.75	7.82	0.93
LPN	25%	2.75	2.28	0.47
PCA	-	-	-	-

Endoscopy Unit

Unit Overview and Organizational Factors

The Endoscopy Unit operates Monday to Friday, 08:00–16:00, with a standardized weekday service model. The unit's staffing structure and daily operations are consistent across the week, supporting scheduled endoscopy procedures within regular hours. Outside of these hours, one designated endoscopy staff member provides on-call coverage and is paired with an operating room (OR) nurse; both are responsible for responding to call-backs as required.

Client Factors

Client-related factors specific to the Endoscopy Unit were limited in scope during engagement. The unit primarily supports scheduled procedural activity within standard operating hours. No significant variability in client acuity, case mix, or procedural demand was identified through available input, and no unique client-driven workload pressures were raised for this unit.

Table 60: Patient Activity in JPMRHC Endoscopy Unit

Patient Activity

ENDOSCOPY	2022-23	2023-24	2024-25
Inpatient	111	113	160
Clinic Visits	3,233	2,865	3,220

Note: Source, Meditech Admissions Module.

Staffing Factors

The staffing model for Endoscopy consists of five RNs scheduled each weekday. In addition to scheduled daytime operations, the unit maintains an on-call model, with 1 RN paired with 1 OR RN to provide call-back coverage as required. Standard shift assignments are structured as follows:

- 1 RN Opening: 07:30–15:30
- 1 RN Admission: 07:30–15:30
- 1 RN Middle/Relief: 08:00–16:00
- 1 RN Recovery: 08:30–16:30
- 1 RN Closing: 08:30–16:30

Staffing has not exceeded budgeted FTEs in the previous 3 years.

Table 61: Actual versus budgeted FTEs for JPMRHC Endoscopy Unit

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
ENDOSCOPY	6.1	6.2	6.1	6.3	6.1	5.7	-0.1
RN	6.14	6.17	6.14	6.34	6.14	5.73	-0.1

Note: NLHS General Ledger.

Workload Analysis – HPPV

The unit's HPPD falls above comparable sites.

Table 62: HPPV Trends for JPMRHC Endoscopy Unit

Hours Per Patient Day (HPPV)			
ENDOSCOPY	2022-23	2023-24	2024-25
Nursing UPP	2.3	2.8	2.5
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Range based on Unit Producing Hours	0.44 – 1.84		

Note: JPM calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT “AC Day/Night Care – Endoscopy” unit data of at least 10 comparable sites – based on the number of visits and nature of services delivered on site.

Future State Recommendations – Endoscopy Unit

This section summarizes the recommended future-state staffing for JPMRHC Renal Dialysis unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for JPMRHC Renal Dialysis unit.

- Target HPPV reflects the average HPPV over the last 3 years (2.5), adjusted down to reflect closer to peer benchmarking; it is assumed operational efficiencies can be explored to reduce the HPPV.

Based on the recommended budgeted (FTE) positions, and with consideration for the assumptions regarding operational efficiencies, a slight adjustment in RN budget is recommended.

Table 63: Recommended Budgeted (FTE) Positions and Skill Mix for JPMRHC Renal Dialysis Unit

Future State

Target Calculations

Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
2.0	3,234	6,468.0	5.1

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	100%	5.10	6.14	-1.04
LPN	-	-	-	-
PCA	-	-	-	-

Western LTC

Site Overview

Located in Corner Brook, NL, the Western Long-Term Care (WLTC) site opened its doors in 2020 following a staggered approach with the first house opening in June of 2020 and the seventh and final house opening in July of 2023. It provides long-term care, restorative care and adult inpatient rehabilitation services to residents of the western region of Newfoundland.

The facility has 145 beds, distributed as follows:

- Long-term Care (LTC): 105 beds
- Restorative Care: 15 beds
- Adult Rehabilitation: 10 beds
- Palliative Care: 15 beds (*out of scope for this review*)

Long-Term Care Program

The Western Long-Term Care program offers 24-hour residential care for up to 105 residents across its seven (7) units. The program does not include specialized units, and residents are not formally placed into cohorts based on common care needs. The units operate at near full occupancy throughout the year.

Table 64: Occupancy of LTC Houses

WLTC House

	% Occupancy		
	2022-23	2023-24	2024-25
% Occupancy	89%	96%	100%

Note: Source, Meditech Admissions Module.

Unit Overview and Organizational Factors

All LTC units (“houses”) consist of 15 beds. LTC Units are distributed across four levels on Levels 1 to 4 (bolded below) as follows:

- Level 0: Palliative Care (out of the scope of this review) and Adult Rehabilitation (10 beds)
- Level 1: Restorative Care (15 beds) and one LTC unit – Birchview House (15 beds)
- Level 2: Two LTC units – Shoreview House and Bayside House (15 beds each, total 30 beds)
- Level 3: Two LTC units – Natures Haven House and Still Waters House (15 beds each, total 30 beds)
- Level 4: Two LTC units – Valleyside House and Balsamview House (15 beds each, total 30 beds)

Levels 2, 3, and 4 have mirrored, rounded L-shaped design with connecting walls between paired units that can be opened for targeted needs (e.g., recreation therapy session) or to support shared staff coverage. All rooms are equipped with fixed mechanical lifts. Shared amenities include shared bathtub and shower areas, dining areas, recreation spaces, and a secure outdoor area (balcony) on each unit that is visible from the nursing station.

Strengths:

- All rooms are equipped with fixed mechanical lifts, supporting safe handling of residents.
- Dedicated end-of-life suites on each LTC units provide privacy enabling residents to stay on their unit during end-of-life episodes and to accommodate additional visitors.

- The connecting wall between paired LTC units can be opened, which eases travel for staff shared across units.
- Pleasurable Dining (Resident-Centred Dining) is an established practice that enables residents to eat meals at their preferred times rather than following fixed schedules. The model has been in place since the site opened with staffing arrangements designed to accommodate the practice.
- Residents have access to a range of allied health services on-site, including occupational therapy, physiotherapy, and therapy assistant support (OTAs/PTAs), through a referral-based model. These resources are available to support resident care planning and functional goals, and shared access enables consultation and involvement as clinically indicated.

Client Factors

Long-term care residents are admitted based on an assessment indicating Level III care needs or more under the NL Level of Care Framework⁴⁶. In the absence of available site-level, provincial-level insights and trends in LTC patient profiles follow.

Table 65: Provincial level- LTC acuity context and trends based on RAI-MDS 2.0 data, 2018/19 to 2022/23⁴⁷

Functional dependency:

- Over 80% of LTC residents were assessed as requiring extensive assistance or total dependence on activities of daily living.

Health instability:

- Over 75% of residents scored 0 or 1 on the CHESS scale, indicating low to mild health instability.
- Overall, CHESS results suggest relative stability in resident health needs over time.

Depression:

- Over 50% of residents had at least some depressive symptoms.

Cognitive impairment:

- Nearly half of LTC residents were assessed as having severe cognitive impairment.

Aggressive behaviours:

- The proportion of residents with more severe aggressive behaviours increased slightly from 7.1% to 9.9%.
- Overall aggressive behaviour patterns were described as relatively stable.

Selected diagnoses:

- Number of LTC residents diagnosed with diabetes (+12.4%), psychiatric/mood disorders (+7.4%), and dementia (+3.5%) increased.

While the provincial data report highlights stable or modest complexity changes over the years, site stakeholders perceived an increase within the care environments they support at WLTC in the complexity of long-term care residents. Examples shared include:

⁴⁶ The Level of Care Framework categorizes individuals into four distinct levels, ranging from I to IV, to determine clinical eligibility and the appropriate care setting for everyone assessed.

⁴⁷ Government of Newfoundland and Labrador, Department of Health and Community Services. (2025). Long-term care and personal care home review. <https://www.gov.nl.ca/hcs/files/Long-Term-Care-and-Personal-Care-Home-Review.pdf>

- Resident profiles include dementia, cognitive decline associated with behavioural symptoms, and the presence of one or multiple chronic medical conditions. Perception of increasing number of residents with bariatric care needs involving frequent use of mechanical lifts and two-person assistance.
- Perception that there are more residents with higher Levels of Intervention (LOI), including full-resuscitation status.
- Increasing the number of residents discharged from acute care require medical interventions; these include intravenous therapies, blood transfusions, and clinical monitoring.

To note, these perceptions could not be quantitatively validated due to limitations in available site-level data.

According to data collected at the site level, the number of constant care hours have increased over three years, in part a reflection of the number of operational beds increasing over the same period. Constant care is indicated for patients who require continuous observation due to behavioural or cognitive instability, or because of complex medical needs.

Table 66: Constant Care Hours Breakdown at WLTC

WLTC	Constant Care Hours		
	2022-23	2023-24	2024-25
Total Hours	434	3,050	12,340

Note: There was a staggered opening, where one of the houses did not open until 2023, which may explain lower constant care hours in 2022-2023. Source, NLHS General Ledger.

Staffing Factors

The LTC program operates in all LTC units under a team based care model. The resident's care plan is developed collaboratively by the interdisciplinary team upon admission, in consultation with the resident and/or their family and is subsequently adjusted as needed.

Below are the current state staffing table and a summary of each core team roles; all validated through site-level stakeholder engagement.

Table 67: Shift Rotation Schedule for WLTC LTC Houses

Shift	NP (whole site)	RN (per house)	LPN (per house)	PCA (per house)
08:00-20:00	1 <i>Mon-Fri From 8:00-16:00</i>	0.25 or 0.33	1	2
20:00-8:00	0	0.25 or 0.33	1	1 or 0.5 (0.5 because PCA is shared across the houses on the same floor)

Note: The PCA working from 24:00-08:00 on Birchview House (15 beds) cannot share staff with adjacent units; at night, it uses a long-night PCA (20:00-08:00) instead of the shared PCA (00:00-08:00).

The RN positions alternate monthly between supporting 3 and 4, 15 bed houses. The table below details the staffing model for the difference in RN FTE ratios between the houses part of the three house vs. four house subsets of units.

Table 68: Staffing model for 4 Houses sharing RN Oversight

Shift (per 15 beds)	RN (per house)	LPN (per house)	PCA (per house)
08:00-20:00	0.25	1	2
20:00-8:00	0.25	1	1 PCA 20-24h, 0.5 PCA 24-8h

Note: 1 RN shared between four 15 bed houses, 7 days a week

Table 69: Shift Staffing model for 3 Houses sharing RN Oversight

Shift (per 15 beds)	RN (per house)	LPN (per house)	PCA (per house)
08:00-20:00	0.33	1	2
20:00-8:00	0.33	1	1 PCA 20-24h, 0.5 PCA 24-8h

Note: 1 RN shared between three 15 bed houses, 7 days a week

Nurse Practitioner

- The Nurse Practitioner (1.0 FTE) provides medical care to long-term care residents within the scope of practice of the role. This position provides weekday coverage for all long-term care beds for approximately eight hours per day, Monday to Friday. In addition to long-term care responsibilities, this position also provides coverage for residents at other sites that are outside the scope of this review.

-

Registered Nurse

- RNs, as integral members of the care team, are accountable for coordinating care, overseeing daily clinical operations, and delivering direct care to residents.
- Overall management and coordination of a resident's integrated care plan is the responsibility of the RN when designated as the care manager; however, this role may be delegated to an LPN as appropriate.

Licensed Practical Nurse

- The LPN position support one (1) LTC house. This ratio of 1 LPN: 15 residents are maintained across all shifts. The LPN role is primarily responsible for medication administration, including intravenous (IV) medications. Additional training may be required at times to ensure proficiency, particularly for internationally educated nurses (IENs), as IV administration is not standardized within the LPN scope of practice across all jurisdictions.

Personal Care Attendants

- The responsibilities of PCAs include assisting with activities of daily living such as mobility and transfers, bathing, dressing, toileting, personal hygiene, and feeding. They also carry out elements of care plans developed by licensed professionals.

Allied Health

- Allied health services are available on site and include occupational therapy, physiotherapy, speech-language pathology, dietetics, social work, and recreation services.
- Dedicated allied health capacity supporting long-term care residents is provided as follows:

- Occupational Therapy, Physiotherapy (including therapy aides), and Social Work services are available 8 hours per day, Monday to Friday (08:00 to 16:00).
- Recreation Workers provide coverage Monday to Friday from 09:30 to 17:30. In addition, each Recreation Worker covers one evening shift per month (Wednesday, 11:00 to 19:00) and one Saturday shift per month (09:30 to 17:30) and may also provide support during scheduled special events occurring during evenings or weekends.
- During evenings, nights, and weekends, when allied health and recreation staff are not routinely on site, the PCAs and nurses may support elements of allied health care plans after hours, where activities are deemed safe and fall within their scope of practice, to support continuity of care in the absence of on-site allied health staff.

Support Staff

- Support staff services supporting long-term care residents include ward clerk and Materials Services Aide (MSA) roles, with coverage provided as follows:
- At Western Long-Term Care, support staff primarily ward clerks and materials services aides provide administrative and logistical support. Ward clerks are responsible for managing documentation, coordinating communications, and handling clerical duties, while MSAs support materials management by ensuring supplies are available and distributed as needed throughout the facility, and assist with patient transport when appropriate.
 - Ward clerk coverage is provided Monday to Friday from 08:00 to 16:00.
 - Materials Services Aides (MSA) provide coverage Monday to Friday from 08:00 to 16:00. MSA coverage is shared across the building, including long-term care, rehabilitation, restorative, and palliative programs. At select sites where MSA capacity allows, these roles also take on transport of materials (e.g., lab specimens) and patients within the site.

As reported through site engagement, PCAs and licensed nursing staff may, at times, be involved in selected clerical or support-related tasks (e.g., patient transport or administrative activities), particularly after hours and in the absence of on-site support staff.

The table below compares workforce-related data and trends based on site level available data.

Table 70: Budget Vs Actual FTEs for Western LTC Houses

	2022-2023		2023-2024		2024-2025		YoY Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
BIRCHVIEW	10.8	0.2	10.7	8.7	10.7	15.0	-2.8
LPN	4.20	-	4.20	2.38	4.20	4.35	-0.8
PCA	6.30	-	6.30	5.57	6.30	9.74	1.4
RN	0.33	0.24	0.25	0.71	0.25	0.95	0.4
SHOREVIEW	10.8	15.9	10.7	15.6	10.7	15.1	4.8
LPN	4.20	5.61	4.20	4.31	4.20	3.79	0.4
NP	-	-	-	-	-	-	-
PCA	6.30	7.11	6.30	8.13	6.30	8.31	1.6
RN	0.34	2.35	0.25	3.17	0.25	2.97	2.6
BAYSIDE	8.73	14.3	9.3	13.4	9.3	16.2	5.5
LPN	4.20	4.68	4.20	3.84	4.20	4.98	0.3

	2022-2023		2023-2024		2024-2025		YoY Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
NP	-	-	-	0.00	-	-	-
PCA	4.90	6.25	4.90	6.40	4.90	8.23	2.1
RN	0.33	3.36	0.25	3.15	0.25	2.94	2.9
NATURE'S HEAVEN	15.03	15.4	12.8	14.4	9.3	15.3	2.7
LPN	4.20	5.47	4.20	4.69	4.20	4.15	0.6
NP	-	-	-	0.00	-	-	-
PCA	6.30	7.59	6.30	7.80	6.30	8.69	1.7
RN	4.53	2.34	2.35	1.95	2.35	2.43	-0.8
STILL WATERS	13.64	14.6	11.4	14.6	11.4	13.2	2.0
LPN	4.20	4.90	4.20	4.26	4.20	3.46	0.0
NP	-	-	-	0.00	-	-	-
PCA	4.90	7.59	4.90	8.41	4.90	7.67	3.0
RN	4.54	2.15	2.35	1.96	2.35	2.07	-1.0
VALLEYSIDE	10.5	17.0	12.8	15.0	11.4	14.7	4.0
LPN	4.20	5.74	4.20	4.82	4.20	4.64	0.9
NP	-	-	-	0.00	-	-	-
PCA	6.30	8.96	6.30	8.04	6.30	8.08	2.1
RN	-	2.29	2.35	2.09	2.35	1.97	-0.3
BALSAMVIEW	9.1	4.8	11.4	13.3	11.4	12.8	-0.3
LPN	4.20	1.31	4.20	4.81	4.20	4.41	-0.7
NP	-	-	-	0.00	-	-	-
PCA	4.90	2.67	4.90	6.71	4.90	6.38	0.4
RN	-	0.78	2.35	1.82	2.35	1.98	-0.5

Note: Source, Actual derived from NLHS General Ledger and Budgeted provided by WLTC site leadership.

The LTC program relies on a dedicated float pool and shared casual resources across all Corner Brook LTC sites.

Increased agency utilization across multiple houses indicates that relief needs were supplemented through agency staffing during the review period.

Table 71: Agency Hours for WLTC Houses

Agency Hours

LTC House		2023-24	2024-25	Average Change
BIRCHVIEW	RN	-	2,385.75	N/A
	LPN	2,160.90	14,097.95	552%
SHOREVIEW	RN	180.75	2,504.75	1286%
	LPN	1,406.50	16,525.30	1075%

LTC House		2023-24	2024-25	Average Change
		88.00		
BAYSIDE	RN	Approach at a glance: Quantitative —analyze enterprise finance/workload/flow/scheduling data to quantify demand, utilization, and staffing patterns; Qualitative —gather staff and leader insight via interviews, survey, site visits/observations, and validation sessions; J-scan —review peer jurisdictions and evidence to identify leading practices and actionable options.	207.75	136%
	LPN	2,517.75	1,290.25	-49%
NATURE'S HEAVEN	RN	11.25	59.00	424%
	LPN	2,400.90	588.55	-75%
STILL WATER'S	RN	11.25	156.50	1291%
	LPN	1,982.00	2,111.25	7%
VALLEYSIDE	RN	198.75	-	N/A
	LPN	980.50	684.75	-30%
BALSAMVIEW	RN	11.25	252.75	2147%
	LPN	1,213.25	1,188.25	-2%

Note: Data for 2022–2023 was not available. Source, data provided from Provincial Data & Information Services Quality & Learning Health Systems.

Workload Analysis - HPRD

WLTC is aligning its practices with the targets established by the provincial staffing model, aiming for a skill mix composition of 70% PCAs and 30% licensed nursing staff, targeting an average of 4.0 direct care hours per resident per day by 2026. Progress toward the target is not consistent across houses, with some improving year over year and others declining. Excluding Birchview and Still Waters House, skill mix across LTC houses is relatively consistent, with licensed nursing staff comprising approximately 45–55% of HPRD and PCAs accounting for the remaining 45–55%.

Table 72: HPRD for Western LTC Houses

Hours Per Resident Day (HPRD)

LTC House		2022-23	2023-24	2024-25
BIRCHVIEW	RN, LPN, PCA	N/A (RN/LPN 100%, PCA 0%)	3.2 (RN/LPN 32%, PCA 68%)	3.9 (RN/LPN 34%, PCA 66%)
SHOREVIEW	RN, LPN, PCA	3.9 (RN/LPN 50%, PCA 50%)	3.9 (RN/LPN 48%, PCA 52%)	3.9 (RN/LPN 45%, PCA 55%)
BAYSIDE	RN, LPN, PCA	3.7 (RN/LPN 58%, PCA 42%)	3.1 (RN/LPN 51%, PCA 49%)	3.9 (RN/LPN 45%, PCA 55%)
NATURE HEAVEN	RN, LPN, PCA	3.8 (RN/LPN 46%, PCA 54%)	3.5 (RN/LPN 45%, PCA 55%)	3.6 (RN/LPN 46%, PCA 54%)
STILL WATER'S	RN, LPN, PCA	3.2 (RN/LPN 56%, PCA 44%)	2.8 (RN/LPN 55%, PCA 45%)	2.9 (RN/LPN 51%, PCA 49%)
VALLEYSIDE	RN, LPN, PCA	3.4 (RN/LPN 54%, PCA 46%)	3.5 (RN/LPN 45%, PCA 55%)	3.8 (RN/LPN 47%, PCA 53%)
BALSAMVIEW	RN, LPN, PCA	3.9 (RN/LPN 50%, PCA 50%)	3.1 (RN/LPN 46%, PCA 54%)	3.3 (RN/LPN 46%, PCA 54%)

Note: Calculated using NLHS General Ledger and discharge data.

Future State Recommendations – WLTC Units

This section summarizes the recommended future-state staffing for WLTC units.

In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for WLTC units:

- All LTC units use the same staffing model, except Birchview, which cannot share staff because it is the only unit on its floor.
- All other units deploy the same staffing model.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended for Birchview:

1. PCA FTEs are budgeted at a higher level than the current budget to account for rural realities, including ongoing vacancies and recruitment challenges; however, actual PCA staffing levels are expected to remain consistent with 2024–2025 actuals.
2. The target skill mix of 30% RN/LPN and 70% PCA here is adjusted based on the workforce reality of the environment (rural site).

Table 73: Recommended Budgeted (FTE) Positions and Skill Mix for WLTC Birchview Unit

Future State

Target Calculations

Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
4	5,475	21,900.0	14.6

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	3%	0.44	0.30	0.14
LPN	29%	4.20	4.20	-
PCA	68%	9.90	6.30	3.60

All other units deploy the same staffing model. In the table below, Shoreview unit is used as a representative unit for all remaining LTC units on site.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended for all other WLTC units:

1. Increase RN capacity by budgeting 3 RN positions to provide site-wide vacancy coverage, equating to 0.42 RN FTE per site, as RN resources are shared across all sites.
2. Increase overnight PCA coverage from 0.5 to at least 1.0 FTE, and beyond where required, to mitigate workforce availability risks in rural areas and support continuity of care.

Table 74: Recommended Budgeted (FTE) Positions and Skill Mix for All Other WLTC Units

Future State

Target Calculations				
Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
4	5,475	21,900.0	14.6	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	3%	0.44	0.30	0.14
LPN	29%	4.20	4.20	-
PCA	68%	9.90	6.30	3.60

Adult Inpatient Rehabilitation and Restorative Care Programs

The Adult Rehabilitation Program provides goal-oriented, interdisciplinary rehabilitation services to individuals with impairments, activity limitations, or participation restrictions, with the aim of supporting functional recovery and maximizing independence. The program focuses on functional abilities and participation, addressing physical, cognitive, and psychosocial needs within the context of an individual's living environment. Rehabilitation is delivered through a client-centred approach, with active involvement from clients and, where appropriate, their families.

The program supports adults with a range of conditions that may benefit from inpatient rehabilitation, including neurological conditions (e.g., stroke), musculoskeletal trauma (e.g., amputations, motor vehicle-related injuries), neuromuscular conditions (e.g., multiple sclerosis), nervous system disorders (e.g., Guillain-Barré syndrome), and other medical conditions requiring rehabilitative care. More complex cases or earlier phases of rehabilitation may be supported through sub-specialized sites, with services at this site focused on ongoing functional recovery within the program's scope.

The Restorative Care Program provides time-limited, goal-focused care for individuals who are medically stable but require additional support to regain functional abilities following an acute care episode or progression of a chronic condition. The program is intended for individuals who are not yet able to return to their previous living arrangement at their pre-admission level of function.

Restorative Care is delivered at a lower intensity and slower pace than inpatient rehabilitation, characterized by fewer formal therapy hours per day and consistent encouragement to participate in daily activities. The program aims to support discharge to a previous living arrangement at an optimal level of functioning and to reduce reliance on acute care beds for Alternate Level of Care (ALC) patients.

Unit Overview and Organizational Factors

The Rehab and Restorative care units are located respectively on Levels 0 and 1 (bolded below).

- Level 0: Palliative Care (*out of the scope of this review*) and Adult Rehabilitation (10 beds)
- Level 1: Restorative Care (15 beds) and one LTC unit – Birchview House (15 beds)

The Adult Rehabilitation unit is located on the ground level and comprises 10 beds, while the Restorative Care unit, with 15 beds, is located on Level 1. The physical separation of the units across different floors results in shared staff travelling between levels, which can affect real-time staff and resource coordination.

Shared amenities available on each unit include bathtub and shower areas, a dining room/social space, and a secure outdoor area (balcony) visible from the nursing station. The units share an Activity of Daily Living (ADL) suite, which is used to simulate real-life home environments during rehabilitation and to support readiness assessments prior to discharge.

The units also have access to two therapy areas (Physiotherapy and Occupational Therapy) and a secure outdoor garden space that is also accessible to Long-Term Care (LTC) program residents.

Strengths:

- Patient rooms are equipped with ceiling-mounted mechanical lift systems, supporting safe resident handling and mobility assistance.
- Participants stated that in accordance with policy, when a patient's care needs exceed the unit's capabilities, transfer back to acute care is facilitated, and the patient's bed is typically held for up to 72 hours prior to formal discharge from the program.
- Interdisciplinary collaboration was noted as a strength by stakeholders. It is supported by regular team rounds and a team-based nursing model that promotes shared accountability and coordinated care delivery.
- The programs benefit from on-site allied health services, including dedicated Physiotherapy and Occupational Therapy support with program-specific aide coverage.

Client Factors

Admission to the Adult Rehabilitation and Restorative Care programs is guided by explicit and distinct eligibility criteria aligned with each program's scope and intensity. Across both programs, eligibility considerations include medical and physical stability, the presence of functional and attainable goals, sufficient cognitive capacity to participate in therapy, and demonstrated motivation to engage in the rehabilitative or restorative process.

All Restorative Care candidates undergo review by the Restorative Care Facilitator to assess suitability and readiness for transfer, supporting appropriate patient placement and effective use of program resources.

At the time of this review, available patient acuity data and functional profiles to substantiate quantitative insights were limited.

The Adult Rehabilitation and Restorative Care units operate at near-full occupancy throughout the year.

Table 75: Patient Activity in WLTC Rehabilitation and Restorative Units

Patient Activity

Unit	2022-23	2023-24	2024-25
REHABILITATION			
Bed Staffed	10	10	10
% Occupancy	96.1%	97.6%	98.2%
Total LOS	3,832	3,163	3,700
Avg LOS	61.8	59.7	55.2
ALC Days	0	6	0

Unit	2022-23	2023-24	2024-25
REHABILITATION			
% ALC	0%	0.2%	0%
Discharges	62	53	67

Unit	2022-23	2023-24	2024-25
RESTORATIVE			
Bed Staffed	15-	15	15
% Occupancy	91.7%	97.0%	97.4
Total LOS	4,938	5,713	5,039
Avg LOS	41.2	45	38.5
ALC Days	175	267	324
% ALC	3.5%	5%	6.1%
Discharges	120	127	131

Note: Source, Meditech Admissions Module.

Stakeholders consistently described a perceived patient complexity and acuity across the Rehabilitation and Restorative Care units. Staff indicated that a substantial proportion of patients admitted to these units require advanced clinical interventions and present with complex medical and functional needs, often following prolonged acute care stays (e.g., post-stroke recovery or extended hospitalizations). Patients were described as frequently presenting with chronic illness, with care needs characterized by functional dependency and routine clinical monitoring at the start of the rehabilitation process.

According to data collected at the site level, the number of constant care hours has increased over the past three years. Constant care is indicated for patients who require continuous observation due to behavioural or cognitive instability, or because of complex medical needs.

Table 76: Constant Care Hours for WLTC

Constant Care Hours

WLTC Rehab & Restorative Care	2022-23	2023-24	2024-25
Total Hours	0	23	264

Note: There was a staggered opening, where one of the houses did not open until 2023, which may explain lower constant care hours in 2022-2023. Source, NLHS General Ledger.

Staffing Factors

The programs operate under a team-based care model. The patients care plans are developed collaboratively by the interdisciplinary team upon admission, in consultation with the patient. For Restorative Care specifically, goals of care are collaboratively established prior to admission to ensure proactive alignment with program intent and expected outcomes.

Below are the current state staffing table and a summary of each role, all validated through site-level stakeholder engagement.

Table 77: Shift Rotation Schedule for WLTC Rehab Unit

Shift	RN	LPN	PCA
08:00-20:00	0.5 (0.5 because 2 LPNs are shared across Restorative Care and Rehab units 16h-20h)	1.5	1 (Sat-Sun 8h shift from 8-16h)
20:00-8:00	0.5	1	1 (Mon-Fri 12h shifts, from 16- 24h)

Table 78: Shift Rotation Schedule for WLTC Restorative Care Unit

Shift	RN	LPN	PCA
08:00-20:00	1.5 (0.5 because one RN is shared across Restorative Care and Rehab Units)	1.5 (0.5 because 2 LPNs are shared across Restorative Care and Rehab units 16h-20h)	1
20:00-8:00	0.5 (One RN shared across Restorative Care and Rehab Units)	1	1

Nurse Practitioner

- Not applicable. These units do not have dedicated capacity from on-site NP who is dedicated to the LTC programs.

Registered Nurse

- RNs are responsible for coordinating care, overseeing day-to-day clinical operations, and providing direct patient care. When designated as the care manager for a patient, the RN holds accountability for the coordination of the interdisciplinary care plan; this responsibility may also be assigned to a LPN, in accordance with the scope of practice and patient needs.
- A portion of RN staffing is shared across the Rehabilitation and Restorative Care units on a 24-hour basis. Given that the units are located on adjacent floors, this shared staffing model requires RNs to move between levels, which increases staff travel as part of routine care delivery.

Licensed Practical Nurse

- LPNs are responsible for medication administration, including IV administration; however, additional training may be required for IENs, as IV administration is not standardized within the LPN scope of practice across jurisdictions.
- A portion of LPN staffing is shared across the Rehabilitation and Restorative Care units on a 24-hour basis. This requires LPNs, like RNs, to move between levels as part of routine care delivery.

Personal Care Attendants

- PCAs are part of the shared care model. They are cross trained to work across both rehabilitation and restorative care units. The responsibilities of PCAs include assisting with activities of daily living such as mobility and transfers, bathing, dressing, toileting, personal hygiene, and feeding. They also carry out elements of care plans developed by licensed professionals.
- As reported through site engagement, PCAs and licensed nursing staff may, at times, be involved in selected clerical or support-related tasks (e.g., patient transport or administrative activities), particularly after hours and in the absence of on-site support staff. Stakeholders indicated that this is exacerbated by the vacancy of the ward clerk position shared across the Rehabilitation and Restorative Care units.

Allied Health

- Allied health services are available on site and include occupational therapy, physiotherapy, speech-language pathology, dietetics, social work, and recreation services.
 - Speech-Language Pathology and Dietetics services from adjacent acute care hospital provide services to both programs on a referral basis, Monday to Friday daily between 8:00 and 16:00
 - Social Worker provides coverage 8 hours per day, Monday to Friday (8:00 to 16:00)
 - Dedicated allied health capacity supporting rehabilitation patients is provided as follows:
 - Occupational Therapy and Physiotherapy services including therapy aide are available 8 hours per day, Monday to Friday (08:00 to 16:00).
 - Recreation Worker (part-time) provides evening coverage Tuesday to Saturday – position vacant
 - Dedicated allied health capacity supporting restorative care patients is provided as follows:
 - Occupational Therapy and Physiotherapy services (part-time) including therapy aide are available 8 hours per day, Monday to Friday (08:00 to 16:00).
 - Recreation Worker (part-time) provides coverage 8 hours per day, Tuesday to Saturday - Temporarily also supporting Rehabilitation due to vacancy
- During evenings, nights, and weekends, when allied health and recreation staff are not routinely on site, the PCAs and nurses may support the implementation of elements of allied health care plans after hours, where activities are deemed safe and fall within their scope of practice.

Support Staff

- Support staff services supporting long-term care residents include ward clerk and Materials Services Aide (MSA) roles, with coverage provided as follows:
 - At Western Long-Term Care, support staff primarily ward clerks and materials services aides provide administrative and logistical support. Ward clerks are responsible for managing documentation, coordinating communications, and handling clerical duties, while MSAs assist with materials management, ensuring supplies are available and distributed as needed throughout the facility. At select sites where MSA capacity allows, these roles also take on transport of materials (e.g., lab specimens) and patients within the site.
 - Ward clerk coverage (part-time) is provided Monday to Friday from 8:00 to 14:00. Clerk coverage is shared across the rehabilitation and restorative care units – vacant
 - Materials Services Aides (MSA) provide coverage Monday to Friday from 08:00 to 16:00. MSA coverage is shared across the building, including long-term care, rehabilitation, restorative, and palliative programs. Additional evening coverage (12:00–20:00, three days per week) has occurred intermittently but is not sustained.
- As reported through site engagement, PCAs and licensed nursing staff may, at times, be involved in selected clerical or support-related tasks (e.g., patient transport or administrative activities), particularly after hours and in the absence of on-site support staff.

The tables below compare workforce-related data and trends based on site level available data.

Table 79: Actual Versus Budgeted FTEs for WLTC Rehabilitation and Restorative Units

	2022-23		2023-24		2024-25		YoY Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
REHABILITATION	8.41	12.3	8.80	13.0	8.60	12.2	-0.80
LPN	4.21	6.14	4.40	7.43	4.20	6.82	-0.61
PCA	-	2.01	-	1.69	-	1.46	-0.23
RN	4.40	4.14	4.40	3.84	4.40	3.96	0.12

	2022-23		2023-24		2024-25		YoY Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
RESTORATIVE	6.05	13.6	10.77	13.6	10.77	13.2	-0.40
LPN	4.20	5.53	4.20	5.55	4.20	5.38	-0.17
PCA	-	4.96	4.72	5.42	4.72	5.06	-0.36
RN	1.85	3.11	1.85	2.66	1.85	2.73	0.07

Note: Source, Actual derived from NLHS General Ledger and Budgeted provided by WLTC site leadership.

Tables below show overtime utilization used to supplement staffing coverage during periods of staff absence.

Table 80: Hours Breakdown for Western Rehabilitation Unit

Overtime and Sick Leave Trends

	2022-23	2023-24	2024-25
REHABILITATION			
Overtime	1,536	1,667	1,528
LPN	688	842	953
PCA	449	478	314
RN	399	347	261
Sick Leave	718	2,001	2,716
LPN	272	515	377
PCA	182	1,197	2014
RN	264	288	326
Constant Care	-	-	87
LPN	-	-	42
PCA	-	-	45

Note: Source, NLHS General Ledger and Payroll.

Table 81: Hours Breakdown for Western Restorative Unit

Overtime and Sick Leave Trends

RESTORATIVE	2022-23	2023-24	2024-25
Overtime	1,615	1,618	1,504
LPN	795	742	649
PCA	441	607	645
RN	379	270	211
Sick Leave	1,604	1,714	1,919
LPN	486	615	731
PCA	924	830	926
RN	195	268	262
NP	-	-	-
Constant Care	0	22	178
LPN	-	11	52
PCA	0	11	126

Note: Source, NLHS General Ledger and Payroll.

Workload Analysis – HPPD

Target for Hours per patient day (HPPD) have not been defined at the provincial level for Inpatient and Restorative Care programs. After relative stability in 2022–23 and 2023–24, HPPD increased materially in 2024–25 in both programs, with Rehabilitation consistently operating at higher HPPD levels than Restorative care and experiencing the largest year-over-year increase.

Table 82: HPPD for Western Rehabilitation and Restorative Units

Hours Per Patient Day (HPPD)				
Unit		2022-23	2023-24	2024-25
REHABILITATION	Nursing UPP	3.8	3.8	5.4
RESTORATIVE	Nursing UPP	2.3	2.1	3.2
Peer Benchmark (HPPD)		2022-23	2023-24	2024-25
Range based on Unit Producing Hours			3.7-7.1	

Note: Calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT “IP Medical Rehabilitation” and “IP Medical Rehabilitation – Combined”) unit data of at least 10 comparable sites – based on the number of visits and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPV.

Future State Recommendations – Adult Inpatient Rehabilitation and Restorative Care Units

This section summarizes the recommended future-state staffing for WLTC Rehab and Restorative care units. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for Rehab and Restorative units:

- The target HPDD for Rehab and Restorative care unit is aligned with peer benchmark.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended for the Rehab and Restorative Care units:

1. Reduce the budgeted LPN FTEs and increase the PCA FTEs to support full coverage on days and nights in the rehabilitation unit.
2. No change to restorative unit.

Table 83: Recommended Budgeted (FTE) Positions and Skill Mix for WLTC Rehab Unit

Future State

Target Calculations				
Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
4.30	3,650.0	15,695.0	10.4	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	40%	4.20	4.40	0.20
LPN	45%	4.70	4.20	0.50
PCA	25%	2.6	Unavailable	Unavailable

Table 84: Recommended Budgeted (FTE) Positions and Skill Mix for Unit LSHC Restorative Care Unit

Future State

Target Calculations				
Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
3.70	5,475.0	20,257.5	13.5	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	35%	4.73	1.85	2.88
LPN	40%	5.40	4.20	1.20
PCA	25%	3.30	4.72	-1.42

Labrador South Health Centre

Site Overview

Located in Forteau, the Labrador South Health Centre (LSHC) serves as a local access point and coordination hub for approximately 2,000 residents across Red Bay to L'Anse au Clair. The site operates as a mixed-service rural facility, delivering acute care, long-term care, community health, and public health services within a single location. This integrated model reflects delivery of services in many remote communities.

Within the regional health system, LSHC's primary role is to provide timely access to assessment, stabilization, and continuity of care for community members, while coordinating escalation to higher-acuity services when required. The site does not function as a specialty or inpatient referral centre; rather, it supports early intervention, ongoing management of stable conditions, and navigation of patients across care settings and external referral pathways.

The Labrador South Health Centre also has a Long-Term Care unit that provides care to patients who require a level three and level four care, due to age or illness as well as a palliative care bed and respite bed for clients in need.

The facility has 20 beds, distributed as follows:

- Long-Term Care (LTC): 16 beds
- Palliative Care: 1 bed
- Respite: 1 bed
- Emergency Room: 2 beds (holding beds, no admission)

Acute Care Program

Unit Overview and Organizational Factors

The Acute Care Program at the Labrador South Health Centre provides 24-hour emergency services and serves as the primary point of access for urgent and emergent care within the community. The program operates within a non-admitting rural facility, where acute care is delivered as part of a broader mixed-service environment rather than as a stand-alone inpatient service.

The program is designed to support initial assessment, stabilization, short-term observation, and coordination of transfer for patients whose needs exceed the site's capabilities. LSHC does not provide inpatient admissions, advanced diagnostics, or specialty acute care. Patients requiring higher-acuity intervention or inpatient treatment are transferred to regional referral centres, most commonly St. Anthony. As such, the Acute Care Program functions primarily as a front-line stabilization and transfer coordination service within the regional care network.

In addition to emergency services, LSHC operates a nurse-led ambulatory chronic disease management clinic that provides scheduled outpatient care by appointment, primarily during weekday hours. The clinic supports assessment, follow-ups, and management of patients whose needs do not require emergency intervention or inpatient admission and operates within the same physical environment as acute care. Ambulatory clinic activity is coordinated alongside emergency services and may be interrupted when urgent or emergent presentations require immediate attention.

The physical environment supporting acute care includes two holding beds located in the emergency room, clinical examination rooms, an emergency treatment space, and a patient waiting area. These spaces are designed to support emergency response, short-duration care, and appointment-based ambulatory services. They are not intended for prolonged inpatient stays; however, patients may be held overnight in acute care beds when transfer is delayed, most commonly due to weather conditions or transportation availability.

Diagnostic infrastructure is limited in scope and availability. Laboratory and X-ray services are available on-site during weekday daytime hours only, with no access to advanced imaging. When required, diagnostic specimens are sent off site for processing, and imaging studies are transmitted electronically for external interpretation. There are two physician positions vacant, so the site does not have an on-site physician presence, therefore, physician support is provided remotely through Teladoc.

Strengths:

- The Labrador South Health Centre operates as a mixed-service rural facility, providing local access to essential health services.
- The Acute Care Program provides 24-hour emergency services and functions as a front-line assessment, stabilization, and transfer coordination site, with established referral pathways to regional centres, most commonly St. Anthony.
- A nurse-led ambulatory chronic disease management clinic operates during weekday hours, supporting scheduled outpatient care for patients whose needs do not require emergency intervention.
- Virtual care tools, including Teladoc, are used to support access to physician services in the absence of consistent on-site medical coverage, contributing to continuity of clinical decision-making.
- Nursing staff practice within an expanded scope of practice appropriate to the rural setting and demonstrate flexibility and collaboration in responding to emergent presentations, competing demands, and limited on-site resources.

Client Factors

The Acute Care Program at the Labrador South Health Centre serves a population with a range of clinical presentations and variable care needs. Patient presentations include minor urgent care and higher-acuity emergencies, such as trauma, acute medical decline, cardiac events, and mental health crises. Some patients require Medevac transfer to higher-acuity facilities, most commonly St. Anthony.

The emergency department at LSHC relies on a fully paper-based triage system; as a result, detailed data on patient presentations, CTAS levels, and acuity trends are limited, and analysis of client factors is informed primarily by qualitative site input and available utilization data such as clinic and emergency room visit volumes.

Table 85: Total Visits to Acute Care at LSHC

ACUTE CARE

	Visits		
	2022-23	2023-24	2024-25
Ambulatory	6,628	5,295	4,016
Emergency	1,723	1,868	2,830

Note: Source, NLHS General Ledger.

Overall acute care utilization is described as relatively stable year over year, with patient visits reflecting a mix of lower-acuity presentations and more complex emergency cases. In addition to episodic urgent care, patients also present with chronic disease-related complications, including diabetes and cardiac conditions, which may require extended observation and repeat clinical assessment. Mental health presentations occur intermittently and may require enhanced monitoring within the acute care setting.

Although LSHC is not a formal admitting facility and does not track Alternate Level of Care (ALC) metrics, patients may be held overnight in acute care holding beds when transfer is delayed, most often due to weather conditions or transportation availability. These overnight holds increase the duration of care delivered within the acute care setting and are not consistently reflected in existing reporting or acuity measurement tools.

Staffing Factors

The Acute Care Program operates without on-site physician presence, placing increased demands on a small, nurse -led staffing model with limited redundancy. Staffing coverage must support 24-hour emergency service delivery, short-term patient holding, and coordination of patient transfers, while also providing the region’s only access to urgent and chronic disease management through its emergency department and ambulatory clinic.

The following table presents the current-state staffing complement and a summary of core team roles, informed by site-level data and validated through engagement with local stakeholders.

Table 86: Shift Rotation Schedule for LSHC Acute Care Program

Shift	Regional RN	LPN
08:00-20:00	2 (one 8h M-F for Chronic Disease Clinic)	1 (8h)
20:00-08:00	1	0

Note: There is one regional nurse that leads the chronic disease management clinic that operates by appointment on weekdays.

Nurse Practitioner

- LSHC currently has no NP on site. A NP was briefly engaged for approximately three months over the summer through a locum arrangement to mitigate two physician vacancies.

Registered Nurse

- RNs function within an expanded scope of practice, assuming responsibility for initial assessment, stabilization, monitoring, and escalation of care across acute care services.
- During weekday daytime hours, acute care coverage includes one regional RN assigned to emergency room triage, assessment, patient care, and monitoring of the waiting area, holding beds, and resuscitation space. This RN works near a second regional RN responsible for the appointment-based ambulatory chronic disease management clinic, with one LPN shared across both areas.
- Daytime RN coverage is maintained until 16:00, after which staffing reduces to a single RN, transitioning to an on-call model overnight. During evenings and nights, the on-site RN provides all acute care functions and responds to emergent needs in LTC.

- After hours and on weekends, staffing transitions to a single-RN model covering the full acute care area. During these periods, a single clinician is responsible for all acute care activity, with access to an additional RN through this on-call structure for emergent situations. For example, escort for patient transfers or resuscitation cases.
- [REDACTED]
- RN prescribing is under consideration; however, limited access to required physician mentorship has prevented implementation to date.

Licensed Practical Nurse

- LPNs work within an expanded scope of practice appropriate to the rural setting. Within acute care, LPN responsibilities include patient monitoring, vital signs, assistance with assessments, and support during triage and treatment activities, under the direction of the RN. LPNs also support ambulatory clinic activity during scheduled appointments and adjust their focus as needed when emergency presentations occur.
- During weekday daytime hours, one LPN is shared between the emergency department and the appointment-based ambulatory chronic disease management clinic, supporting patient care across both areas.
- LPN coverage is limited to weekday daytime hours, with no scheduled LPN support during evenings, nights, or weekends.

Personal Care Attendants

- There are no PCAs.

Allied Health

- Allied health support at the Labrador South Health Centre is provided through a combination of limited on-site diagnostic services and periodic visiting or regional programs reflecting the operational realities of a small, rural site.
- Diagnostic services: One full-time role covering both laboratory and x-ray, providing on-site diagnostic services Monday to Friday from 08:00 to 16:00. There is no on-site diagnostic coverage during evenings, nights, or weekends.
- Other allied health and specialty services: Additional services, including dental, dental hygiene, and mental health, are delivered through in-person clinics at varying intervals, depending on availability.
- In the absence of consistent on-site allied health and diagnostic coverage, nursing staff assume responsibility for tasks that would typically be supported by allied health professionals, diagnostic staff, or physicians. The use of virtual tools such as Teladoc, as well as ongoing communication with off-site providers, are integrated into the nursing workflow alongside direct patient care.

Support Staff

- The Acute Care Program at the Labrador South Health Centre has limited support staff capacity. RNs and LPNs are often required to manage supply orders and stocking materials and medications.
- The site has a maintenance repair role that completes errands, provides basic maintenance support, and manages material services support across the facility. This role is shared across all programs and is not dedicated to acute care.

- Two administrative support roles are present Monday to Friday during daytime hours, providing clerical and administrative assistance for the site.
- There is no on-site security presence at the facility. Safety-related issues and escalation are managed without dedicated security support, which is particularly challenging during after-hours periods when staffing levels are reduced. Panic buttons are not routinely carried, and when activated, alerts are not audible across all areas of the site, including long-term care.
- As a result, during periods without administrative or support staff coverage—particularly after hours—nursing staff assume responsibility for transport coordination, logistical tasks, and communication activities that would typically be supported by non-clinical roles. These functions are incorporated into the nursing workflow alongside direct patient care.

Table 87: Breakdown of Overtime, Extra Workload, and Sick Time Hours in LSHC Acute Care

Hours Breakdown

ACUTE CARE	2022-23	2023-24	2024-25	YoY trend from 2022-23 to 2024-25
Overtime	1,262	1,164	2,109	54%
RN	1,235	1,125	2,059	67%
LPN	27	39	50	85%
Extra Workload	96	205	221	32%
RN	93	135	198	113%
LPN	6	52	23	283%
Sick Leave	2,425	312	314	(87%)
RN	2,385	289	247	(90%)
LPN	40	23	67	68%

Note: Source, NLHS General Ledger, payroll, and manual data entry.

Table 88: Actual FTEs for LSHC Acute Care

	2022-23	2023-24	2024-25	Average FTE
ACUTE CARE	8.0	6.8	7.7	7.50
LPN	1.34	1.16	1.19	1.23
NP	0.17	0.06	-	0.12
RN	6.48	5.61	6.52	6.20

Note: Source, NLHS General Ledger.

Workload Analysis – HPPV

The unit's HPPV is in line with comparable sites.

Table 89: HPPV for Acute Care in LSHC

Hours Per Patient Day (HPPV)			
ACUTE CARE	2022-23	2023-24	2024-25
Nursing UPP	1.1	1.2	1.5
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Average based on Unit Producing Hours		0.7 - 3.9	

Note: Calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT 'AC Emergency' unit data of at least 10 comparable sites – based on the number of beds, volume of ED visits, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPV.

Future State Recommendations – LSHC Acute Care Units

This section summarizes the recommended future-state staffing for LSCH acute care units (ambulatory and ED). In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for LSHC acute care unit:

- Target HPPV was obtained through peer benchmarking.
- Target HPPV for ED is reflective of RN-only model and rural realities (e.g., RN coverage shared with LTC units).

Based on the recommended budgeted (FTE) positions, it is recommended that the ambulatory unit:

1. Maintain the current LPN budget, recognizing that LPN resources are shared across ED and ambulatory services.
2. Undertake a deeper analysis of patient-level data to better assess population needs, as current assumptions treat visits as home-based; access to patient data is required to inform an appropriate allocation of resources across PH and CC.

Table 90: Recommended Budgeted (FTE) Positions and Skill Mix for Unit LSHC Acute Care – Ambulatory
Future State

Target Calculations			
Target	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
0.6	4,016	2,409.6	1.6
Skill Mix			
Role	Target Skill Mix	Recommended Budgeted (FTE) Positions	
NP	-	-	
RN	80%	1.30	
LPN	20%	0.30	
PCA	-	-	

Note: Based on the GL Data the budgeted FTEs are listed as 0.00 for all LSHC units, and LSHC data may be unreliable because it was recorded manually.

Based on the recommended budgeted (FTE) positions, it is recommended that the ED unit:

1. Expand cross-training opportunities for Long-Term Care (LTC) staff to support Emergency Department (ED) operations.
2. Continue efforts to fill the vacant physician position to stabilize clinical coverage.
3. Address key implementation considerations by:
 - a. Reviewing the NLHS Medavie contract to reinforce consistent service-level agreements (SLAs) for paramedic attendance and minimize the impact of RN transfers.
 - b. Ensuring sufficient change-management capacity, including dedicated management and professional practice oversight, to guide workforce changes such as cross-training.
 - c. Exploring appropriate primary care support options and care models for the site, taking into account ongoing physician and workforce vacancies.

Table 91: Recommended Budgeted (FTE) Positions and Skill Mix for Unit LSHC Acute Care – ED

Future State

Target Calculations			
Target	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
3	2,830	8,490.0	5.6

Skill Mix		
Role	Target Skill Mix	Recommended Budgeted (FTE) Positions
NP	-	-
RN	90-95%	5.10
LPN	5-10%	0.60
PCA	-	-

Note: Based on the GL Data the budgeted FTEs are listed as 0.00 for all LSHC units, and LSHC data may be unreliable because it was recorded manually.

LTC Unit**Unit Overview and Organizational Factors**

The Long-Term Care (LTC) Program at the Labrador South Health Centre is a small, rural residential care unit providing 24-hour long-term care services to 16 residents, with one additional respite bed and one palliative care bed. The LTC unit is physically co-located with acute care within a shared facility, allowing proximity to emergency services when required while also necessitating coordination across shared space and resources with acute and community health programs.

Medical oversight for the LTC program is not provided on site. Clinical oversight and medical orders are obtained through virtual or external provider arrangements, requiring coordination with off-site medical resources.

The physical environment includes unit-level safety and communication infrastructure that is described as limited. Emergency alert systems (e.g., panic buttons) and communication tools are not consistently reliable across the unit, which can affect response processes during urgent situations.

Client Factors

The LTC population includes residents with chronic health conditions, functional limitations, and individuals from the community admitted with palliative care needs, site-level data to further characterize the LTC resident population is limited. Detailed information on resident acuity, functional dependency, cognitive status, and clinical complexity is not consistently available at the site level. As a result, analysis of client factors for the LTC program is informed primarily by program designation, bed mix, and qualitative input from site engagement, rather than by resident-level quantitative data.

Residents admitted to the LTC unit meet eligibility for Level 3 or Level 4 care under the Newfoundland and Labrador Level of Care Framework, which reflect residents who require moderate to high levels of assistance with activities of daily living and ongoing clinical oversight. The unit has operated at or near-full occupancy over the past three years, indicating sustained utilization of available beds.

Table 92: Bed Occupancy in LTC Units at LSHC

Bed Occupancy

LTC UNITS	2022–2023	2023–2024	2024–2025
Bed Occupancy	100%	100%	100%

Note: Source, Meditech Admissions Module.

Table 93: Constant Care Hours at LTC Units at LSHC

Constant Care Hours

LTC UNITS	2022–2023	2023–2024	2024–2025
Constant Care	6	8	33.75
LPN	6	8	33.75

Note: Source, NLHS General Ledger.

Staffing Factors

The LTC unit staffing model consists of dedicated LPNs, and PCAs, with RN oversight provided through the acute and community programs regional nurses.

Below are the current state staffing table and a summary of each core team roles; all validated through site-level stakeholder engagement.

Table 94: Shift Rotation Schedule for LSHC LTC Unit

Shift	Care Facilitator/RN	LPN	PCA
08:00-20:00	0.5	2	2
20:00-08:00	0.5	2	0

Note: There is one RN who is shared: 0.5 is spent as LTC RN/Care facilitator, the other 0.5 is used for community services.

Access to allied health services within the LTC program is intermittent and limited. Rehabilitation and therapy services are not routinely available on site and are accessed through visiting or regional service models, depending on availability.

Administrative and coordination functions within the LTC program are not supported by a dedicated, unit-based ward clerk or on-site management role. RNs, LPNs and PCAs are responsible for stocking shelves and administrative duties. Documentation processes and coordination with external providers are managed within existing operational structures.

Nurse Practitioner

- There is no NP available on site.

Registered Nurses

- A portion of RN capacity is shared between the LTC program and community health services during weekday daytime hours, which constrains the amount of RN time available solely for long-term care.
- Outside of daytime hours, acute care regional nursing staff may provide oversight or assistance as needed; however, this support is subject to competing demands within acute care.
- RN involvement therefore focuses on clinical oversight, escalation, support, and coordination.

Licensed Practical Nurse

- LPNs provide the primary licensed clinical presence within the LTC unit.
- The unit is staffed with two LPNs from 08:00 to 20:00, supporting resident care during the daytime and evening hours.
- Two LPNs also provide coverage during the night-time hours (20:00 to 08:00), ensuring continuous licensed nursing presence overnight.
- LPN responsibilities include direct resident care, medication administration, monitoring, and coordination of care activities.

Personal Care Attendant

- PCAs support residents with activities of daily living, including personal care, mobility assistance, and routine support tasks.
- Two PCAs provide coverage from 08:00 to 20:00, supporting resident needs during daytime and early evening hours.

Allied Health

- Occupational Therapy supports the LTC program through in-person visits approximately one to two times per year.
- Pharmacy supply and delivery services are supported through an external pharmacy located in St. Anthony. Medication orders and renewals are coordinated through off-site medical providers, with prescribing support provided virtually.
- Other allied health and specialty support, including dental, dental hygiene, and mental health services, are delivered through in-person clinics at varying intervals, depending on service availability.
- In the absence of consistent on-site allied health, nursing staff in the Long-Term Care unit assume responsibility for a range activities, including coordinating virtual medical oversight and medication orders, monitoring medication inventories, and planning medication needs in advance of scheduled deliveries. Nurses incorporate elements of mobility support, functional maintenance, and ongoing observation into daily care routines between visiting allied health services.

Support Staff

- There is no dedicated ward clerk or unit-based administrative support role assigned to the Long-Term Care unit.
- Administrative, materials management, and other support functions available at the site are shared across programs.
- Participants reported that, in the absence of dedicated support staff, nursing staff routinely complete non-nursing tasks as part of their workflow, including ordering and stocking supplies, organizing resident charts, retrieving equipment, managing documentation, and coordinating medication-related processes, alongside direct resident care.

Table 95: Actual FTEs for LTC in LSHC

	2022-23	2023-24	2024-25	Average FTEs
LTC	14.8	14.6	13.0	14.13
LPN	10.99	10.74	9.18	10.30
PCA	3.08	3.12	3.15	3.12
RN	0.70	0.75	0.70	0.73

Note: Source, Meditech Admissions Module.

Workload Analysis – HPRD

Across the review period, the LTC unit at LSHC maintained a predominantly licensed nursing skill mix, with RNs and LPNs accounting for approximately 73–76% of total Hours Per Resident Day (HPRD); PCAs contributed 24–27%. The relative distribution of licensed nursing and PCA hours remained stable year over year, with modest variation in total HPRD.

Table 96: HPRD for LTC in LSHC

Hours Per Patient Day (HPRD)			
LTC	2022-23	2023-24	2024-25
RN, LPN, PCA	3.0 (RN/LPN 76%, PCA 24%)	2.8 (RN/LPN 74%, PCA 26%)	3.1 (RN/LPN 73%, PCA 27%)

Note: Calculated using NLHS General Ledger and discharge data.

Future State Recommendations – LSHC LTC Unit

This section summarizes the recommended future-state staffing for LSHC acute care units (ambulatory and ED). In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for LSHC acute care unit:

- Budgeted FTEs data for LSHC LTC is not available. Thus, the assumptions for the recommended budgeted (FTE) positions are based on the actual FTEs.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

- Provincial target skill mix is tailored here due to the staffing model covering other acute areas at the site.
- Increase overnight PCA coverage by adding one PCA on the night shift, raising coverage from 0.5 to 1.0 FTE, to strengthen overnight operations and mitigate workforce availability risks in a rural context.

Table 97: Recommended Budgeted (FTE) Positions and Skill Mix for Unit LSHC LTC Units

Future State

Target Calculations			
Target HPRD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
4.00	6570.00	26280.0	17.5

Skill Mix		
Role	Target Skill Mix	Recommended Budgeted (FTE) Positions
NP	-	-
RN	0%	0.0
LPN	50%	4.20
PCA	50%	4.20

Note: Based on the GL Data the budgeted FTEs are listed as 0.00 for all LSHC units, and LSHC data may be unreliable because it was recorded manually.

Community Health Program

Program Overview and Organizational Factors

The Community Health Program provides primary and community-based care for approximately 2,000 residents across a large, rural and geographically dispersed catchment area. Services include chronic disease management, ongoing follow-up, monitoring, education, coordination of care, treatment, wellness checks, and wound care. Service delivery is guided by provincial program standards rather than site-specific program design and considers travel requirements, client location, and weather condition factors.

Scheduling, documentation, and data capture are largely manual leading to limited availability of site-level utilization data.

Client Factors

The Community Health client population includes individuals with ongoing and varied clinical needs, many of whom require longitudinal follow-ups and monitoring. A significant portion of care delivery relates to the management of chronic conditions, including diabetes, as well as support for individuals experiencing changes in functional status over time.

Mental health needs are also encountered within this client population. Some presentations involve behavioural or psychosocial concerns that require additional assessment, monitoring, and coordination with external mental health services to support client safety and continuity of care.

Staffing Factors

The community health program relies on one RN FTE to support a geography with roughly 2,000 residents.

Table 98: Shift Rotation Schedule for LSHC Community Health

Shift	RN Community Health
08:00-16:00	1

Registered Nurse

- Community Services are provided Monday-Friday, 8:00-16:00. The workload is shared across two RNs, with one overseeing both the LTC unit and delivery community services, while the other works across community services and public health services. Services are provided through this dyad model and amount to 1 FTE of community services RN.
-

Allied Health

- Other services and allied health supports are provided with in-person clinics at different time intervals (dentist, dental hygienist, mental health).
-

Table 99: Actual Versus Budgeted FTEs for Community Health Care at LSHC

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
Community	0.0	0.2	0.0	0.6	0.0	0.8	0.5
RN	0.00	0.24	0.00	0.58	0.00	0.80	0.5

Note: Source, NLHS General Ledger.

Table 100: Caseload Breakdown for LSHC Community Health

Caseload Averages

Average Across 2022-2025	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
caseload	70	71	71	72	72	71	71	71	70	73	74	73	857
# visits	45	40	42	45	52	41	47	31	38	34	43	42	997
# referral	3	3	2	1	1	1	1	1	4	5	1	3	46

Table 101: Hours Breakdown for Community Care in LSHC

Hours Breakdown

COMMUNITY CARE	2022-23	2023-24	2024-25
Worked Hours	330.55	877.62	1,169.01
RN	330.55	877.62	1,169.01

Note: Source, NLHS General Ledger.

Future State Recommendations – Community Health Program

No recommendations can be made due to missing data.

Public Health

Program Overview and Organizational Factors

The Public Health function serves a dispersed catchment population and a student population of about 150, supporting a broad range responsibilities, including immunization services, communicable disease surveillance and follow-up, school and student health programming, sexual health services, population health promotion, and outbreak prevention and response activities. Public Health is now delivered as a provincial program under NLHS, with ongoing efforts to standardize services across the province. This transition has shifted governance from zone-based management to a provincial model, while working through aligning standardized programming with local, site-specific realities.

Client Factors

Although the population size is modest, service delivery is influenced by unpredictable weather conditions, reliance on coordinated access to other health services (e.g., OT, PT, and acute care), and increasing client needs.

Public Health services are delivered through scheduled clinics, with the average length of a clinic visit being approximately one hour.

Client revisits and return rates are determined by provincially mandated service schedules. For example:

- Child Health Clinics follow required visit intervals at two, four, six, twelve, and eighteen months of age, as well as at two and a half years and four years of age.
- Long-Term Healthy Beginnings program includes additional appointments between these standard child health intervals.
- School Health programming includes scheduled services at kindergarten and Grades 4, 6, 8, 9, and 12.

These provincially defined schedules create predictable and ongoing service demand.

Staffing Factors

Public Health at the Labrador South Health Centre (LSHC) is delivered through a nurse-led model, with services solely delivered by an RN.

Registered Nurse

- One RN position is allocated as 0.5 full-time equivalent to Public Health and 0.5 full-time equivalent to Community Supports. The RN works an eight-hour day shift from 8:00 a.m. to 4:00 p.m., Monday to Friday.
- The reliance on a single RN in a blended role limits redundancy and flexibility within the staffing model and increases vulnerability to service disruption in the event of absences or competing demands from Community Support’s responsibilities.

Table 102: Actual FTEs for Public Health at LSHC

	2022-23	2023-24	2024-25	Average FTE
Public	1.0	0.8	0.5	0.8
RN	1.0	0.8	0.5	0.8

Note: Source, NLHS General Ledger.

Future State Recommendations – Public Health

No recommendations can be made due to lack of data shared at the time of the review. .

Placentia and Lions Manor

Site Overview

Located in the Town of Placentia, the Placentia & Lions Manor site is a rural health care facility serving residents of Placentia and surrounding communities in Eastern Newfoundland and Labrador. It provides a range of essential health services, including:

- Inpatient medicine beds, with 8 budgeted beds including one dedicated palliative care room.
- Emergency Department (24/7) with 3 budgeted stretchers
- Ambulatory and family practice services, providing over 2,000 visits a year
- Routine diagnostic services
- Allied health services, shared with adjacent Lions Manor Nursing Home and other sites
- Pharmacy services provided remotely from the regional pharmacy department at Carbonear General Hospital.
- Chemotherapy services, including administration and take-home chemotherapy disconnects.

Adjacent to Placentia is Lions Manor, the LTC component of the site, which delivers 24-hour nursing care, personal support, and a range of allied health services shared across the local system, ensuring residents receive ongoing medical oversight, daily living assistance, and therapeutic programming.

As a regional service hub, the Placentia & Lions Manor site support timely access to care for local populations and reduces the need for patients to travel to larger referral centres such as St. John's and Carbonear for lower-acuity services.

Placentia Emergency Department (ED) Unit

Unit Overview and Organizational Factors

The ED is located on the acute care side of the facility and provides 24-hour emergency services to the local population.

- The ED includes three budgeted stretchers; however, five are currently in use to accommodate demand.
- To support patient flow, two medicine beds were converted to emergency use out of one room repurposed from the Medicine Unit.
- The ED is situated near key diagnostic and clinical services, including:
 - Laboratory services
 - X-ray and ultrasound
 - Outpatient areas
 - Converted medicine rooms within the acute care zone

Strengths:

- Physician coverage is available when required, supporting clinical decision-making and escalation of care.
- Participants described strong collaboration among nursing staff, particularly during periods of high activity or staffing variability.

- [REDACTED]
- [REDACTED]

Client Factors

Overall client demand is characterized by variability in acuity, unpredictability in volume, and intermittent surges, consistent with rural emergency care settings. Participants also indicated that a portion of ED presentations involve patients with limited access to primary care. It was reported that the ED manages patients presenting for care needs typically addressed in primary care settings, including prescription renewals and routine clinical assessments.

ED length of stay has been stable for the past 3 years.

Table 103: Average ED Length of Stay for Placentia Emergency Department

Wait Times

EMERGENCY DEPT.	2022-23	2023-24	2024-25
Average Length of Stay in ED (hours)	2.83	2.67	2.73

Note: Source, Cognos.

The CTAS distribution shows that CTAS 4–5 presentations accounted for most ED visits, representing 67% in 2022–23, 63% in 2023–24, and 61% in 2024–25. Some of these lower-acuity presentations are generally associated with conditions that could be managed through primary care or alternative ambulatory care clinics.

Table 104: CTAS in Placentia Emergency Care Unit

CTAS Characteristics

EMERGENCY CARE	2022-23	2023-24	2024-25
CTAS 1	0%	0%	0%
CTAS 2	2%	2%	5%
CTAS 3	26%	27%	29%
CTAS 4	55%	55%	53%
CTAS 5	12%	8%	8%
Not Specified	5%	6%	5%

Note: Source, Cognos.

Staffing Factors

The Emergency Care Unit is staffed with RNs – one FTE for all shifts, without LPN or PCA support. [REDACTED]

There is 1 RN staffed on days (08:00-08:00) and 1 RN staff on nights (08:00-08:00) – 12-hour shifts.

Table 105: Shift Rotation Schedule for Placentia ED Unit

Shift	RN	LPN
08:00-08:00	1	0
08:00-08:00	1	0

Nurse Practitioner

- No NPs provide coverage in the ED.

Registered Nurse

- RNs are staffed in the ED for 12-hour shifts.
- After 4:30 p.m., when outpatient administrative services conclude, the RN is responsible for patient registration and triage, direct patient care, documentation and administrative tasks, access control, and basic patient support activities.
- [REDACTED]
- [REDACTED]
- Participants noted the use of mandatory overtime, with RNs working extended shifts and anticipating overtime at the end of scheduled hours.
- [REDACTED]
- [REDACTED]

Allied Health

- Allied Health (shared with LTC):
 - SW 0.2 FTE
 - PT 0.2 FTE
 - OT 0.3 FTE
 - Dietician and Diabetic nurse 2x/week shared between LTC & Acute
- 4 Physicians on site (challenge in consistency) shared between Family Practice, Medicine unit and LTC
- 1 Physician on site in the ED with evening/night on call

Support Staff

- Ward Clerk shared with LTC & Acute.
- Registration Clerk M-F 8h-16h30
- Storage / supply resource M-F for 4hr shared between Acute and LTC.

Table 106: Trends in Overtime, Constant Care, and Extra Workload for Emergency Care

Hours Breakdown

EMERGENCY CARE	2022-23	2023-24	2024-25	YoY trend from 2022-23 to 2024-2025*
Overtime	354	418	617	74%
LPN	9	0	42	367%
RN	345	418	575	67%
Extra Workload	328	108	34	(90%)
LPN	0	1		N/A
RN	328	107	0	(-100%)
Constant Care	23	15	-	(-35%)

EMERGENCY CARE	2022-23	2023-24	2024-25	YoY trend from 2022-23 to 2024-2025*
LPN	23	-	-	N/A
RN	0	15	-	

Note: *YoY trend for constant care hours calculated from 2022-23 to 2024-2025. Source, NLHS General Ledger.

Table 107: Budget Versus Actual FTE in Emergency Care in Placentia

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
EMERGENCY CARE	6.2	5.5	6.2	5.1	6.2	6.2	-0.5
RN	6.16	5.46	6.16	5.12	6.16	6.16	-0.6

Note: Source, NLHS General Ledger.

Table 108: Reported Orientation Hours by ED nurses

Orientation Hours

EMERGENCY CARE	2022-23	2023-24	2024-25
Total Hours	203	-	2,510

Note: Source, NLHS General Ledger.

Workload Analysis – HPPV

The units HPPV falls below comparable sites. This variance may reflect differences in the acuity of the patient population, including a high proportion of CTAS 4-5.

Table 109: HPPV for Emergency Care in Placentia

Hours Per Patient Day (HPPV)			
EMERGENCY CARE	2022-23	2023-24	2024-25
Nursing UPP	0.5	0.5	0.7
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Average based on Unit Producing Hours		0.7-3.9	

Note: Calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT 'AC Emergency' unit data of at least 10 comparable sites – based on the number of beds, volume of ED visits, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPV.

Future State Recommendations – Emergency Department Unit

This section summarizes the recommended future-state staffing for Placentia ED unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for Placentia ED unit

- Target HPPV is reflective of peer benchmarking.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Increase the budgeted RN complement from current budgeted 6.2 to 6.7 FTE to enable two RNs on day shifts in the ED, reducing the need to redeploy the RN from the Med unit to support the ED.

- 2. Increase the budget and utilization of LPNs on the unit to the equivalent of 1.0 FTE on the night shift to support the only RN providing overnight ED coverage.
- 3. Increase the budget and utilization of PCAs, with 1.4 FTEs shared across the ED, Med, Ambulatory Care, and Family Care Team, to support integrated service delivery and coverage flexibility.

Table 110: Recommended Budgeted (FTE) Positions and Skill Mix for Placentia ED Unit

Future State

Target Calculations				
Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
1.5	9,501	14,251.5	9.5	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	70%	6.70	6.16	0.54
LPN	15%	1.40	-	1.40
PCA	15%	1.40	-	1.40

Placentia Medicine Unit

Unit Overview and Organizational Factors

The Medicine Unit is an eight-bed inpatient medical unit located adjacent to the Emergency Department outpatient area. While ten beds are budgeted, two beds have been repurposed to support Emergency Department patient flow. The nursing station is located within a repurposed family room, which limits visibility across the unit and constrains workflow.

Physician coverage on the Medicine Unit includes scheduled attendance twice per week. In the absence of consistent on-unit physician presence, Emergency Department physicians provide medical oversight for Medicine patients.

Strengths:

- The Medicine Unit provides inpatient medical care within proximity to the ED, supporting operational coordination between inpatient and emergency services.
- The physical adjacency of the Medicine Unit to the ED enables shared clinical oversight when required.
- ED physicians provide coverage for Medicine patients, if needed
-

Client Factors

The Medicine Unit supports a medically complex inpatient population requiring ongoing monitoring and physician oversight.

Relative to 2022–23, average occupancy on the Medicine Unit increased. LOS rose from 2022–23 to 2023–24 before declining in 2024–25. [REDACTED]

[REDACTED] ALC days accounted for 52.1% of inpatient days in 2023–24 and 38.4% in 2024–25 on the Medicine Unit, indicating that a proportion of inpatient utilization was attributable to patients designated as alternate level of care.

Table 111: Patient Activity in Placentia Medicine Unit

Patient Activity

MEDICINE UNIT	2022-23	2023-24	2024-25
Bed Staffed	-	-	-
% Occupancy	51.6%	73.3%	62.9%
Total LOS	1,867	2,682	2,206
Avg LOS	20.1	27.4	21.2
ALC Days	436	1,118	705
% ALC	24.9%	52.1%	38.4%
Discharges	93	98	104

Note: Source, Meditech Admissions Module. A breakdown of ALC by discharge destination was not available at the time of this report; however, this information could provide additional context to better understand the drivers of these rates

Staffing Factors

The Medicine Unit and adjacent ED follow a team-based model, with RNs and LPNs working together to manage patients. There are no PCAs on the unit. [REDACTED]

[REDACTED]

Below are the current state staffing table and a summary of each core team roles, with one RN 24/7 and one LPN for the day shift.

Table 112: Shift Rotation Schedule for Placentia Medicine Unit

Shift	RN	LPN
08:00-20:00	1	1 (8h only present from 8-16h)
20:00-08:00	1	0

Nurse Practitioner

- There is no NP providing coverage on the unit.

Registered Nurse

- [REDACTED]

Licensed Practical Nurse

- For 12-hour day shifts, workload increases are typically addressed by assigning two LPNs or one LPN paired with one PCA, while night shifts may see an additional LPN assigned, contingent on staff availability.
- [REDACTED]

Allied Health

- Allied Health (shared with LTC):
 - Social Worker (0.2 FTE)
 - Physiotherapist (0.2 FTE)
 - Occupational Therapist (0.3 FTE)
 - Dietician and Diabetic nurse shared between LTC and Acute visits two times a week
- 4 Physicians on site shared between Family Practice, Medicine unit and LTC
 - Limited on-site physician presence requires nursing staff to escalate clinical concerns and coordinate care across units.

Support Staff

- Ward Clerk shared with LTC & Acute.
- Registration Clerk M-F 8h-16h30.
- Storage / Supply resource M-F for 4hr shared between Acute & LTC

The data highlighted below show that actual FTEs for the Medicine Unit exceeded budgeted levels across all years. This pattern indicates a variance between budgeted and actual staffing levels.

Table 113: Actual versus Budgeted FTE in Placentia Medicine Unit

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
MEDICINE UNIT	7.1	7.8	7.1	8.3	7.4	10.3	1.6
LPN	1.19	1.80	1.19	1.93	1.19	2.15	0.8
RN	5.95	5.75	5.95	6.14	6.24	7.36	0.4

Note: Source, NLHS General Ledger.

Workload Analysis – HPPD

The HPPD for the inpatient unit falls below the peer benchmark range. This variance may reflect differences in the acuity of the patient population, including ALC percentages and the unique team-based model with the ED.

Table 114: HPPD for Medicine Unit in Placentia

Hours Per Patient Day (HPPD)			
MEDICINE UNIT	2022-23	2023-24	2024-25
Nursing UPP	4.8	3.2	5.1
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Average based on Unit Producing Hours		5.6-6.8	

Note: Calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT 'IP Medical Inpatient Services' unit data of at least 10 comparable sites – based on the number of beds, volume of visits, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Medicine Unit

This section summarizes the recommended future-state staffing for Placentia Medicine unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for Placentia Medicine unit

- Target HPPD is reflective of the average HPPD over the last 3 years.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Maintain the current level of budgeted RN FTEs, as an additional RN has been added to day coverage in the ED to avoid redeploying the RN from the Medicine unit for triage support.
2. Maintain the current level of budgeted LPN FTEs, as one LPN has been added to provide overnight support in the ED when a single RN is on duty
3. Leverage ED-based PCA resources shared across the Emergency Department, Medicine unit, Ambulatory Care, and the Family Care Team to support integrated service delivery and provide flexible coverage, where required.

Table 115: Recommended Budgeted (FTE) Positions and Skill Mix for Placentia Medicine Unit

Future State

Target Calculations				
Target HPPD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
4.5	2,206	9,927.0	6.6	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	92%	6.24	6.24	-
LPN	8%	1.20	1.20	-
PCA	-	-	-	-

Placentia Family & Ambulatory Care Unit

Unit Overview and Organizational Factor

The Ambulatory Care Clinic in Placentia provides scheduled, appointment-based outpatient services, including chemotherapy administration and take-home chemotherapy disconnect, enabling patients to receive oncology care locally.

The clinic is supported by a NP who provides assessment and follow-up care for scheduled patients. The NP role is shared with LTC, requiring coordination across programs. The clinic does not operate on weekends, and patient needs during this period are redirected to the ED.

Strengths:

- Provides scheduled, appointment-based services that support predictable patient flow and coordinated care delivery.
- NP support contributes to continuity of care through assessment, monitoring, and follow-ups for enrolled patients.
- Participants have indicated that existing NP provide mentorship support to newly appointed NP, contributing to role transition and continuity within the service.

Client Factors

Care is delivered through predictable, scheduled treatments and follow-up visits, including chemotherapy administration, take-home chemotherapy disconnects, and routine clinical monitoring.

Patient visits increased by 7% and 24% for ambulatory and family units respectively, over the past three years from 2022 to 2025.

Table 116: Patient Visits to Placentia Family Practice and Ambulatory Units

Patient Visits

UNIT	2022-23	2023-24	2024-25
AMBULATORY	1,584	1,645	1,697
FAMILY	592	652	732

Note: Source, NLHS General Ledger.

Staffing Factors

The Family and Ambulatory Care Clinic is staffed by NP, RN, and LPN and operates within a team-based care model. Below are the current state staffing table and a summary of each core team roles.

Table 117: Shift Rotation Schedule for Placentia Family and Ambulatory Care Unit

Shifts	NP	RN	LPN
8:00-16:00 (Mon-Fri)	0.92 (Mon 13-17h, Thur-Fri 9-17h)	1	1 (12-16)

Note: Reported by unit.

Nurse Practitioner

- One NP works M-F 8hr per day. The NP does LTC on Monday morning from 9 to 12 only, so would go back to ambulatory care from 13 to 17h. This split assignment adds predictability to daily operations. In addition to core staff, the clinic has one casual RN who provides intermittent support.
- NP provides mentorship support to newly appointed NP, contributing to role transition and continuity within the service.

Registered Nurse

- One RN assigned to an 8-hour day shift (Monday to Friday).
- Participants reported that there is one casual RN position for the unit.

Licensed Practical Nurse

- One LPN scheduled from 12:00 to 16:00 during weekdays.

- [REDACTED]
- [REDACTED]

Personal Care Attendants

- No PCA on the unit.

Allied Health

- Allied Health (shared with LTC):
 - SW 0.2 FTE
 - PT 0.2 FTE
 - OT 0.3 FTE
 - Dietician and Diabetic nurse 2x/week shared between LTC & Acute

Support Staff

- Ward Clerk shared with LTC & Acute.
- Registration Clerk M-F 8h-16h30
- Storage / Supply resource M-F for 4hr shared between Acute & LTC

Table 118: Actual Versus Budget FTEs for Family and Ambulatory Care Units

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
FAMILY	1.6	1.9	1.6	1.7	1.6	1.6	0.1
LPN	0.64	0.85	0.64	0.69	0.64	0.57	0.1
NP	1.00	1.06	1.00	1.01	1.00	1.01	0.0
AMBULATORY	1.4	1.2	1.4	1.1	1.4	1.2	-0.2
RN	1.36	1.14	1.36	1.13	1.36	1.24	-0.2

Note: Source, NLHS General Ledger.

Table 119: Hours Breakdown in Placentia Ambulatory Units

Hours Breakdown

FAMILY	2022-23	2023-24	2024-25	YoY trend from 2022-23 to 2024-25
Overtime	50	130.5	45.5	-9%
NP	-	3	8	167%*
LPN	45	127.5	37.5	(17%)
RN	5	-	-	N/A
Sick Time	138	172	370	168%
NP	-8	128	103	+111**
LPN	83	39	37	(55%)
PCA	63	5	230	265%
RN	50	130.5	45.5	(-9%)

Note: *For Overtime LPN, YoY calculated from 2023-24 to 2024-25. **Reported increase in hours, not percent increase. Source, NLHS General Ledger and Payroll.

Workload Analysis – HPPV

The unit's HPPV falls in line with comparable sites.

Table 120: HPPV for Family and Ambulatory Care Units

Hours Per Patient Visit (HPPV)				
Unit		2022-23	2023-24	2024-25
AMBULATORY	Nursing UPP	1.0	0.9	0.8
FAMILY	Nursing UPP	2.0	1.6	1.2
Peer Benchmark (HPPV)		2022-23	2023-24	2024-25
Average based on Unit Producing Hours			0.12 -1.28	

Note: Calculated using NLHS General Ledger and discharge data. Peer Benchmarks were calculated using Ontario HIT 'AC Clinic Medical' and 'AC Medical Combined' unit data of at least 10 comparable sites – based on number of beds, volume visits, and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPV.

Future State Recommendations – Family & Ambulatory Care Unit

This section summarizes the recommended future-state staffing for Placentia Family & Ambulatory care unit. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for Placentia Family & Ambulatory unit

- Target HPPV is reflective of peer benchmarking.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

- Family Care Unit:
 1. Increase NP staffing to 2.0 FTE to support the current Family Practice and Ambulatory Clinic, and to expand coverage for the LTC units (currently limited to emergency coverage on Monday mornings for 4 hours). Recognizing that one NP is currently in training and is expected to transition into the second NP role upon completion.

2. Maintain the current LPN budget. LPN resources support both Family Practice and Ambulatory care.
- Ambulatory Care Unit:
 1. Maintain current state staffing. The LPN is assumed to support across the Family and Ambulatory care unit.

Table 121: Recommended Budgeted (FTE) Positions and Skill Mix for Placentia Family Care Unit

Future State

Target Calculations				
Target HPPV	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
0.5	732	366.0	0.2	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	2.0	1.0	1.0
RN	-	-	-	-
LPN	100%	0.64	0.64	-
PCA	-	-	-	-

Table 122: Recommended Budgeted (FTE) Positions and Skill Mix for Placentia Ambulatory Care Unit

Future State

Target Calculations				
Target	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
0.6	1,697	1,018.20	0.6	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	100%	1.36	1.36	-
LPN	-	-	-	-
PCA	-	-	-	-

Lions Manor Long-Term Care Unit I, II, III**Unit Overview and Organizational Factors**

Lions Manor is the long-term care component of the Placentia site and delivers residential care across three units with distinct capacity and care environments. Participants mentioned that the Lions Manor provides Level III and Level IV nursing care and is co-located with 40 accessible cottages offering supportive housing for seniors and adults with disabilities aged 50 and over.

- Unit I accommodate 30 residents and includes a dedicated palliative care bed.
- Unit II comprises 28 beds within a protective and behaviourally supportive neighbourhood.

- Unit III includes 17 residential beds, with some beds intermittently unavailable due to staffing-related absences.

The facility includes a mix of private and double rooms, supported by shared indoor communal areas and accessible outdoor spaces used across all units. Of the 75 licensed long-term care beds at the site, 28 are located within the Protective Care unit. Two rooms are designated for respite care and have been used for extended admissions. Most resident rooms are equipped with mechanical lifts. Protective Care residents use a shared shower space, with privacy enhancements underway. Private rooms include individual bathrooms, while double rooms share bathroom facilities. Communal spaces are available for residents and family use.

Strengths:

- Clearly defined unit structure supports differentiated care environments, including general long-term care, protective care, and palliative care capacity.
- Most resident rooms are equipped with mechanical lifts, supporting safe mobility and transfers.
- On-unit occupational therapy and physiotherapy services support resident mobility and functional maintenance.

Client Factors

It was mentioned from participants that residents admitted to Lions Manor LTC present with complex clinical needs and higher acuity profiles. They described that residents are entering LTC later in the disease trajectory, often with multiple comorbidities and advanced care requirements. Participants reported that routine care needs include:

- Ongoing clinical monitoring
- Medication administration
- Wound management
- Intravenous therapy
- Mobility assistance
- Support with activities of daily living

Additionally, participants indicated that residents typically undergo a comprehensive physician review at least annually.

Table 123: Resident Days Trends for Lions Manor LTC

Resident Days Trend

2022-23	2023-24	2024-25
23,598	20,863	21,303

Note: Source, NLHS General Ledger.

Staffing Factors

Lions Manor’s staffing model NPs, RNs, LPNs, and PCAs for its three long-term care units, supported by clinical resources. [REDACTED] The float pool comprises three RNs rotating among Med, ER, and LTC, with an additional casual employee providing intermittent support.

Units may deliberately overstaff to mitigate anticipated sick time. When sick time does not occur, staff remain on shift, resulting in actual staffing levels exceeding budget. Regional workforce availability constraints further influence the achievable skill mix. Additionally, the inclusion of TCI in actuals can inflate reported staffing levels relative to budget.

Below are the current state staffing table and a summary of each core team roles.

Table 124: Shift Rotation Schedule for Placentia LTC I, II, III Unit

Unit	Lions Manor LTC Unit I (30 beds & 1 palliative bed)				Lions Manor LTC Unit II (28 beds)				Lions Manor LTC Unit III (17 beds)			
Shifts	NP	RN	LPN	PCA	NP	RN	LPN	PCA	NP	RN	LPN	PCA
8:00-20:00	0.03 (One NP in LTC on Mondays 9-12)	0.5 (12hr shift RN covers Unit 1&3)	2	3 (2 12h & 1 8h)	0.03 (One NP in LTC on Mondays 9-12)	1	2	3 (2 12h & 1 8h)	0.03 (One NP in LTC on Mondays 9-12)	0.5 (12hr shift RN covers Unit 1&3)	1	2 (1 12h & 1 8h)
20:00-8:00	0	0.33 (12hr shift RN covers all units)	1	1	0	0.33 (12hr shift RN covers all units)	1	1	0	0.33 (12hr shift RN covers all units)	1	1

Note: Unit III was recently reopened due to previous staffing shortages.

Nurse Practitioner

- One NP provides coverage for LTC on Monday mornings from 9 to 12 only and goes back to family/ambulatory care from 13 to 17h.

Registered Nurse

- From 8:00-16:00, 1 RN (12-hour RN shared with Unit 3) and from 16:00-00:00, 1 RN (shared across all the LTC units). Unit 2 has 1 dedicated RN.
- RNs are responsible for a wide range of tasks, including staffing coordination, patient care, medication management, and frequent communication with dispatch and physicians, which significantly limits their available time for clinical care.
- RN additions are used when licensed scope coverage is still required.

Licensed Practical Nurse

- Participants report that during patient bathing an LPN must always be present, and most patients require two staff members for lifting assistance.
- All LTC units, LPNs are present on days, evenings, and nights. Typically:
 - Days: 1–2 LPNs per unit
 - Evenings: 1 LPN per unit
 - Nights: 1 LPN per unit

Personal Care Attendants

- All LTC units, PCAs are present on all shifts. Typical pattern:
 - Days: 2–3 PCAs per unit

- Evenings: 1 PCA per unit
- Nights: 1 PCA per unit
- PCAs are used specifically as a mitigation strategy for LPN shortages (within scope).

Allied Health

- Allied Health (shared with Acute Care):
 - SW 0.2 FTE
 - PT 0.2 FTE
 - OT 0.3 FTE
 - Dietician and Diabetic nurse 2x/week.
 - Recreation Specialist 1 FTE
 - Recreation Worker 1 FTE
 - Recreation Therapy: 1 Recreational Worker vacancy (position currently unfilled).
 - TCI 1 FTE used for constant care relief
- Occupational therapy and physiotherapy services are delivered directly on the units.
- 4 Physicians on site shared between Family Practice, Medicine unit and LTC – ¾ of the physician will round LTC unit 1x per week and have their own assigned unit (challenge with consistency).
- All physicians are assigned to their respective units once per week, usually conducting rounds in the morning for several hours. Physicians do not see all patients; rather, they review a list of assigned patients requiring attention.

Support Staff

- 1 Ward clerk shared between Acute & LTC
- Storage / Supply resource M-F for 4hr shared between Acute & LTC

The data highlighted below show a declining trend in agency hours over time, alongside differences between budgeted and actual FTEs across units, indicating that staffing coverage was managed through a combination of agency utilization and adjustments to permanent staffing levels, with reduced agency reliance in 2024–25 occurring alongside increased actual FTEs in Units 1 and 2.

Table 125: Annual Agency Hours by Unit for Placentia

Agency Hours

Unit	2022-23	2023-24	2024-25
Total	3,910	5,336	356
LIONS MANOR UNIT I	1,139	2,011	255
LIONS MANOR UNIT II	1,223	342	101
PLACENTIA HEALTH CARE	1,548	2,983	-

Table 126: Actual Versus Budget FTEs for Placentia LTC Units

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
UNIT I	30.5	29.7	29.9	31.3	28.9	34.8	2.2
LPN	9.64	12.62	9.63	12.20	8.63	10.02	2.3
PCA	13.91	10.87	13.43	12.36	13.43	13.74	-1.3

RN	6.93	6.18	6.82	6.76	6.82	11.07	1.1
UNIT II	23.5	23.8	22.7	25.1	22.1	23.8	1.5
LPN	8.95	10.39	8.90	10.22	8.33	8.78	1.1
PCA	11.84	10.93	11.08	13.02	11.09	13.44	1.1
RN	2.71	2.48	2.71	1.88	2.71	1.54	-0.7
UNIT III	14.3	10.8	13.6	1.9	13.6	5.1	-7.9
LPN	6.23	7.06	5.98	1.22	5.98	2.44	-2.5
PCA	8.03	3.78	7.63	0.65	7.63	2.64	-5.5
RN	0.00	0.00	0.00	0.07	0.00	0.01	0.00

Note: Source, NLHS General Ledger.

Table 127: Hours Breakdown in Placentia Lions Manor LTC Units

Hours Breakdown

Lions Manor LTC I, II, III	2022-23	2023-24	2024-25	YoY trend from 2-22-23 to 2024-25
Overtime	10583	9705	7851	-25.8%
PCA	3131	3418	2879	-8.0%
LPN	6859	5802	4483	-34.6%
RN	594	485	488	-17.8%
Sick Time	17203	19615	7353	168.1%
NP	-	-	-	-
LPN	4594	6394	4179	-55.4%
PCA	9233	9236	7252	265.1%
RN	3376	3985	-4078	-9.0%

Note: Source, NLHS General Ledger and Payroll.

Workload Analysis – HPPV

Lions Manor LTC units have experienced fluctuating HPRD. Staff have stated that as the aging population remains at home longer, residents enter LTC with more comorbidities and higher care needs.

Table 128: HPRD for Placentia LTC Units

Hours Per Resident Day (HPRD)

LTC Unit	2022-23	2023-24	2024-25
UNIT 1 LPN, RN, PCA	2.9 (RN/LPN 60%, PCA 40%)	2.9 (RN/LPN 56%, PCA 44%)	3.4 (RN/LPN 55%, PCA 45%)
UNIT 2 LPN, RN, PCA	3.0 (RN/LPN 58%, PCA 42%)	2.7 (RN/LPN 53%, PCA 47%)	2.9 (RN/LPN 46%, PCA 54%)
UNIT 3 LPN, RN, PCA	3.6 (RN/LPN 66%, PCA 34%)	N/A	N/A

Note: Calculated using NLHS General Ledger and discharge data. Data for 2023-24 and 2024-25 is N/A due to the unit being closed because of staffing shortages.

Future State Recommendations

This section summarizes the recommended future-state staffing for Placentia Lions Manor LTC Unit I, II, III. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for Placentia Lions Manor LTC Unit I, II, III:

- Target HPRD is based on the provincial government Long-Term Care and Personal Care Review.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model of Unit I, II, III are recommended to align with target skill mix noted in methodology on page 4:

Unit I:

1. Maintain the current level of budgeted LPN FTEs while increasing PCA support, which frees up LPN capacity to focus on licensed nursing duties and reduces the need for LPNs to perform non-nursing tasks (e.g. multiple patient washes per day).
2. Add three PCA positions, consisting of one on the day shift and two on the night shift, to strengthen direct care coverage and improve workforce sustainability.
3. Reduce RN FTEs compared to the current budgeted level, as the addition of PCA resources enables more effective use of LPN capacity while maintaining safe and appropriate care delivery.

Unit II:

1. Increase RN FTEs compared to the current budget to meet the target HPRD and support achievement of the required staffing level.
2. Maintain the LPN staffing level relatively unchanged, recognizing its continued role in supporting care delivery under the revised model.
3. Increase PCA staffing by adding one PCA on the day shift and one PCA on the night shift to strengthen direct care coverage and support overall workforce sustainability.

Unit III:

1. Increase night-shift PCA coverage to two PCAs and standardize PCA scheduling by moving to two 12-hour PCA shifts, replacing the current model of one 12-hour shift and one 8-hour shift.

Table 129: Recommended Budgeted (FTE) Positions and Skill Mix for Placentia Lions Manor LTC Unit I

Future State

Target Calculations

Target HPRD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
4	10,950	43,800.00	29.20

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	15%	4.38	6.82	-2.44
LPN	30%	8.63	8.63	-
PCA	55%	16.10	13.43	2.67

Table 130: Recommended Budgeted (FTE) Positions and Skill Mix for Placentia Lions Manor LTC Unit II

Future State

Target Calculations

Target HPRD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
4	10,220	40,880.0	27.2

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	15%	4.10	2.71	1.39
LPN	30%	8.3	8.3	-
PCA	55%	15.0	11.10	3.90

Table 131: Recommended Budgeted (FTE) Positions and Skill Mix for Placentia Lions Manor LTC Unit III

Future State

Target Calculations

Target HPRD	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions
4	6,205	24,820.00	16.55

Skill Mix

Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	-	-	-
RN	13%	2.20	-	2.20
LPN	30%	5.00	6.00	-1.00
PCA	57%	9.40	7.60	1.80

Health Science Centre

Site Overview

The Health Sciences Centre (HSC) in St. John's is the province's primary tertiary acute care and teaching hospital, providing specialized services to patients from across the province. The site supports a broad range of complex medical and surgical programs and is closely affiliated with Memorial University, serving as a key teaching environment for medicine, nursing, and allied health professionals.

Two inpatient units are in the scope of this review:

- Unit 4NA: specializes in hematology and oncology and has a total of 35 beds, including 8 dedicated oncology beds and 12 hematology beds.
- Unit 4NB: focuses on surgical, plastics, and burn care, effectively operating as a mixed surgical and trauma unit. The unit has a total of 42 beds, including dedicated space for burn patients (e.g., inpatient rooms, burn tub room).

Review of these units will support matching of staffing levels and skill mix with the highly acute, and specialized nature of services.

Key Observations by Role:

Charge Nurse

- 4NA and 4NB still utilize the traditional charge nurse role on night shifts, when care coordinators are unavailable. Both the charge nurse and the care coordinators are not intended to take patient assignments.

Nurse Practitioner

- NP roles embedded on both inpatient units (one NP on 4NA; two NPs on 4NB, 1 for burns and plastics and 1 assigned to ED admissions)
- NP coverage identified as a key clinical resource for nursing staff
- NP role is vital for care coordination due to units having mixed patient populations
- NP presence mitigates gaps related to off service- or distributed physician coverage
- Expanded NP coverage identified by staff as beneficial to care delivery and team support

Registered Nurse

- RNs provide primary clinical oversight across both inpatient units
- Specialized RN care models in place for high acuity, complex medical and surgical patients
- RNs manage care for patients from multiple services on mixed population units
- RNs absorb indirect and non-clinical tasks where support roles are limited

Licensed Practical Nurse

- LPN role limited or not consistently referenced across inpatient units

- LPNs not identified as a consistently embedded component of HSC inpatient staffing models

Patient Care Assistant

- PCA availability inconsistent across inpatient units
- Limited PCA support contributes to increased reliance on RNs for basic and indirect care tasks
- PCA coverage is not embedded as a consistent feature of inpatient staffing models

Unit 4NA

Unit Overview and Organizational Factors

4NA is the inpatient hematology oncology unit, located on the 4th floor, north wing of the main campus. It comprises 8 medicine beds, 26 hematology/oncology protected beds, and 1 surge bed, with no OCP spaces. The configuration of private rooms and 4-bed wards allows the unit to cohort patients with specialized needs.

The physical layout of the unit includes a stretcher in the hallway with privacy curtains, a shower room now functioning as coat/jacket storage, and a very small supply room. The team culture is positive, with a strong sense of teamwork.

Strengths:

- The unit has integrated (temporarily) a mentor support role, with demonstrated success in support for onboarding, preceptorship, and clinical skill development.
- The unit has expanded its pool of chemotherapy trained RNs to meet specialized care needs.
- RN-led model supported by a dedicated Hematology/Oncology NP and supplemental PCA support (via central staffing) enables care delivery for high- acuity-, clinically complex patients despite sustained high occupancy.

Client Factors

The unit cares primarily for hematology and oncology patients, including individuals on extended treatment regimens, often with six-week admissions and intermittent home discharge. Admissions are a mix of direct admissions, emergency department admissions, and recurring oncology patients.

Patients have moderate to high acuity with frequent variability in clinical status. Care needs commonly include frequent monitoring, oxygen therapy, telemetry, and neurological or neurovascular assessments, with the potential for rapid escalation. Level of acuity is guided by site definitions used in the Acuity Assignment Manager (AAM) platform implemented at the site.

Table 132: AAM Definitions for HSC 4NA

Acuity Level	Patient Condition	Typical Care Needs	Illustrative Ratio Implications
Level 1 – Very High Acuity	Unstable or deteriorating patients requiring the highest level of care and escalation to Critical Care or tertiary services.	Continuous monitoring; rapid clinical changes; high risk of deterioration; potential transfer to Critical Care.	1:1 or 1:2 depending on workload
Level 2 – High Acuity	Patients with high acuity medical needs requiring frequent monitoring, advanced therapies, and intensive nursing care.	Frequent vital signs; advanced respiratory or cardiac support; total assist with ADLs; complex medication management.	1:2 nurse assignment

Acuity Level	Patient Condition	Typical Care Needs	Illustrative Ratio Implications
Level 3 – Moderate Acuity	Patients requiring regular monitoring, intermittent supports, and moderate nursing involvement.	Regular assessments; intermittent oxygen or telemetry; assistance with mobility or ADLs; scheduled treatments.	1:2 to 1:3 assignment
Level 4 – Lower Acuity	Stable medical patients requiring routine monitoring and minimal assistance.	Minimal interventions; routine assessments; basic medications; largely independent care needs.	1:3 or greater assignment

Note: Source, ICM – Acuity Assignment Manager definitions.

Patients on the unit present with high clinical complexity, including cardiac and respiratory conditions, delirium, withdrawal syndromes, and significant mobility limitations.

Patient length of stay often exceeds the expected length of stay.

Unit occupancy consistently exceeds 95%, resulting in a recent increase in beds from 31 to 35 staffed beds – budgeted staff has not increased (see Staffing Factors). While ALC days have declined by 22% over the last 3 years, off-service patients, admitted due to limited bed capacity across the site (e.g., general medicine), contribute to ALC pressures – with LTC discharges representing >50% of ALC.

Table 133: Patient Activity Data for HSC 4NA

Patient Activity

HSC 4NA HEAMO/ONCOLOGY	2022-23	2023-24	2024-25
Bed Staffed	31.00	35.00	35.00
% Occupancy	100%	99%	93%
Total LOS	13,829.0	13,838.0	13,682.0
Avg LOS	12	12	12
ALC Days	1,598	1,221	1,129
% ALC	12.5%	9.7%	9.1%
Discharges	1,117	1,142	1,173

Note: Source, Meditech Admissions Module.

Table 134: Reason for ALC for HSC 4NA

Reason for ALC – waiting for:

HSC 4NA HEAMO/ONCOLOGY	2022-23	2023-24	2024-25
LTC	928	575	649
Palliative	343	403	184
Community Health	7	46	4
Home Supports	77	92	74
Other Services (e.g., OT/PT, Rehab)	131	57	144

HSC 4NA HEAMO/ONCOLOGY	2022-23	2023-24	2024-25
Other (e.g., patient refusing discharge, other assessment)	87	27	144
Equipment	4	8	18
Personal	21	8	33

Note: Source, Meditech Admissions Module.

Staffing Factors

The unit operates with an RN-only model. The unit utilizes 2 unfunded PCA roles supplied through central staffing at the site level. There are no current RN vacancies. However, budgeted roles have not increased despite the number of staff beds increasing over the last 2 years; actuals have increased proportionally.

The unit employs Internationally Educated Nurses (IENs), who require extra orientation time, which have resulted in unplanned vacant shifts.

Specialized competencies, such as running chemotherapy protocols, are required, and the number of chemo-trained nurses has increased to meet patient needs. The unit has one Nurse Practitioner (NP) for Hematology-Oncology, with a 1:24 ratio that fluctuates based on admissions, and no General Practitioner in Oncology (GPO).

High rates of overtime are common,

Table 135: Actual Versus Budgeted FTEs for HSC 4NA

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
HSC 4NA HEAMO/ONCOLOGY	49.4	47.7	49.4	47.8	49.6	50.5	0.8
LPN	0.38	0.57	0.38	0.02	0.38	0.10	0.2
NP	0.50	0.00	0.50	0.43	0.50	1.08	0.0
PCA	1.35	2.05	1.35	0.58	1.35	0.12	0.5
RN	47.17	45.04	47.17	46.72	47.37	49.18	0.3

Note: Source, NLHS General Ledger.

Table 136: Shift Rotation Schedule for HSC 4NA

Shift	RN (Facilitator)	RN (Educator)	NP	RN	LPN	PCA
07:30-19:30	1	0	0	10	0	2 (Unfunded)
08:00-16:00	0	0.33	1	0	0	0
19:30-07:30	0	0	0	7	0	0

Note: Information collected from site engagement. The clinical nurse educator is shared between 3 units at HSC. The 2 PCA positions on Days are unfunded.

Workload Analysis – HPPD

The unit's HPPD falls in line with comparable sites.

Table 137: HPPD for HSC 4NA

Hours Per Patient Day (HPPD)			
HSC 4NA HEAMO/ONCOLOGY	2022-23	2023-24	2024-25
Nursing UPP	4.4	5.4	5.3
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Range based on Unit Producing Hours		5.4 – 9.9	

Note: HSC 2022-23 actuals calculated using General Ledger and Distract Abstract Data. HSC 2023-24 and 2024-25 actuals provided by ANSOS Productivity Reports. Peer Benchmarks were calculated using Ontario HIT data of at least 10 comparable sites – based on the number of beds, total patient days and nature of services delivered on site. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Unit 4NA

This section summarizes the recommended future-state staffing for Unit 4NA. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for 4NA:

- Target HPPD was obtained through ICM reporting modules.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Increase NP budget from part time to full time role, to maintain patient flow and quality care, reflected in the current staff model.
2. Increase in RN budget to maintain current scheduling approach, and cover expected and unexpected vacancies.
3. Increase PCA budget and utilization of 1 PCA on days and 1 PCA on nights.

Table 138: Recommended Budgeted (FTE) Positions and Skill Mix for Unit 4NA

Future State

Target Calculations				
Target	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
5.61	13,350.00	74,893.5	49.9	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	1.25	0.5	0.75
RN	95-99%	49.90	47.37	2.53
LPN	-	-	0.38	-0.38
PCA	1-5%	2.50	1.35	1.15

Unit 4NB

Unit Overview and Organizational Factors

Unit 4NB is a 42-bed unit located on the fourth floor of the north wing of the main campus. The unit is divided into:

- 36 core beds
- 4 special care beds
- 1 OCP beds and
- 1 surge beds

This delineation of beds allows the unit to accommodate a diverse patient population with varying levels of care needs and cohort appropriately. The special care unit is isolated with a dedicated nursing station. All other rooms are covered by a central nursing station.

Strengths:

- Senior RNs provide ongoing onboarding, supervision, and competency support for new graduates and IENs, sustaining clinical capability in a high acuity environment.
- Clear delineation of core, surge, and Special Care beds, supported by AAM guided acuity levels and ratios, enables flexible staffing and cohorting for unpredictable trauma, burn, and surgical demand.
- RN-led model with dedicated NP support, Special Care staffing, burn care roles, and shared educator/facilitator functions supports delivery of complex, resource intensive- care.

Client Factors

The unit supports a complex and high-acuity adult patient population, including general surgery, plastics, burns, trauma, post-operative robotics, and some medical overflow patients. Effectively operating as the only trauma and burn unit in the province, the unit receives patients from all zones and manages some of the most clinically unstable and resource-intensive cases. Patient mix and acuity are unpredictable, which requires flexible bed allocation and an inability to protect beds, resulting in frequent capacity pressures and occasional service disruptions. Level of acuity is guided by site definitions used in the Acuity Assignment Manager (AAM) platform implemented at the site.

Table 139: AAM Definitions for HSC 4NB

Acuity Level	Patient Condition	Typical Care Needs	Illustrative Ratio Implications
Level 1 – Very High Acuity	Special Care or unstable patients requiring enhanced staffing ratios or escalation to Critical Care or tertiary services.	1:1 or 1:2 staffing; continuous monitoring; burn or special care needs; high risk of deterioration.	1:1 or 1:2 depending on workload
Level 2 – High Acuity	Patients with high acuity medical or post-operative needs requiring frequent monitoring, complex pain control, and intensive nursing care.	Frequent vital signs; advanced respiratory or cardiac support; complex pain management; total assist with care needs.	1:2 nurse assignment
Level 3 – Moderate Acuity	Patients requiring regular monitoring, post-operative or medical care, and moderate nursing involvement.	Regular assessments; post-operative monitoring; assistance with mobility or feeding;	1:2 to 1:3 assignment

Acuity Level	Patient Condition	Typical Care Needs	Illustrative Ratio Implications
		scheduled treatments and education.	
Level 4 – Lower Acuity	Stable medical or post procedure patients requiring routine monitoring and minimal assistance.	Minimal interventions; routine post procedure care; basic medications; patient largely independent.	1:3 or greater assignment

Note: Source, ICM – Acuity Assignment Manager definitions.

Patient acuity on the unit ranges from low, typically off-service patients, to very high, including designated Special Care patients requiring 1:2 or 1:1 nursing ratio. High-acuity patients frequently require continuous monitoring, complex clinical interventions, and extensive assistance with daily care, resulting in consistently high-intensity nursing assignments.

A sustained volume of off-service patients has historically altered the unit's patient mix and contributed to a higher proportion of Alternate Level of Care (ALC) patients. However, the rates of ALC have decreased by half in the last year, while occupancy, discharges, length of stay and beds staffed remained stable – indicating an overall higher acuity of patient population.

Table 140: Patient Activity Data for HSC 4NB

Patient Activity

4NB GENERAL SURGERY	2022-23	2023-24	2024-25
Bed Staffed	40	34	39
% Occupancy	99%	99%	98%
Total LOS	12,953	13,864	14,696
Avg LOS	8.1	9.1	8.9
ALC Days	798	858	476
% ALC	7.2%	7.3%	3.9%
Discharges	1,605	1,519	1,656

Note: Source, Meditech Admissions Module.

Table 141: Patient Activity Data for HSC 4NB Special Care Unit

Patient Activity

4NB Special Care	2022-23	2023-24	2024-25
Total LOS	299	257	288
Avg LOS	4	9	7
ALC Days	1	3	0
Bed Staffed	4	4	4
% Occupancy	92.9%	95.4%	94.7%

Note: Source, Meditech Admissions Module.

Table 142: Reason for ALC for HSC 4NB

Reason for ALC – waiting for:

4NB GENERAL SURGERY	2022-23	2023-24	2024-25
LTC	573	610	270
Palliative	11	42	8
Community Health	0	10	5
Home Supports	53	71	74
Other Services (e.g., OT/PT, Rehab)	105	81	57
Other (e.g., patient refusing discharge, other assessment)	32	21	5
Equipment	18	13	30
Transportation	3	10	14
Personal	3	0	13

Note: Source, Meditech Admissions Module.

Staffing Factors

Unit 4NB is staffed primarily by RNs with access to limited PCAs – with 1 on days (budgeted) and 1 on nights (unfunded) - and 2 NPs (1 covering burns and plastics and 1 covering ED admissions). There are no LPNs assigned to the unit. In addition to general inpatient care, Unit 4NB functions as the Burn Care Unit, requiring a high level of specialized clinical knowledge, technical skill, and competency to safely manage complex burn patients.

High turnover, sick and other leave has resulted in frequent number of short-staffed shifts and intermittent vacancy challenges. In response, the unit has increasingly relied on travel nursing, Internationally Educated Nurses (IENs) and new graduates to maintain baseline staffing levels. This has resulted in senior staff dedicating more time to onboarding, supervision, and competency support for novice nurses while balancing their patient assignments. RN agency hours indicate travel/agency utilization, with 400 hours in 2024 and 91 hours to date in 2025.

A recently established central float pool process has resulted in short staffing on the unit to resource level other units, specifically cardiology and orthopaedics.

This has resulted in the unit often working short staffed, reflected in the -2.4 RN FTE variance between budgeted and actual FTEs.

Table 143: Actual Versus Budgeted FTEs for HSC 4NB

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
4NB GENERAL SURGERY	61.3	57.5	61.4	58.4	62.0	61.9	-2.3
LPN	0.14	0.05	0.14	0.05	0.14	0.22	0.0
NP	1.00	1.13	1.00	1.11	1.00	2.00	0.4

PCA	3.36	3.91	3.36	2.75	3.39	2.76	-0.2
RN	56.82	52.38	56.86	54.49	57.48	56.99	-2.4

Note: Source, Meditech Admissions Module.

Table 144: Shift Rotations for HSC 4NB

Shift	RN (Facilitator)	RN (Educator)	NP	RN	LPN	PCA
07:30-19:30	2 (07:30-15:30)	0.25 (08:00-16:00)	2 (07:30-15:30)	12 (9 on the floor, 2 SCU, 1 Burn)	0	2
15:30-23:30	1	0	0	1 (Burn Care Assist)	0	0
19:30-07:30	0	0	0	9 (7 on the floor, 2 SCU)	0	1

Note: Information collected from site engagement. The clinical nurse educator is shared between 4 units at HSC. On Sundays, 4NB goes down to 1 PCA. The PCA on nights is an unfunded position.

Workload Analysis – HPPD

The unit's HPPD falls below comparable sites.

Table 145: HPPD for HSC 4NB

Hours Per Patient Day (HPPD)			
4NB GENERAL SURGERY	2022-23	2023-24	2024-25
Nursing UPP	5.7	5.6	5.5
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Range based on Unit Producing Hours		6.2 – 14.3	

Note: HSC 2022-23 actuals calculated using General Ledger and Distract Abstract Data. HSC 2023-24 and 2024-25 actuals provided by ANSOS Productivity Reports. Peer Benchmarks were calculated using Ontario HIT data of at least 10 comparable sites – based on the number of beds, total patient days, nature of services, and academic site designation. HIT Unit Producing Hours may include roles not in scope of review, resulting in a higher range of HPPD.

Future State Recommendations – Unit 4NB

This section summarizes the recommended future-state staffing for Unit 4NB. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for 4NB:

- Target HPPD was obtained through ICM reporting modules.

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

4. Increase NP budgeted positions and optimize utilization to support efficient patient flow.
5. Maintain current RN budget and scheduling approach, including coverage for the Special Care unit.
6. Increase LPN budgeted positions and optimize utilization to support care for predictable patient populations.
7. Increase PCA budgeted positions and ensure full utilization of budgeted PCA hours.

Table 146: Recommended Budgeted (FTE) Positions and Skill Mix for Unit 4NB

Future State

Target Calculations				
Target	Total Patient Days	Total Hours to Schedule	Recommended Budgeted (FTE) Positions	
6.78	13,500	91,530	61.0	
Skill Mix				
Role	Target Skill Mix	Recommended Budget (FTE)	2024-2025 Current Budget	Budget Impact
NP	-	2.00	1.00	1.00
RN	95-99%	61.00	57.50	3.50
LPN	0%	-	-	-
PCA	1-5%	3.39	3.39	-

Mount Pearl Square

Site Overview

Mount Pearl Square is situated in St. John's West and acts as a centre for various services, such as:

- Community clinics
- Districts (home visits)
- Public health services
- Mental health and addictions support

Mount Pearl Square offers nursing and community-based care, including health assessments, clinical follow-up, nursing support, information sharing, referrals, service navigation, outreach, and programs for families, youth, and seniors. Home- and community-based nursing services help clients stay safely at home by providing in-home nurse visits and care.

Public Health and Mental Health and Addictions services emphasize prevention, early intervention, and recovery-oriented care. Public health programming includes health promotion, immunization, disease prevention, and maternal, child, and family health supports. Mental Health and Addictions services provide counselling, peer support, and integrated harm reduction and overdose prevention services. Together, these programs align with NL Health Services priorities, improve access to care, reduce reliance on acute settings, and support population health outcomes in Eastern Urban Newfoundland and Labrador.

Community services are allocated to site operations based on district assignments informed by civic address data. Historically, Mount Pearl Square has managed approximately six districts within the St. John's West area, which has an estimated population of approximately 239,300 as of 2024. At the time of this review, district boundaries were undergoing rebalancing with neighbouring operations to support a more equitable distribution of workload. As part of this realignment, districts within Zone 3 were adjusted, resulting in the transfer of approximately 50–60 clients from Mount Pearl Square's catchment area to a Zone 4 team. The impact of this redistribution on staff workload and client outcomes are currently unknown and should be assessed at a later date.

Table 147: District (Home) and Clinic Referrals for MPS

MPS Referrals

MPS	2022-23	2023-24	2024-25
Total Home Visit Referrals	1225	1102	1292
Total Clinic Referrals	2021	2010	2364
Total Chemo Clinic	106	94	121
Total New Referrals	3246	3112	3656

Community Services – Clinics

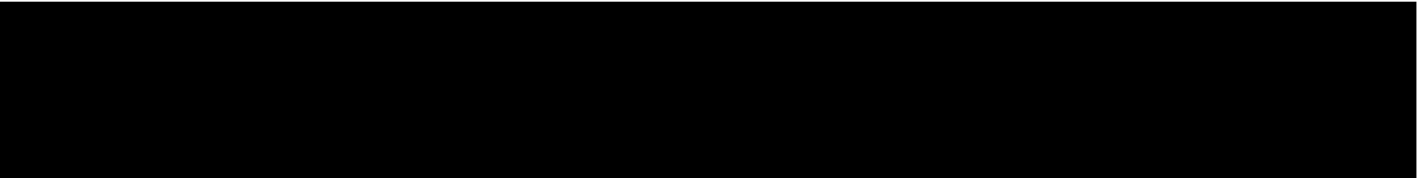
Program Overview and Organizational Factors

Situated in St. John's West, Mount Pearl Square Clinics provides care to the local community and surrounding areas. There are five clinics in operation Clinic 1, Clinic 2, Clinic 9, Clinic 10, and Clinic 12, offering services Monday to Friday, with two clinics extending their hours into the evening to accommodate a wider range of clients. Clinic 9 operates only on Wednesday to Friday and there is one clinic on Saturday and Sunday. It was mentioned that the Community Health services operate under a flex-time agreement.

Flex time is accrued when nurses work beyond regularly scheduled day-shift hours for operational reasons and may be used for leaving in accordance with established leave approval processes. Overtime is managed separately and requires prior approval.

MPS operates in a renovated former mall, the main entrance leads to a small waiting area with three registration windows.

Strengths:



Client Factors

Clients accessing services at Mount Pearl Square clinics present with a wide range of healthcare needs and levels of clinical complexity. Participants reported that services are delivered through scheduled appointments, with no formal wait times for initial assessments, and that care is provided based on client need and service type. Participants described a diverse client population, including individuals requiring:

- Chronic disease management
- Intravenous (IV) therapy
- Vaccinations and communicable disease follow-up
- Support for newcomers, including health education and care coordination

Participants reported that recent outbreaks of communicable diseases, including tuberculosis, measles, varicella, and pertussis, have increased vaccination activity and appointment volumes, including pre-travel and catch-up immunizations.

Since October 2025, participants indicated that a high volume of IV admissions has required repeated clinical reassessments. Participants noted that extended treatment courses may result in multiple reassessment visits, contributing to increased ED utilization for follow-up care. Participants further described that client needs have increased in both volume and complexity, particularly among newcomer populations. Reported care requirements include additional time for education and assessment, informed consent, interpretation, and follow-ups.

Table 148: Patient Activity Data for MPS – Clinics

Patient Activity

MPS – Clinics	2022-23	2023-24	2024-25
Clinic Visits — Total Number	9671	9815	11043
Clinic Visits — Average per day	27	27	30
Average Duration of Clinic Visit (min)	30.11	30.53	29.69
Total Number of Virtual Visits	7688	7601	7799
Virtual Visits — Average per day	21	21	31
Average Duration of Virtual Visit (min)	15.89	15.94	16.8

Note: Source, NLHS CRMS Data.

Table 149: Patient ED Referrals Request for MPS – Clinic

Patient ED Referrals Request

Period	Total IV admissions	ER returns for reassessment
Oct 1 – Dec 31, 2025	100	39

Note: Source, MPS Site Manager.

Staffing Factors

Participants have mentioned that the clinics at Mount Pearl Square operates with a staff-to-patient ratio that generally ensures individualized care, with nurses seeing patients on a 1:1 basis. In cases where client or site risk assessments indicate a need for additional support, or the treatment requires it, a 2:1 ratio may be implemented. Each clinic is scheduled for 11 appointments per day, from 8:30 AM to 4:30 PM, though double booking may occur to accommodate varying visit lengths and increased demand. All visits are appointment-based to maintain efficient workflow and minimize wait times.

Clinic operations involve ongoing tasks such as stocking supplies, which are managed throughout the day as needed.

The clinics also field numerous patient calls, including requests to reschedule appointments and inquiries about services.

Table 150: Actual Versus Budgeted FTEs for MPS - Clinics

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
MPS – Clinics	1.00	1.01	1.00	1.01	1.00	1.10	0.0
RN	1.00	1.01	1.00	1.01	1.00	1.10	0.0

Note: Source, NLHS Statistical General Ledger.

Below are the current state staffing table and a summary of each core team roles; all validated through site-level stakeholder engagement.

Table 151: Opening Hours for MPS - Clinics

Opening Hours		Clinic	RN	LPN
Mon-Fri	08:30-16:30	Clinic 1	1	-
		Clinic 2	1	-
		Clinic 10	1	-
		Clinic 12	-	1
Wed-Thurs-Fri only	08:30-16:30	Clinic 9	1	-
Mon-Fri	13:00-21:00 (<i>pilot until Feb 28</i>)	Evening Clinic	2	-
Sat & Sun	08:30-16:30	-	1	-

Nurse Practitioner

- There are currently no NPs supporting the program despite perceived benefits from staff to reassess patients, facilitate referrals, and potentially reduce ED visits.

Registered Nurse

- Clinic hours are Monday through Friday, 8:30 AM to 4:30 PM, with Clinics 1, 2, and 10, each staffed by an RN
- Clinic 9 operates exclusively on Wednesdays, Thursdays, and Fridays, also with one RN
- An evening clinic, piloting until February 28th, runs Monday through Friday from 1:00 PM to 9:00 PM and is staffed by two RNs. Staff have noted that the addition of this evening clinic has significantly alleviated workload pressures and improved overall efficiency.
- Weekend coverage consists of one RN from 8:30 AM to 4:30 PM on both Saturday and Sunday.
- On-call coverage is provided from 16:30 to 24:00 Monday through Friday, and from 08:30 to 24:00 on Saturday and Sunday by one RN shared between the clinic and district visits.
- An RN Team Lead (CHNII position) is shared between the districts and clinics, fulfilling responsibilities like those of a care coordinator, working Monday to Friday from 08:30 to 16:30.
- There is a float pool consisting of five staff members to cover unfilled positions; however, these individuals cannot be utilized for sick leave coverage as they are allocated to vacancy management, and recruitment is currently delayed by five to six months. Since the float pool cannot be used to cover sick calls, nurses on duty must absorb the extra workload left by colleagues on sick leave, increasing their daily responsibilities.
- Nurses retrieve patients from the waiting room and manage their clinic rooms and supplies.

Licensed Practical Nurse

- Clinic hours are Monday through Friday, 8:30 AM to 4:30 PM, with clinic number 12 staffed by a LPN.

Personal Care Attendants

- No PCA supporting the program.

Allied Health

- No Allied Health dedicated capacity to support the program.

Support Staff

- Clerical staff are available on site to alleviate some of the administrative workload.
- Clerical staff registers patients and notifies the nurse of their arrival.

Workload Analysis – HPPV

Table 152: HPPD for MPS – Clinics

Hours Per Patient Day (HPPD)			
MPS - Clinics	2022-23	2023-24	2024-25
Nursing UPP	0.84	0.83	0.80

Future State Recommendations – MPS - Clinics & Home Visits

This section summarizes the recommended future-state staffing for MPS – Clinics and District Visits. As the available data combined both clinic and home visits, the recommendations are presented jointly for the MPS Community Services Program.

In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for MPS – Clinic & Home Visits

- Target HPPV was calculated using the average 3 years

Based on the recommended budgeted (FTE) positions, the following adjustments to the staffing model are recommended:

1. Adding one NP to the MPS Community Services Program to address gaps identified by staff related to increasing client complexity, limited access to primary care, IV-reassessments, palliative and end-of-life care, and the lack of timely in-community assessment for clients requiring medical decision-making, which currently results in avoidable referrals to the Emergency Department and additional pressure on community nursing staff
2. Explore the application of additional analytical considerations to inform resourcing decisions for home visits in community care services to account for key variables associated with this care delivery model. NLHS should assess staff modelling approaches that other regional or national home and community care providers to determine characteristics applicable for MPS or other community sites. For example, SE Health applies a geo-optimization model. These tools support decision-making by assessing how workforce capacity, geographic distribution, and future demand can be better aligned. This may include:
 - Incorporating demand forecasting inputs such as projected visit volumes, geographic distribution of clients, and workload trends over time to anticipate future service.
 - Establishing clear performance KPIs (e.g., visits per nurse, productivity targets, travel distance per nurse) to define expected workforce output and ensure alignment with service demand.
 - Accounting for geographic factors, including travel time, distance between visits, and client dispersion, to better understand their impact on productivity and staffing.

- Assessing workforce capacity relative to demand, by comparing required versus current FTE based on forecasted workload, productivity assumptions, and geographic realities to identify potential gaps or surpluses.

Table 153: Current Budgeted (FTE) Positions and Target HPPV for MPS – Clinics

Future Stat=[

Target	Total Patient Days	Total Hours to Schedule
0.82	24 640	20 294.8

Role	2024-2025 Current Budget
NP	0.0
RN	15.0
LPN	1.9
PCA	-

Note: The future-state recommendations outlined here apply to the entire Mount Pearl Square Community Services Program.

Community Services – Districts (Home Visits)

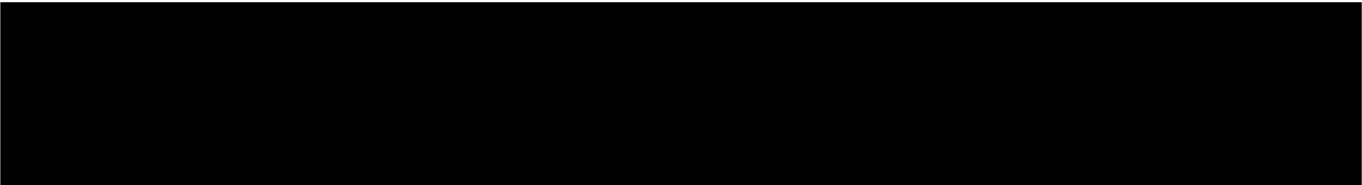
Program Overview and Organizational Factors

Mount Pearl Square – Districts (Home Visits), located in St. John’s West, functions as a central hub for community health services. The program delivers scheduled home-based care to clients across five defined geographic zones. As part of the provincial Community Health program, services are provided to individuals requiring ongoing health support in the home setting, including:

- Chronic disease management
- Post-discharge follow-up
- Ongoing clinical monitoring and intervention
- Other community-based health services delivered outside of facility settings

Care delivery is organized by geographic districts to support coverage, coordination, and continuity of services across the catchment area.

Strengths:



Client Factors

Participants reported that Mount Pearl Square community service home visits support clients with a range of clinical and social care needs, including:

- Newcomer populations
- Individuals requiring palliative and end-of-life care
- Clients receiving intravenous (IV) therapy
- Clients with combined medical and social complexity

Participants indicated that IV therapy and palliative care delivered in the home setting often involve multiple visits over extended periods. These visits may include repeated clinical monitoring and assistance with activities of daily living. It was reported that some clients require extensive support with activities of daily living, including bed-bound clients receiving IV antibiotics. IV therapy was described as requiring repeated home visits as part of treatment courses.

Participants also reported an increase in overall client complexity and associated care coordination requirements across programs.

Table 154: Patient Activity Data for MPS – Districts (Home Visits)

Patient Activity

MPS – Clinics	2022-23	2023-24	2024-25
Home Visits — Total Number	11,147	11,965	13,597
Home Visits — Average per day	31	33	37
Average Duration of Home Visit (min)	35.57	35.16	34.43

Note: Source, NLHS CRMS Data.

Staffing Factors

Community Health – District services operate with a staffing ratio of one nurse per client. A two-nurse assignment is used when required based on client needs, treatment requirements, or documented risk assessments. District nurses are scheduled for an average of six home visits per day, with visit volume adjusted as service demand requires.

District nurses manage a range of responsibilities, including scheduled home visits, intake of referrals, and provision of care to clients receiving palliative services. Nurses are assigned either to clinic-based duties or community-based care, with assignment adjusted based on operational requirements.

Table 155: Actual Versus Budgeted FTEs for MPS – Districts (Home Visits)

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
MPS – Districts (Home Visits)	16.74	19.06	16.59	19.97	16.85	22.67	3.8
RN	1.89	1.99	1.89	2.00	1.89	1.63	0.0
LPN	14.86	17.07	14.71	17.97	14.97	21.04	3.9

Note: Source, NLHS Statistical General Ledger.

Below are the current state staffing table and a summary of each core team roles; all validated through site-level stakeholder engagement.

Table 156: District Hours Schedule for MPS District Visits

Shifts		RN	LPN
Mon-Fri	08:00-16:30	8 +1 float	1
Sat-Sun	08:00-16:30	2	0

Nurse Practitioner

- There are currently no NPs supporting the program despite perceived benefits from staff to reassess patients, facilitate referrals, and potentially reduce ED visits.

Registered Nurse

- Monday to Friday, between 08:00 and 16:30, the staffing complement consists of eight RNs and one float RN.
- At weekends, from 08:00 to 16:30, staffing is reduced to two RNs, with no LPN coverage.
- On-call coverage for both the clinic and district visits is provided by a single RN, who is responsible for the period between 16:30 and 24:00 on weekdays, and from 08:30 to 24:00 on Saturdays and Sundays.
- RNs are assigned their own caseloads and, in the mornings, nurses prioritize home and district visits. Their responsibilities shift during the afternoons and evenings to tasks such as charting, completing special assistance program (SAP) forms, screening referrals, making client phone calls, and entering data.
- District nurses frequently work alone and rely on their colleagues for assistance when managing high-acuity cases.
- Staff absences are not routinely covered, which places additional pressure on the remaining team members and a float pool of five RNs is used to fill vacancies only since recruitment is behind by approximately five to six months.
- During flu season, nurses are reassigned to vaccination clinics but are still expected to complete their district responsibilities in reduced time frames, increasing both workload and stress.
- RNs may spend several days coordinating home support services, a task that social workers can accomplish more efficiently, further adding to their workload.

Licensed Practical Nurse

- Monday to Friday, between 08:00 and 16:30, the staffing complement consists of one LPN.
- LPNs are assigned their caseloads based on their scope of practice and are shared between districts as required.

Personal Care Attendants

- There are no PCAs supporting home visits.

Allied Health

- No Allied Health dedicated capacity to support the program.

Support Staff

- Clerical staff registers patients and notifies the nurse of their arrival.

Workload Analysis – HPPV

The workload analysis can be found in the section above and applies to the entire Mount Pearl Square Community Services Program.

Future State Recommendations – MPS - Districts (Home Visits)

The future-state recommendations outlined in the section above applies to the entire Mount Pearl Square Community Services Program.

Public Health

Program Overview and Organizational Factors

The Mount Pearl Square Public Health Program is a community-based initiative committed to delivering coordinated prevention, health promotion, and outreach activities. Its primary aim is to improve population health, reduce health risks, and support the well-being of residents through organized, equitable, and evidence-informed public health actions.

Public Health services at Mount Pearl Square are offered from Monday to Friday, between 8:30 a.m. and 4:30 p.m. Clinics 3, 4, 5, 6, 7, 8, and 11 are dedicated to Public Health. In addition to these clinic-based services, nurses also travel to schools to provide support for children's health needs.

The Communicable Disease Control (CDC) function operates as an integral part of Public Health and is co-located with Mount Pearl Square. The CDC supports surveillance and response activities, working in coordination with other programs as a component of the broader public health system.

Strengths:

- Public Health services are delivered through a provincial program model, supporting standardized service delivery and alignment with provincially defined mandates and schedules.
- Services are RN-led, with clearly defined roles focused on preventive care, child health, immunization, and population-based programming.
- The Communicable Disease Control (CDC) function is integrated within Public Health and co-located at Mount Pearl Square, supporting coordinated surveillance and response activities.

Client Factors

Public Health delivers clinic-based services across a defined set of programs, including:

- Child Health Clinics (2–18 months)
- Child Health Clinics (4 years)
- Adult Clinics
- Scheduled appointments such as immunizations, individual health assessments, weight checks, and targeted follow-up visits

Participants reported changes in client profiles associated with newcomer populations, including:

- Communicable disease presentations such as tuberculosis, measles, chickenpox, and whooping cough
- Increased immunization activity, enhanced surveillance, and additional follow-up, particularly for children and other priority populations
- Increased use of education, counselling, and repeat engagement
- Rebooking and multiple follow-ups, particularly for child health and family-based services
- Alternative communication approaches (e.g., three-way calls) when interpreter services are unavailable, with repeat visits required in some cases

Participants also noted expanded immunization requirements related to:

- Early Measles, Mumps, and Rubella (MMR) vaccination
- Infant travel outside the province
- Outbreak response activities

School health programming includes:

- Immunization clinics
- Coordinated follow-up related to communicable disease cases within classroom settings

Collectively, it was described that there is a variability of time requirements per visit associated with coordination, communication, and follow-up activities across Public Health services.

Table 157: Patient Activity Data for MPS – Public Health

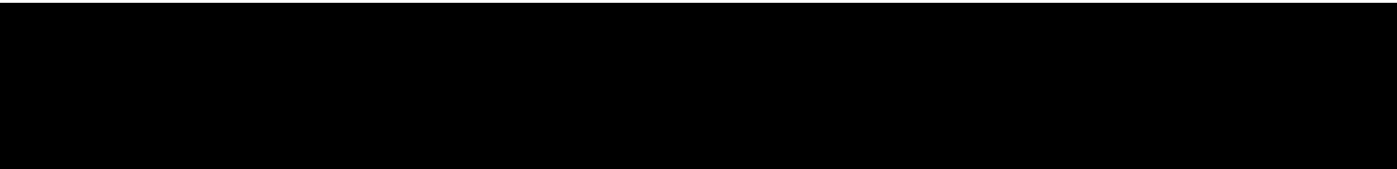
Patient Activity

MPS – Public Health	2022-23	2023-24	2024-25
Home Visits — Total Number	643	532	605
Home Visits — Average per day	2	2	2
Average Duration of Home Visit (min)	90	90	90
Clinic Visits — Total Number	7752	7752	7752
Clinic Visits — Average per day	21	21	21
Average Duration of Clinic Visit (min)	60	60	60

Note: Source, NLHS CRMS Data.

Staffing Factors

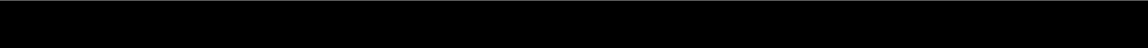
Public Health services are delivered by RNs and LPNs across school based and clinic-based programs.



A significant portion of nursing time is dedicated to administrative and non-clinical activities, including:

- Filing and chart management
- Data entry and reporting
- Processing school health records and related documentation

These activities reduce the time available for direct care within existing staffing resources.

 Following discharge after birth, responsibility for postnatal follow-ups is transferred from Family Care Teams to Public Health. In the context of limited general practitioner availability, Public Health nurses initiate referrals for newborn care. In some cases, this transition has been associated with delays in early follow-up appointments.

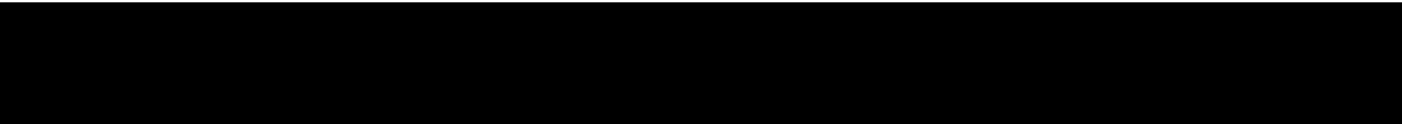


Table 158: Actual Versus Budgeted FTEs for MPS – Public Health

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
MPS – Public Health	24.79	26.12	27.08	28.39	26.36	31.39	2.6
NP	0.92	1.01	1.00	1.03	1.00	1.00	0.0
RN	21.09	22.39	22.86	24.43	22.64	27.28	2.5
LPN	2.78	2.72	3.22	2.94	2.72	3.11	0.0
PCA	0.00	0.00	-	-	-	-	0.0

Note: Source, NLHS Statistical General Ledger. Note that Public FTEs include Communicable Disease Control (CDC)

Table 159: Clinic Operating Hours for MPS Public Health

Operating Hours		Clinic	RN	LPN	PCA
Mon-Fri	8:30-4:30	Clinics # 3, 4, 5, 6, 7, 8 & 11 are dedicated to Public Health	13.5 RN CHN I	2.5 FTE	Not applicable

Nurse Practitioner

- No NP supporting the program.

Registered Nurse

- Public Health clinics operate Monday to Friday from 8:30 a.m. to 4:30 p.m. across designated clinic spaces and are staffed by 13.5 RNs Community Health Nurse I positions.
- Weekend Public Health services are primarily delivered through home visits rather than clinic appointments, with two RNs scheduled each weekend to respond to urgent public health needs.

-
-

Licensed Practical Nurse

- Public Health clinics operate Monday to Friday from 8:30 a.m. to 4:30 p.m. across designated clinic spaces and are staffed by 2.5 full-time equivalent LPNs.

-

Personal Care Attendants

- No PCAs assigned.

Allied Health

- No Allied Health dedicated capacity to support the program.
- Specialized roles, such as lactation consultants, contribute valuable expertise.

- [REDACTED]

Support Staff

- Clerical support is available to support the program and takes on some supply management related responsibilities (e.g. ordering, restocking the clinic rooms, etc.) in addition to administrative and clerical support (e.g. faxing documents to schools).

Workload Analysis – HPPV

The unit’s HPPV falls in line with comparable sites.

Table 160: HPPD for MPS – Public Health

Hours Per Patient Day (HPPV)			
MPS – Public Health	2022-23	2023-24	2024-25
Nursing UPP	0.14	0.11	0.11
Peer Benchmarks (HPPV)	2022-23	2023-24	2024-25
Range based on Unit Producing Hours			

Note: x

Future State Recommendations – MPS - Public Health

This section summarizes the recommended future-state staffing for MPS – Public Health. In addition to the approach described in the Data and Analytics section of the Context and Approach chapter, the following assumptions apply to calculations for MPS – Public Health

- Target HPPV was calculated using the average 3 years

The following adjustments to the staffing model are recommended:

1. Explore the application of additional analytical considerations to inform resourcing decisions for home visits in community care services, similar to geo-optimization approaches used by SE Health. These tools support decision-making by assessing how workforce capacity, geographic distribution, and future demand can be better aligned. This may include:
 - Incorporating demand forecasting inputs such as projected visit volumes, geographic distribution of clients, and workload trends over time to anticipate future service.
 - Establishing clear performance KPIs (e.g., visits per nurse, productivity targets, travel distance per nurse) to define expected workforce output and ensure alignment with service demand.
 - Accounting for geographic factors, including travel time, distance between visits, and client dispersion, to better understand their impact on productivity and staffing.
 - Assessing workforce capacity relative to demand, by comparing required versus current FTE based on forecasted workload, productivity assumptions, and geographic realities to identify potential gaps or surpluses.

Table 161: Current Budgeted (FTE) Positions and Target HPPV for MPS - Public Health

Future State

Target	Total Patient Days	Total Hours to Schedule
0.12	8,357	893.4

Role	2024-2025 Current Budget
NP	1.0
RN	22.6
LPN	2.7
PCA	0.0

Mental Health and Addictions

Program Overview and Organizational Factors

The Community Mental Health Discharge Liaison Nurse role focuses on assessment and consultation. This is a one-of position within the West Team and includes responsibility for independently case-managing an assigned client caseload. The West Team meets weekly, providing regular opportunities for consultation. Management support is readily available, with the manager on site as needed.

Strengths:

- The implementation of the CorCare system is expected to strengthen documentation in community settings and improve communication.
- Admission criteria are broad and inclusive, allowing access for all clients awaiting community mental health services.
- The program currently has no waitlist.

Client Factors

Participant stated that clients served by the role are individuals discharged from acute care who are awaiting access to community Mental Health and Addictions services. Admission criteria are broad and open to all clients awaiting community mental health services. Clients present with varied diagnoses and complex needs, including financial and housing challenges.

Services provided may include assistance with housing needs, linking clients to community resources, supportive counselling, community integration, assistance with employment needs, and medication education. The program serves clients across the Eastern Urban Zone, including St. John's and surrounding communities. At the time of reporting, there is no waitlist for services. The primary diagnosis may encompass a range of mental health and addiction conditions based on the specific program to which the patient is referred. Possible diagnoses include anxiety, depression, substance use disorders, suicidal ideation, schizophrenia, bipolar disorder, among others, depending on individual patient needs.

It was mentioned that the length of each visit varies depending on the scope of work required and may range from approximately 30 minutes to several hours.

Caseload volume and acuity fluctuate based on client needs and the availability of downstream services.

Service delivery was described as involving a combination of office-based, community, and home visits, along with virtual and telephone contacts. In addition, the role includes frequent consultation and coordination with the interdisciplinary care team and community partners to support clients' recovery goals, including housing, finances, medication management, and access to services.

It was further mentioned that returns to acute care are rare, as clients remain with the Discharge Liaison program only until they are successfully connected to appropriate community MH&A services.

Table 162: Patient Activity Data for MPS MH&A

Patient Activity

MPS MH&A	2023	2024	2025
Total Number of Clients Served	51.00	67.00	48.00

Note: Source, Manager of Mental Health and Addictions.

Staffing Factors

The Discharge Liaison Nurse manages the client caseload independently. Responsibilities include assisting clients with activities of daily living, housing support, linking clients with community resources, and employment support. These responsibilities include tasks outside the traditional nursing scope of practice. It was also mentioned that the Discharge Liaison program supports clients with high and variable acuity as they transition from acute care settings to community-based services. The role provides interim support while clients await acceptance into appropriate Mental Health and Addictions community programs.

Table 163: Actual Versus Budgeted FTEs for MPS MH&A

	2022-23		2023-24		2024-25		Average Variance
	Budget	Actual	Budget	Actual	Budget	Actual	
MPS MH&A	1.01	0.86	1.01	1.01	1.01	1.00	0.05
RN	1.01	0.86	1.01	1.01	1.01	1.00	0.05

Note: Source, NLHS Statistical General Ledger.

Nurse Practitioner

- No NP coverage provided for the program.

Registered Nurse

- A single RN works Monday to Friday from 8 a.m. to 4 p.m., with no coverage if the nurse is absent due to illness or other reasons. The role is designed for one person and covers a wide geographic region.
- This position requires working independently across a large area.

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Licensed Practical Nurse

- No LPNs supporting the program.

Personal Care Assistant

- No PCAs supporting the program.

Allied Health

- It was reported that there are no dedicated allied health or support staff assigned to this role. The position operates as a single shared role covering a large geographical area.

Support Staff

- There is no dedicated support staff assigned to this role.

Workload Analysis – HPPV

The unit’s HPPV falls in line with comparable sites.

Table 164: HPPD for MPS – MH&A

Hours Per Patient Day (HPPV)			
MPS – MH&A	2022-23	2023-24	2024-25
Nursing UPP	4.4	5.4	5.3
Peer Benchmarks	2022-23	2023-24	2024-25
Range based on Unit Producing Hours		5.4 – 9.9	

Note: x

Future State Recommendations – MPS - Public Health

Due to limitations in site-provided data regarding the full scope of activities associated with this role, a comprehensive service review is recommended. This will enable a clearer understanding of service delivery and support the development of population-based staffing recommendations.



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