BRITISH COLUMBIA
Ministry of Health

MINIMUM NURSE-TO-PATIENT RATIO

Implementation Instructions for B.C. Health Organizations

Ministry of Health

Division

Nursing Policy Secretariat

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Acknowledgment

The Ministry of Health acknowledges the traditional territories of the Indigenous Peoples, First Nations, and Métis chartered communities throughout B.C. and welcomes their graciousness toward our work that strives to support the health and wellness for all in B.C.

Introduction

Background on minimum Nurse-to-Patient Ratios in British Columbia

Nursing is complex work, often undertaken in challenging clinical environments. Nurses are skilled, emotionally resilient, and are responsible for providing effective and safe patient care that adheres to quality practice standards. The implementation of minimum Nurse-to-Patient Ratios (mNPRs) in British Columbia (BC) is intended to contribute to enabling nurses to provide safe patient care within improved quality practice and learning environments.

A Memorandum of Understanding (MoU) was signed between the Ministry of Health (the Ministry) and the Nurses' Bargaining Association (NBA) to implement minimum Nurse-to-Patient Ratios alongside the Provincial NBA Collective Agreement and as part of the Shared Recovery Mandate on April 4, 2023.

On March 1, 2024, B.C. became the first jurisdiction in Canada to announce 10 ratios for hospital-based care for nurses, anchoring the delivery of patient care to a standard formula. The ratios represent a minimum number of nurses deemed necessary to care for a number of patients[1]. The ratio includes licensed practical nurses (LPN), registered psychiatric nurses (RPN), and registered nurses (RN), working in BC. Planning is underway to establish minimum Nurse-to-Patient Ratios in all nursing practice contexts.

What is mNPR?

Achieving healthy workplace environments for nurses requires implementing new strategies. mNPRs have shown to save lives and improve patient and nurse experiences.[2] As per the policy directive, ratios are absolute at the unit level and prescribe the total number of nurses to be scheduled per shift. The implementation of mNPRs will strive to ensure that patient assignments are always regularized and in ratio. At times patient assignments will not be in ratio due to unforeseen changes in patient acuity and/or intensity requiring nursing teams to work together to ensure safe patient care while immediate efforts are undertaken to secure additional workload to bring patient assignments on the unit into ratio. The charge nurse plays a key role in coordinating patient assignments.

mNPR Proposed Outcomes

[1] Patients, clients, and residents of long-term care or assisted living facilities.
[2] Evidence that Reducing Patient-to-Nurse Staffing Ratios Can Save Lives and Money | National Institute of Nursing Research (nih.gov)

Provincial mNPR Governance Structure

A provincial Executive Steering Committee (ESC) comprised of members of the Ministry of Health, the NBA, Health Employers Association of BC (HEABC) and Health Organization leaders was established in 2023 to facilitate the introduction of mNPRs. Working groups, made up of staff and leaders from the Ministry, NBA, HEABC, and Health Organizations, provide recommendations on establishing mNPR (see Appendix A).

Collective Agreement Conflict

If there is conflict between the NBA Collective Agreement and mNPR implementation, senior leadership from the Ministry and NBA will attempt to resolve by mutual agreement.

About this Implementation Instruction Manual

Who is this Implementation Instruction Manual intended for?

The manual is developed to provide implementation instructions to the BC Health Organizations[3] who are implementing the Ministry's mNPR policy direction. The manual is designed to enable Health Organizations to use a standardized approach as the mNPR policy directives are implemented.

For **BC Health Organizations**, this manual provides direction and information on:

- The Ministry's policy direction, definitions, and supplementary direction.
- Roles and responsibilities for supporting successful implementation.
- The development of the mNPR implementation plan.
- Monitoring and sustainment.

How to use this Manual

We acknowledge that this is a lengthy and comprehensive document. Sections of this manual have been divided to help with providing the reader an understanding of the mNPR model in BC, the implementation documents, and the submission templates. This manual will be augmented over time through the incorporation of lessons learned from the planning and implementation process, along with a focus on continuous improvement processes for future implementation.

[3] Regional Health Authorities, Providence Health Care, and the Provincial Health Services Authority

Section 1: Implementation Principles

Section 1 provides instructions and direction to Health Organizations in pre-planning and preparing their submission for implementing the ratios. Health Organizations will work with NBA partners through the Joint Regional Implementation Committee (JRIC) to receive enabling guidance, expert advice, and input as the implementation plans are being developed. mNPRs will be implemented through a phased approach, starting with the 10 mNPRs in hospital-based care settings announced in March 2024.

Implementation Principles

The Memorandum of Understanding outlines the following principles:

- Builds on actions within the Provincial Health Human Resources (HHR) Strategy.
- Aligns with ongoing work to advance effective team-based models of care.
- Uses continuous improvement approaches to transfer knowledge quickly.
- Includes LPN, RPN, and RN nursing designations.
- Implement in hospital-based care, long term care (LTC) and assisted living (AL), and community and non-hospital care settings across the province, per the MOU.

The above principles are strengthened by the below set of principle elements:

1. **Safety**
   - Patient care outcomes
   - Meeting practice standards
   - Quality practice and learning environments
   - Cultural, physical, and psychological safety for everyone (staff and patients)
2. **Transparency**
   - Information and sharing
   - Respectful
   - Clear language
   - On-going, open, two-way communication
3. **Courage**
   - New initiatives and processes embraced
   - Address challenges, conflicts, and potential roadblocks to align discussions with desired outcomes
4. **Innovation**
   - Seek opportunities
   - Adaptive and forward thinking
   - Continuous improvement of processes, practices, and outcomes
5. **Accountability**
   - Clear, transparent, enforceable, and backed by appropriate actions
6. **Indigenous Health and Reconciliation**
   - Addressing anti-Indigenous specific racism

- Aligning with commitments in DRIPA, notably themes number three and four, in the In-Plain Sight, BC Cultural Safety and Humility Standards, and other foundational documents

7. **Diversity, Equity, Inclusion, Accessibility and Belonging**
   - Unique needs of staff and patients/families are realized/accepted
8. **Collaboration**
   - Mindful inclusion approach – participation of multiple individuals working together to develop alternatives and identify the preferred solution

Implementation Requirements

The Ministry's policy directive applies to all BC Health Organizations and defines mandatory expectations for mNPR including objectives, scope, population outcomes, governance, and accountability framework. The governance and accountability framework will allow the Ministry to evaluate and assess if Health Organizations have achieved the intended outcomes.

Additional clarity on the Charge Nurse, break coverage, rotation changes, hold and evaluate, nursing designations (nursing mix), patient assignment, team-based care, mixed units, and off service patients is provided in Section 3. These must be used to complete the Implementation Planning Template.

Joint Regional Implementation Committee (JRIC)

The purpose of the Joint Regional Implementation Committee (JRIC) is to provide guidance, expert advice, and support the resolution of issues or barriers as the Health Organization develops and executes the implementation plan for each of the mNPR policy directives that are in scope within their respective regions. The Health Organization holds accountability for the implementation of the Ministry of Health's mNPR policy directives. The Health Organization and NBA are responsible for developing partnered approaches through the JRIC that support mNPR implementation in the region.

JRICs will have six (6) **core members**, with equal representation from the NBA and the Health Organization. Membership for the Health Organization must include the Chief Nursing Officer, one (1) senior operational leader with a nursing background, and one (1) senior labour relations leader; and from the NBA, representation will include one (1) elected representative, one (1) senior labour relations leader, and one (1) other NBA representative.

The Executive Director, mNPR Implementation will be a non-voting ex-officio member of the JRIC and uphold responsibility to engage with the JRIC regarding the implementation plan, implementation progress, implementation quality improvement efforts, and implementation challenges, including opportunities for issues mitigation.

The NBA and Health Organizations will respectively submit names for their co-chair recommendations and the MOH will review the submissions and endorse the two **co-chairs**.

Role and Responsibilities of mNPR Executive Director

The Executive Director, mNPR Implementation reports to the Chief Nursing Officer in the Health Organizations. The ED provides leadership on the implementation of mNPRs across

nursing practice areas in Health Organizations in alignment with the MoU, the Ministry policy direction, supplementary directive documents, and the NBA Collective Agreement. The ED, mNPR also collaborates with the Health Organizations Human Resources and Operations Leadership and engages with direct care nursing staff and NBA regional and local representatives to enable site and/or unit level implementation. The ED liaises between the Health Organization, JRIC, and the Ministry Project Office to provide progress reports, identify challenges and risks, and seek feedback where appropriate.

Ministry of Health Project Office

Under the guidance of the Provincial Executive Lead, Nursing Ratios, and the Ministry's Executive Director of mNPR, the Project Office will be responsible for ESC secretariat support, centralized project oversight, implementation supports, and communications. The Project Office will also support coordination efforts for the review of the implementation plans.

Resolving Challenges

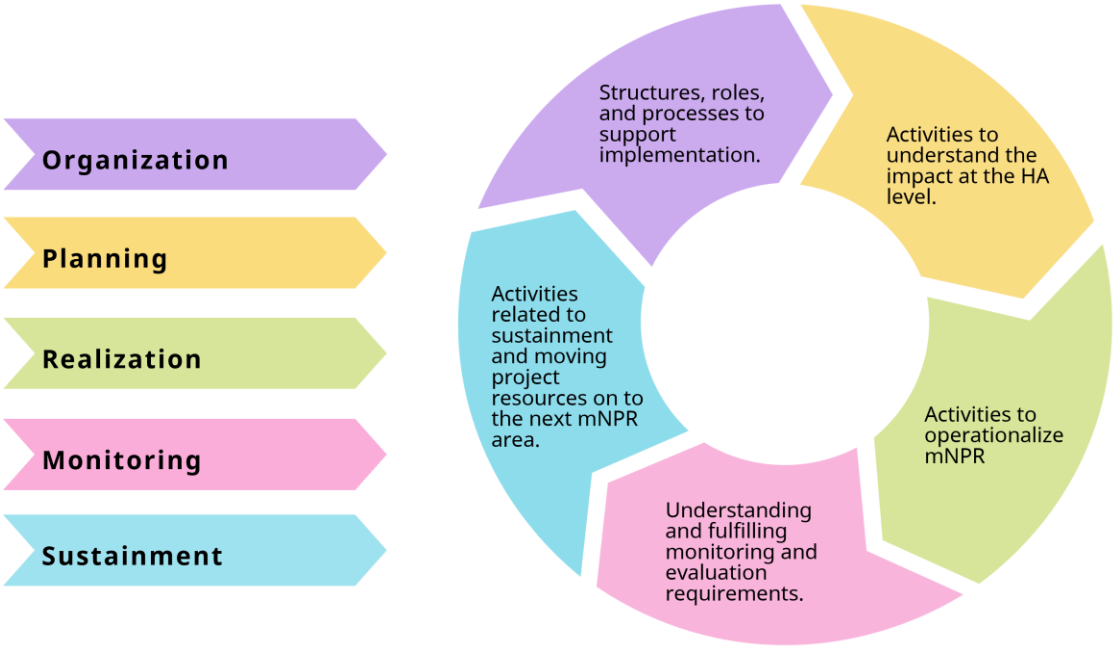
The purpose of the escalation process is to provide a responsive pathway for the JRICs to seek provincial level support in resolving implementation challenges, removing barriers, resolving committee disputes that cannot be successfully resolved locally and regionally. The mNPR centralized inbox will be used to receive escalation requests that will then be shared with the Provincial Chief Nursing Officer for preliminary review and triage, as appropriate (see Appendix B)

All issues will be collated, tracked, and trended to ensure matters in question receive due care and attention, are managed consistently, and communicated to all partners effectively.

Section 2: Development and Implementation Plan Submission

All Health Organizations are required to complete and submit the Implementation Planning Template to the mNPR centralized inbox. The ED, mNPR Implementation will be responsible for engaging with the JIRC on the iterative review of the implementation plan as it develops.

mNPR Implementation Phases [4]



Implementation Cycle Overview

Upon Executive Steering Committee review and Ministry of Health approval of the implementation plan, the Health Organization will proceed to implement mNPRs at their sites/units. The Health Organization will use the below phases to complete their Implementation Planning Template. Health Organizations will engage the JRIC on the implementation plan and progress reports for input, guidance, and advice. Below is a list of items to support Health Organizations in preparing for implementation:

Organization:

- Establish a Health Organization JRIC.

Planning:

- Validate bed and unit base data relevant to the particular mNPRs to be implemented.
- Analyze the current state and staffing gap in alignment with mNPR policy directives. More specifically, the number of nurses on any given unit is calculated based on the established/base number of beds on a unit. If the base bed allocation of a unit is modified, then the number of nurses will be adjusted to maintain the ratio. The

[4] Project Management Body of Knowledge (PMBOK) Guide, 2021

calculation of mNPR staffing needs for a unit must include break relief over and above the ratio; whereas, leaves, including (but not limited to) vacation, sick time, education, and union leave are calculated in the ratio and as part of standard workforce planning requirements. Any time additional patients above the bed base are admitted to the unit (overcapacity beds), every reasonable effort will be made to call in additional nursing staff, including for overtime, to bring the unit back up to the required ratio.

- Develop internal policies, procedures, and quality improvement processes, including process to ensure every reasonable effort will be used to first fill a vacancy with the same designation and specialty training (e.g. RN with RN, ERQ with ERQ) prior to securing a different designation or level of training.
- Create a human resources plan and determine the staffing approach needed to close the staffing gap for each relevant unit or site.
- Establish a plan to prioritize and sequence the closing of the staffing gap.
- Determine educational needs for specialty nursing or program specific competency upskilling from entry to practice level.
- Ensure that clinical infrastructure such as IM/IT, clinical equipment etc., are in place.
- Establish a communications/engagement plan to communicate with internal staff on mNPR related information.

Realization:

- Create new nursing positions as applicable.
- Commence Health Organization processes to:
  - Advertise, post and recruit for new positions.
  - Onboard and orient new hires.
  - Leverage existing provincial processes for recruitment and retention.
- Ensure human resources supports are in place.
- Calculate leaves, including (but not limited to) vacation, sick time, education, and union leave into the ratio as part of standard workforce planning requirements.
- Calculate break coverage for mNPR staffing needs for a over and above the ratio, as applicable.

Monitoring:

- Create or use existing regional feedback loops (as per standard labour relation and professional practice processes).
- Provide implementation progress reports to the ESC and JRICs and lessons learned for the purpose of quality improvement and identifying and resolving barriers and challenges to implementation.

Sustainment:

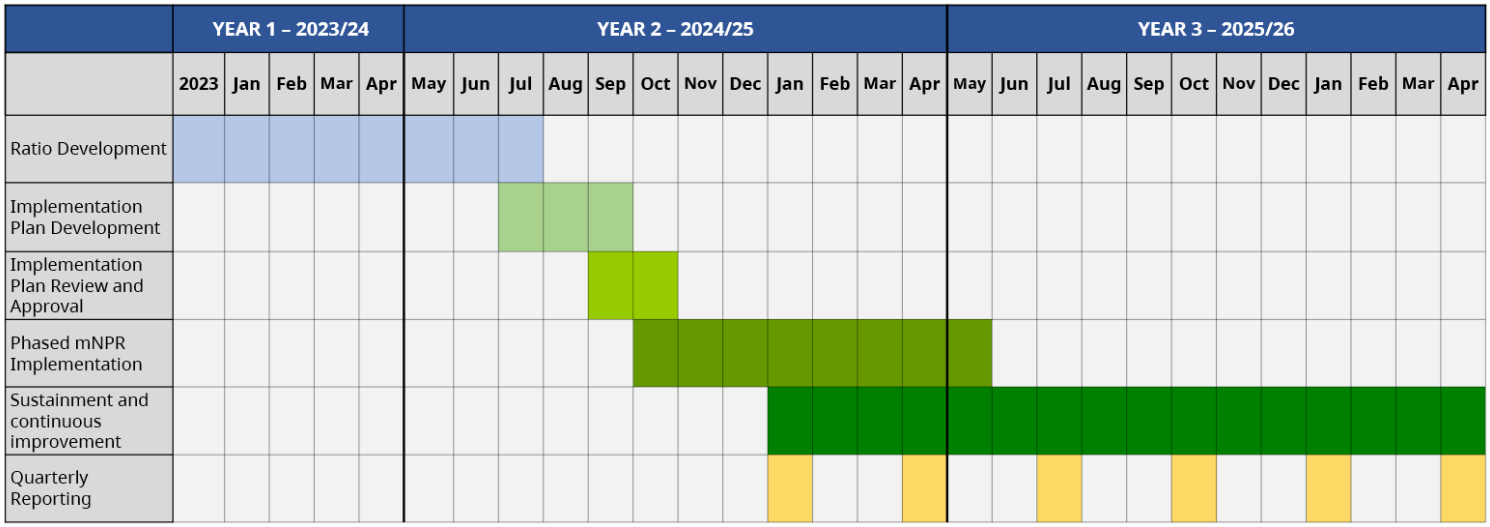
- Develop a sustainability plan that considers the resources needed for mNPR implementation and the ways to sustain mNPRs after the realization phase.
- Embed elements of continued quality improvement to ensure on-going sustainability of mNPRs.

Submission of Implementation Plan

The Implementation Planning Template must include the following details:

- An overview of the key planning features, including members of the JRIC.
- The plans to dismantle harm to Indigenous peoples when accessing health care and provide culturally safe patient care.
- A high-level estimate of current vacancies and the staffing gap.
- Sequencing of implementation in units across sites and Health Organization.
- Strategies to achieve and support quality practice and learning environments.
- Identify the additional Charge Nurse positions pursuant to Ministry direction.
- Describe engagement efforts to engage with partners, staff, and stakeholders.
- Identify risks and mitigation strategies to allow for successful mNPR implementation.
- Phasing of implementation will align with the Hospital Sector GANTT Chart.
- See Appendix C for Implementation Planning Template and Review Process.

Hospital Sector GANTT Chart



Section 3: Supplemental Direction

Direct Care Supervision (Charge) Model – Hospital Settings

The mNPR MoU expressly states the "Ministry, working with the NBA, will implement and evaluate an expanded direct care supervision (charge) model to support safe nursing practice" (Objective Two).

Direct care support for nurses varies throughout BC with several existing roles referred to as Clinical Nurse Leader/Coordinator, Patient Care Coordinator, Clinical Manager, and In-Charge (I/C) nurse, to name a few.

The Ministry recognizes that due to an increasing number of new and novice nurses within practice settings, increasingly complex patient care needs, and ongoing recruitment and retention issues, the importance of standardized supports for safe, quality clinical care and professional practice is evermore. The Ministry aims to expand and ensure direct care supervision strengthens direct, timely, hands-on clinical support and guidance to nurses in all hospital settings.

Direct care supervision (charge) model, referred to as Charge Nurse, is defined as:

- Practicing nurse(s) available to provide clinical practice supervision, guidance, and support for nurses within the care delivery area/unit.

Charge Nurses' duties and responsibilities include:

- Provide clinical supervision, guidance, and support to nurses by:
    - Acting as a clinical resource for the assigned nursing team to deliver safe, quality nursing care.
    - Determining nurses' patient assignments by working with the nursing team to determine nurses' patient assignments.
    - Working with site management to identify tangible short-term solutions to ensure patient needs are met in the event nursing staff are unavailable to meet and maintain ratios as per the Ministry Directive.
    - Identifying patient safety concerns calling for additional resources in collaboration with leadership based on their professional judgment.
    - Coordinating and ensuring break relief
    - Providing temporary direct care support to the nursing team when additional acuity/complexity needs, overcapacity, or changing patient needs (e.g. workload) arise until either the patient is transferred, or additional staff are located.
- Advancing nursing professional practice by promoting:
    - The commitment to cultural safety, humility, and anti-Indigenous specific racism
    - An environment of diversity, equity and inclusion
    - Team-based care
    - Trauma informed and harm reduction in all nursing practice.
    - Effective conflict resolution

    - Ensure professional rights and obligations are understood and respected.
- Advancing quality practice and learning environments by:
    - Sharing learning needs of nursing team with others (e.g. Clinical Nurse Educator, Clinical Mentors, Clinical Manager, Clinical Patient Care Coordinator, etc.) to ensure education and support can be made available.
    - Ensuring employee and patient safety incidents are reported and documented according to employer policy (e.g. PSLS, WHITE etc.)
    - Promoting workplace psychological health and safety
    - Promoting safety and emergency procedures
    - Promoting safe and appropriate use of physical facilities, supplies, and equipment
    - Practicing infection control procedures.
    - Supporting standards of practice

Charge Nurse – Adult Medical / Surgical Units

With respect to charge nurses, adult medical/surgical units will have a Charge Nurse *without assignment*. Charge nurses will facilitate the coordination of break relief and can, by exception, assist with break relief in rare circumstances. Charge nurses will not be responsible for providing break relief on a consistent basis.

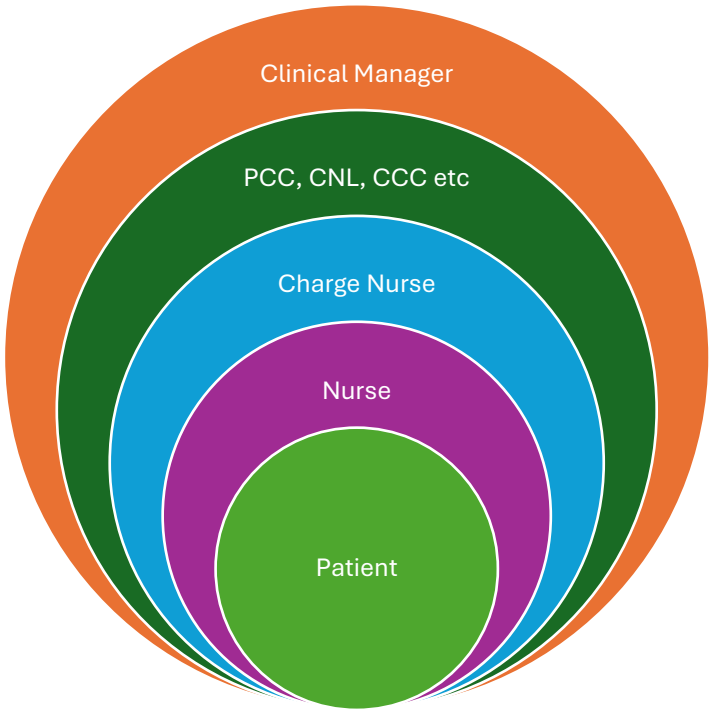
- **Charge Nurse without Assignment** – this is a staff nurse working on a unit/area without a patient assignment.
    - A Charge Nurse without assignment can provide the full complement of duties including temporary break coverage and temporary patient care due to changes in acuity/complexity until either the patient is transferred, or additional staff are located.

Charge Nurse Expectations

- Must be competent and capable of providing care to patients/clients in assigned unit/area.
- Must be physically working with the nursing team to provide timely hands-on clinical support and guidance.
- Does not replace the role of the Most Responsible Nurse (MRN) for a patient assignment rather complements this role with advice, guidance, or support related to clinical practice, professional practice, quality, and safety.
- Not responsible for administrative/management functions including but not limited to hiring, discipline, or budget monitoring.
- May provide virtual supervision and supports where necessary and appropriate.

Charge Nurse – All other areas

All non-Medical/Surgical hospital units will continue without change current charge models. Additional evaluation of charge structures will continue, and additional direction will be shared by January 2024.



DRAFT Degree from Patient Care: Role Diagram[5]

Team-Based Care

Team-based care is a model of health care delivery where many health professionals work together to support a patient and client needs. mNPR will align with ongoing health system strategic and operational priorities that are working hard to advance effective team-based models of care and assumes nurses are working within a broader team context.

mNPR identifies the minimum number of nurses for a specific number of patients within a given hospital setting. The ratio was determined by assuming availability of other complementary health professionals and clinicians working together in a given care setting. mNPR does not change the existing team complement, rather, mNPR aims to standardize the minimum number of nurses for each ratio.

Implementation and Reporting Instructions

mNPR recognizes variation in the team complements throughout Health Organizations. As BC implements mNPR, it is anticipated changes to staffing might be required as we learn from our implementation experiences. Understanding the baseline complement for team-based models of care in hospital settings will help to identify team-based enhancements in the future.

Hold and Evaluate

There is known variation across and between the Health Organizations regarding existing nursing complements. The following situations are anticipated to occur at implementation:

[5] NBA Contract 2022-2025

- Existing Nursing Complement is **LOWER** than assigned ratio
    - The unit currently has a lower nurse to patient ratio or fewer nurses scheduled
    - Implementation requirements – Hire additional nurses to meet assigned ratio
- Existing Nursing Complement is **AT** assigned ratio
    - The unit currently at nurse-to-patient ratio
    - Implementation requirements – Support ongoing quality practice and learning environment activities focusing on retention
- Existing Nursing Complement is **HIGHER** than assigned ratio
    - The unit currently has a higher number of nurses than the ratio requires.
    - Implementation requirement
        - Hold for **4 months** and then evaluate:
            - the team complement and patient complexity trends
            - validate the most appropriate mNPR has been assigned and
            - identify additional considerations which would impact the assigned ratio

If any changes are required to align with the assigned mNPR, the terms of the NBA Collective Agreement will apply.

Nursing Designations (Nursing Mix)

mNPR Nursing Designations

Per the mNPR MoU, there are 3 designations of BC nurses included in mNPR: Licensed practical nurse (LPN); Registered Nurse (RN); and Registered Psychiatric Nurse (RPN).

The intention of mNPR is not to change the overall provincial distribution of these nurses; rather, the aim is for the total number of all 3 designations (RN, RPN, and LPN) of nurses to have increased proportionally once mNPR is fully implemented.

Excluded from Ratio Calculations

- Any nurse unable to take a full patient assignment is excluded from mNPR calculations, including but not limited to:
    - Employed Student Nurses (ESN)
    - Employed Student Psychiatric Nurses (ESPN)
    - Supernumerary nurses.

Implementation Instructions

- There is an intentional and complementary overlap in scopes of practice and competencies between nursing designations and variation between Health Organization across nursing teams. The contributions of all designations are important to support safe quality care. Health Organizations will consider the following when expanding the nursing complement:
    - What are the care needs of the target population?
    - What is the patient presentation, acuity, and demand?
    - What is the current complement of competencies of the existing nursing team?

    - Which designations could be added to the existing nursing team to expand and improve the ability to provide safe, quality care?
- The overall proportion of each nursing designation at the site will not change without prior agreement at the JRIC and consistent with NBA Collective Agreement. Where JRIC is unable to reach agreement, decisions will be escalated as per escalation process.

Break Coverage

Break Coverage – Principles

- The Ministry is committed to establishing a principle-based funding formula to support break coverage at the shift level over and above the unit ratio at 14.6%.
- The Ministry acknowledges that leaves, including (but not limited to) vacation, sick time, education, and union leave are calculated in the ratio and as part of standard workforce planning requirements
- The Ministry acknowledges that employees are entitled to meal breaks and rest periods pursuant to the NBA Collective Agreement; as such, the calculation of mNPR staffing needs for a unit must include break relief over and above the ratio.
- The employer, on behalf of the Ministry, has the responsibility to schedule adequate staffing for all shifts within a 24-hour period, enabling meal breaks and rest periods.
- The employer's unit manager will work with the Charge Nurse and unit nurses to develop a break coverage approach that balances the scheduling of breaks and distribution of break coverage with the preferred break pattern for nurses and the patient care needs.

Mixed Units and Off Service Patients

Mixed Units
Where a unit has a regular mix of patient populations (e.g medicine and focused care), the Unit ratio will be determined based on either:

1. <u>Mixed Patient Population with assigned beds.</u>
    - If a unit can identify the total assigned beds for each patient population all appropriate mNPRs can be applied.
        - Example: inpatient med/surg unit with close observation beds. If the close observation beds are assigned (e.g. specific bed and/or room assignment) and the med/surg beds are also assigned both mNPR ratios can be applied
            - Med/Surg Beds 24 Ratio 1:4
            - Close Observation (focused) 6 Ratio 1:3
            - Min number of nurses required: 6 (med/surg) + 2 (focused) = 8 nurses/shift

2. <u>Mixed Patient Population without assigned beds.</u>

- If a unit is unable to identify the total assigned beds for each patient population (next available bed goes to next admission regardless of type), the ratio providing the highest number of nurses will be applied to all beds
    - Example: inpatient med/surg unit with some rehab beds with no room assignments and any bed could accommodate either rehab and/or med/surg patients
        - Med/Surg Beds 22 Ratio 1:4
        - Rehab beds 6 Ratio 1:5/day
        - Min number of nurses required: 28 beds @ 1:4 =7 nurses/shift

Off Service Patients

There may be times when a unit will be required to support an off-service patient or a patient who is usually admitted onto a different unit requiring a different nurse to patient ratio to be applied. The ratio providing the highest number of nurses will be applied to all off service patients.

Section 4: Monitoring and Sustainment Phase

Reporting, Monitoring, Evaluation, and Research

As implementation occurs, Health Organizations will be required to monitor and report metrics on a quarterly basis. The Monitoring, Reporting and Evaluation Working Group (MREWG) will develop the mNPR metrics for Health Organization monitoring and reporting. The Ministry will provide a reporting template for implementation progress reporting and an evaluation template to measure against intended outcomes. Health Organizations must meet these reporting requirements as outlined in the policy directive. Health Organizations will establish a baseline to conduct a pre and post implementation evaluation.

The implementation progress reporting and evaluation template reporting will be reviewed at the JRIC for the purpose of quality improvement and identifying and resolving barriers and challenges to implementation. The information in the reports will be reviewed, used, and actioned by the Health Organizations, the Ministry, and ESC to strengthen implementation.

If specific data is required for implementation purposes, research initiatives will be conducted accordingly. ESC and MREWG will be responsible for discussing and strategizing research opportunities as needed. Data sharing parameters to be developed by MREWG.

Sustainment

For the mNPR initiative to be successful both in the short and long-term, Health Organizations must establish and implement incremental improvement mechanisms, reporting metrics, and monitoring and evaluation measures. The ED, mNPR at the Ministry of Health will function as a liaison between the Health Organization, the JRIC, and the ESC to ensure on-going sustainability supports/resources are provided when needed for mNPR implementation as it continually evolves.

Implementation Process Improvement (Continuous Improvement)

The Provincial Nurse Allied Health Council and Ministry of Health will work in collaboration with Health Organizations and with support of the JRICs to identify areas of focus for ensuring quality of care process improvements. The Monitoring, Reporting, and Evaluation Working Group are in the process of identifying metrics to support mNPR implementation. Health Organizations, with support from the Chief Nursing Officer and the professional practice team, Health Organization Operational Leadership, and the NBA, will engage direct care nurses in processes that enable a safe, positive, and healthy workplace culture and care process improvement strategy for their sites:

- Improving quality of care as mNPR is implemented with a focus on nursing-sensitive patient outcomes, nurse satisfaction and patient satisfaction.
- Supporting the development of quality of care improvement goals at the site/unit level.
- Dismantling systemically racist healthcare structures and anti-Indigenous specific racism by providing high quality, culturally safe, anti-racist, trauma-informed care, and services.

- Cultivating and promoting a psychologically safe work environment that supports open and on-going communication, inclusivity, and accessibility for quality patient care.
- Collaborating with NBA leadership and representatives to support quality of care improvement goals at the regional and unit levels.

Communication Tools and Resources

Clear channels of communication will need to be established to ensure that information is being shared and disseminated efficiently and to all appropriate groups/individuals. To describe these channels and the communication strategies at the Health Organization level, Health Organizations will develop a communications/engagements plan using content and messaging that is developed by the Communications Working Group and endorsed by ESC.

Quality Practice and Learning Environments (QPLE)

QLPE refers to the conditions and factors that support effective and optimal delivery of care in clinical settings. Key elements include communication, intra- and interprofessional collaboration, responsibility and accountability, realistic workload, effective leadership and engagement in clinical decision-making, evidence-informed practice, workplace culture/ wellness (including psychological safety and cultural safety and humility), professional development, and support for information and knowledge management.

By nurturing QPLEs, healthcare organizations can empower team members in the team-based care context, improve patient care outcomes, enhance job satisfaction and retention, promote a culture of excellence and continuous learning, and ultimately contribute to the delivery of high-quality and person and family centred care.

Linking mNPR to Quality Practice and Learning Environments:

Minimum Nurse-to-Patient Ratios refer to the minimum number of nurses deemed necessary to care for patients in a healthcare setting. mNPRs are implemented to ensure patient safety and quality care, with an aim toward positive patient outcomes. It should be noted that sufficient nurse staffing is but one of several essential elements that contributes to an overall quality practice and learning environment (QPLE). A link between mNPRs and QPLEs can be established through several key points:

1. **Patient Safety and Quality of Care:** Adequate nurse staffing levels directly impact patient safety and the quality of care delivered. They can provide attentive and comprehensive care, aligned with professional and care standards, reducing the risk of errors and adverse events, improved patient outcomes, including reduced mortality rates, shorter hospital stays and improved experience.
2. **Nurse Satisfaction and Retention:** minimum Nurse-to-Patient Ratios contribute to a more favorable work environment for nurses. When nurses have manageable workloads, they experience less stress and burnout, leading to higher job satisfaction and retention rates. Patients and families also experience increased satisfaction with the care received.
3. **Preceptorship and Mentorship Opportunities:** In environments where mNPRs are well-maintained, experienced nurses have the capacity to serve as preceptors and mentors for

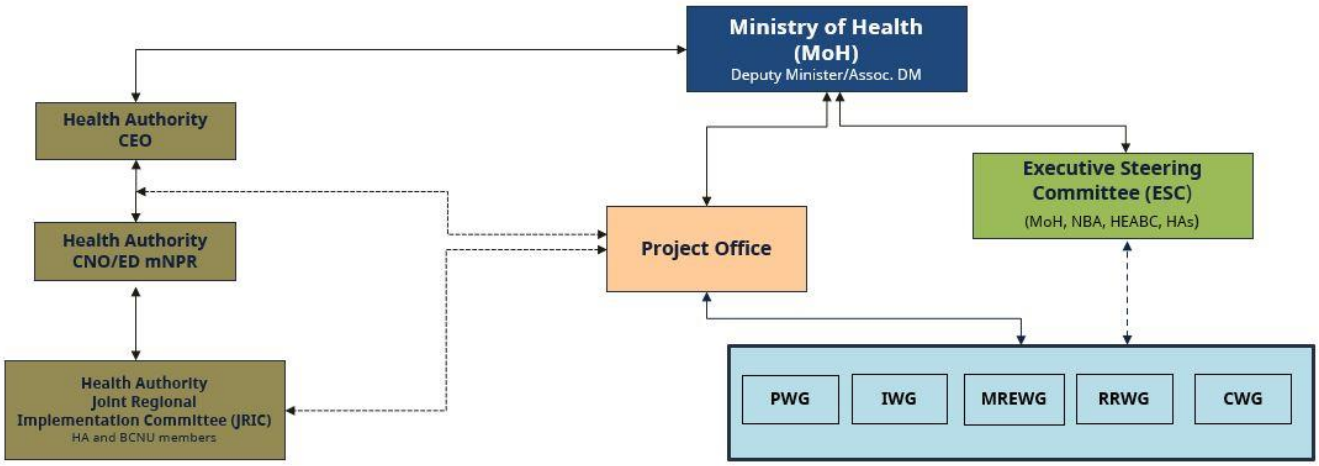
novice nurses and nursing students. These mentorship opportunities foster professional growth, competency development, and knowledge transfer, creating a supportive learning environment for all nurses, and particularly aspiring nurses.

4. **Clinical Education and Experiential Learning:** Adequate staffing levels facilitate meaningful and supportive clinical education experiences for nursing students and staff. Patient assignments can be designed to consider nurse experience and professional development goals. When there are enough nurses available to supervise and guide learners, they can actively participate in patient care activities, apply theoretical knowledge in real-world scenarios, and develop foundational and vital clinical competencies under the guidance of experienced professionals.
5. **Organizational Culture and Continuous Improvement:** Adequate staffing levels foster a culture of excellence, continuous improvement, and evidence-informed practice. Such environments promote a culture of learning, innovation, and psychological safety, benefiting both practicing nurses and nursing students.

Overall, mNPRs play a crucial role in shaping the quality of practice and learning environments in healthcare settings. By ensuring appropriate nursing staffing levels, healthcare institutions can promote patient safety, enhance nurse satisfaction, facilitate clinical education, and cultivate a culture of excellence and continuous improvement in nursing practice.

Thank you for your commitment to achieving mNPRs in BC.

APPENDIX A – mNPR Governance Structure



APPENDIX B – Escalation Process

APPENDIX C – Implementation Plan Development and Approval Process