The Manitoba Nurse-Patient Ratio

EXECUTIVE SUMMARY FOR NURSES

Manitoba

Preamble

The Manitoba Nurse-Patient Ratio (NPR) Sub-Committee was established under the 2024–2028 Collective Agreement as a tri-partite Sub-Committee of the Joint Nursing Council, and includes representatives from the Employer, the Union and Government. Our mandate was to develop recommendations for a Made-in-Manitoba framework for minimum Nurse-Patient Ratios (mNPRs) in all facilities and programs across the province. The Sub-Committee's recommendations were submitted to the Minister of Health, Seniors and Long-Term Care for their review as an initial step toward strengthening patient safety and supporting nursing workforce sustainability.
The mNPR framework recommendations are intended to serve as a starting point, not a final determination. Continued engagement with direct care nurses and other stakeholders will be essential to further refine, validate and operationalize mNPRs across care settings to ensure successful implementation.

Background

Decades of research demonstrates that mNPRs improve patient outcomes and safety, including reductions in mortality and hospital-acquired infections. Evidence also confirms their positive impact on nurse wellbeing and job satisfaction, attributed to lower rates of burnout and workplace injury. Beyond individual outcomes, mNPRs strengthen recruitment and retention, improve workforce stability, and generate broader system benefits, including meaningful cost savings. This evidence suggests that while implementing mNPRs will require sustained government investment in staffing, reductions in readmissions and length of stay for patients, combined with improved workforce stability for nurses, would produce net cost benefits for Manitoba's health system.

Process & Methodology

The report proposes standardized mNPRs tailored to Manitoba's healthcare system. To determine mNPR recommendations, the Sub-Committee used a collaborative, data-driven and evidence-informed approach to develop a mNPR framework. This process included:

- Three province-wide surveys with a total of 4,831 frontline nurse respondents, representing all acute and non-acute care units/programs in Manitoba. Respondents proportionally represented all nursing classifications and health employers/regions with varying levels of experience.

- A jurisdictional scan of 43 regions internationally that have established mNPRs, including an in-depth consultation with British Columbia (BC), the only Canadian province with negotiated mNPRs.
- Participation in the Canadian Federation of Nurses Unions' NPR Summit in Fall of 2024.
- Analysis of Manitoba system data including a review of provincial bed maps and current staffing practices.
- Consultation with key stakeholders including presentations from the Provincial Clinical Leadership teams on specialty care areas including Mental Health, Obstetrics and CancerCare and the Long Term and Continuing Care Association of Manitoba

Key Findings

Survey data demonstrated both a strong need and significant nurse support for mNPRs. Province-wide, nurses consistently reported:

- Increasing workloads, rising patient acuity and complexity
- High rates of missed breaks
- Significant intention to leave their positions within four years
- Moral distress and burnout related to unsafe staffing levels

Critically, nurses consistently reported that implementing safe, established mNPRs would significantly influence their decision to remain in their current roles. They emphasized that establishing a mNPR framework in Manitoba is essential to protecting both the sustainability of the nursing workforce and the safety of patients across the province.

Core Recommendations

The Sub-Committee's recommendations are intended to mark the beginning of the process of establishing safe, effective, mNPRs in Manitoba, rather than the conclusion. The recommended ratios represent minimum baselines, not ceilings, and should be adjusted as required.

The Sub-Committee recommends:

1. Implementation of unit/ program-specific mNPRs across acute and non-acute areas (See Appendices A, B and C for initial ratio recommendations).
2. Minimum baseline staffing of two nurses per unit/program, alongside ratios (the exact number may vary by unit /program and site).
3. Development of a Rural and Northern Framework to reflect geographic realities.

4. Support for structured mentorship positions to assist novice nurses and protect experienced nurses from burnout.
5. Ongoing frontline nurse engagement prior to and during implementation.
6. Continued collaboration with BC to leverage lessons learned.
7. An independent pre- and post-implementation evaluation using validated indicators.
8. Investment in staffing, infrastructure, and workforce initiatives to ensure sustainability.
9. Apply continuous improvement principles through ongoing evaluation (e.g., an annual review), regular input from frontline nurses and other key partners to ensure mNPRs remain dynamic and responsive to the needs of Manitoba's healthcare system.

The Sub-Committee met with the Minister following the submission of the report and highlighted the importance of continued collaboration between Government, Employer, and Union representatives. Implementation of mNPRs will require a phased and carefully coordinated approach across care settings. Next steps discussed were as follows:

- Legislation was introduced in the Spring 2026 session to establish and protect the future of mNPRs in Manitoba, making Manitoba the first province in Canada to introduce Nurse-Patient Ratios legislation.
- Develop a formal governance structure to begin implementation planning.
- Ensure Manitoba nurses are aware that frontline nurse engagement will continue throughout this process.

Conclusion

The establishment of safe, effective, mNPRs is crucial for the future of Manitoba's healthcare system. Implementation of mNPRs must be well-resourced and supported by frontline engagement, independent evaluation and continuous improvement principles.

By formally implementing mNPRs, Manitoba would become a national leader, alongside BC, in advancing evidence-based nurse staffing standards that improve outcomes for patients, nurses, and the healthcare system.

This work represents a fundamental perspective shift in healthcare in Manitoba, where patient care and staffing needs are proactive, rather than reactive.

British Columbia Context for Implementation

BC's experience with mNPR implementation provides context on timelines, scope, and resource requirements, reflecting a multi-year, phased approach supported by dedicated investment.

$750 million of federal funding was allocated to support mNPR implementation:

- $200 million in 2023/24
- $250 million in 2024/25
- $300 million in 2025/26

Phased Implementation

BC's phased, setting-specific implementation strategy prioritizes acute care hospital settings, with planning underway for community and long-term care. mNPRs have been defined for the following units, and 73% of Phase 1 units have been activated with defined ratios to date.

Phase 1:

- General Medicine/Surgical Inpatient
- Rehabilitation
- Palliative Care
- Focused Specialty Care
- High Acuity/Step Down
- Intensive Care Units (ICU)
- Pediatric Medical/Surgical
- Pediatric Focused Care
- Pediatric ICU
- Pediatric High Acuity

Phase 2:

- Neonatal ICU
- Operating Rooms
- Post-Anesthetic Care Units
- Maternity (Antepartum, Labour and Delivery, Postpartum, Newborn Care Nursery)
- Emergency departments

Implications for Manitoba

BC's experience demonstrates that mNPRs are a longer-term system objective requiring phased implementation, sustained investment, and alignment with workforce capacity and system readiness.

Appendix A

mNPR Recommendations: Priority Areas[1]

<table>
<tr><th>Unit</th><th>Adult Intensive Care</th></tr>
<tr><td>Definition</td><td>A multi-day inpatient unit which is organized, operated, and maintained to provide specialized care for adult patients who:
• are at risk of developing, or currently have an acute, life-threatening organ dysfunction. Intensive care uses technologies that support failing organ systems, particularly the lungs, cardiovascular system, and kidneys
• receive care from a collaborative, multidisciplinary team with the objective of preventing further physiologic deterioration while treating the underlying disease/ injury

<table>
<tr><th>Included</th><th>Excluded</th></tr>
<tr><td>• See definition</td><td>• Pediatric Intensive Care Units
• Special Care Units
• Step-Down Units
• High Observation Units</td></tr>
</table>
Patient Care Needs:
<u>Level 3</u>
• Continuous invasive monitoring required (arterial line with VS Q 15-60 minutes)
• Intraventricular Drain with neuro-vitals less than Q1H
• Frequent vasopressor/inotrope dose adjustment probable and/or IV medications for hemodynamic and or endocrine stabilization (e.g. anti-hypertensives, insulin, vasopressin antagonists, glucocorticoids etc.)
• Blood product administration probable
• Non-invasive ventilation with administration of HFNC-O2 > 60% FIO2 OR Invasive ventilation required (intubation and mechanical ventilation), OR Extracorporeal Membrane Oxygenation (ECMO)
• Continuous Renal Replacement Therapy (CRRT)
• Temporary pacemaker
• NIV/CPAP and vasopressor support required concomitantly with agitation/delirium
• Chronic impairment of one or more organ systems sufficient to restrict daily activities (co-morbidity) and who require intensive support for an acute reversible failure of another organ system OR</td></tr>
</table>

[1] Priority areas were a starting point for the sub-committee's work and do not necessarily reflect implementation process

	• Complex patients requiring support for multiple organ failures, this may not include advanced respiratory support OR • Major trauma or surgery OR complex wound management (e.g. extensive burns) with fluid replacement demand/hemodynamic instability <u>Level 2</u> • Close observation: non-invasive vital sign monitoring or art line measurement Q1-2h, continuous O2 saturation monitoring, continuous ECG monitoring • May require ventilation (invasive or non-invasive); oxygen demand/pressure stable • Single organ system monitoring and monitored and supported at an advanced level (excludes advanced respiratory support) OR • Two or more organ system monitoring and support; may be acute or chronic condition exacerbations contributing to hemodynamic instability OR • Extended post-operative care, due to the nature of the procedure and/or the patient's condition and co-morbidities. • Major uncorrected physiological abnormalities with care needs exceeding step down or inpatient unit capacity • IV medication administration to maintain hemodynamic stability: low dose/limited dose modification vasopressors /inotropes <u>Post-Acute</u> • Hemodynamic instability resolved with return to baseline oxygen demand OR demand met with face mask/nasal prong oxygen delivery OR • Long term advanced respiratory support anticipated as baseline and hemodynamically stable. • Care requirements at or approaching capacity of clinical specialty units (e.g. burn/ stroke/ respiratory/ oncology neuro/ortho etc.)
Ratio	**1:1-2** <u>Range Guideline:</u> • 1:2: may include patients in post-acute stage, as defined. At the discretion of unit CRN.
Additional Comments	24/7 CRN

<table>
<tr><td>Unit</td><td colspan="2">Inpatient Psychiatry Unit</td></tr>
<tr><td>Definition</td><td colspan="2">A multi-day inpatient secure unit that provides round-the-clock care in a secure therapeutic setting for:
Individuals experiencing acute or chronic mental health conditions requiring specialized psychiatric and rehabilitative care;
Individuals admitted for short-stay observation, assessment, or stabilization; and/or
Individuals involved with the criminal justice system requiring forensic psychiatric assessment or treatment within a controlled environment.</td></tr>
<tr><td rowspan="8">Ratio</td><td>Mental Health Rehabilitation:</td><td>1:6-8</td></tr>
<tr><td>General Inpatient Psychiatry Unit (includes Geriatric Inpatient):</td><td>1:4-5</td></tr>
<tr><td>Crisis Stabilization:</td><td>1:4-5</td></tr>
<tr><td>Forensic:</td><td>1:3-4</td></tr>
<tr><td>Mental Health Intensive Care Unit:</td><td>1:3-4</td></tr>
<tr><td>Pediatric Mental Health:</td><td>1:3</td></tr>
<tr><td colspan="2"><u>Range Guideline:</u>
Ratio should be decided on at a facility-by-facility basis, with local engagement of frontline staff and key stakeholders.</td></tr>
<tr><td>Additional Comments</td><td colspan="2">There should always be a minimum of two nurses included in the staffing model to avoid single nurse coverage.

Crisis Stabilization Units:
To ensure provincial consistency, nurses should be included in the staffing model to allow for expanded admission criteria to accommodate patients with medical needs.
Pre-Implementation Requirements:
Local input</td></tr>
</table>

<table>
<tr><th>Unit</th><th>Medicine</th></tr>
<tr><td>Definition</td><td>A multi-day adult inpatient unit in which either of the following are cared for:
patients with an acute or chronic illness or an injury; and/or a
short stay (observation) patient care area
<table>
<tr><th>Included</th><th>Excluded</th></tr>
<tr><td>• Palliative patients
• Alternate Level of Care patients
• Remotely monitored telemetry patients</td><td>• Monitored beds
• Critical Care (adult, neonatal, psychiatry)
• Specialty Units (higher level of care but not critical care)
• Maternity
• Emergency
• Inpatient Psychiatry Units
• Rehabilitation
• Designated Alternative Level of Care Units i.e. Transitional Care Units
• Surgical Services (OR, PARR)
• Ambulatory Units
• Surgical Day Care
• Designated Palliative and Hospice Units</td></tr>
</table></td></tr>
<tr><td>Ratio</td><td>1:4-6

<u>Range Guideline:</u>
1:4: Large urban facilities with ICUs
1:5: Regional facilities
1:6: Community acute facilities</td></tr>
<tr><td>Additional Comments</td><td>Pre-Implementation Requirements:
Local input</td></tr>
</table>

<table>
<tr><th>Unit</th><th>Operating Room</th></tr>
<tr><td>Definition</td><td>A specially designed room in a controlled environment within a health care facility equipped and staffed to perform operative or invasive procedures, requiring anesthesia.
<table>
<tr><th>Included</th><th>Excluded</th></tr>
<tr><td>• See definition</td><td>• Operating rooms conducting procedural sedation
• Endoscopy
• Endoscopy suites
• Procedure suites</td></tr>
</table></td></tr>
<tr><td>Ratio</td><td>2.5:1 per OR theater / procedure
2:1 for an on call situation</td></tr>
<tr><td>Additional Comments</td><td></td></tr>
</table>

Appendix B

mNPR Recommendations: Acute Areas

<table>
<tr><td>Unit</td><td colspan="3">Emergency Department (ED)/Urgent Care (UC)</td></tr>
<tr><td>Definition</td><td colspan="3">An acute care unit designed to provide rapid access to care for individuals with serious and acute illnesses or injuries.

<table><tr><td>Included</td><td>Excluded</td></tr><tr><td>• Pediatric Emergency Department</td><td>• Rural and Northern Emergency Department/Urgent Care (see below for the Emergency Department Rural and Northern Framework)</td></tr></table></td></tr>
<tr><td>Ratio</td><td colspan="3">Ratios are based on Care Area/Patient Needs. See definitions and recommended ratios below.</td></tr>
<tr><td></td><td>Care Area/Patient Needs</td><td>Ratio</td><td>Additional Comments</td></tr>
<tr><td></td><td>Resuscitation Room/
Critical Care:
Patients with life-threatening conditions requiring the highest level of medical attention and monitoring. The focus of this area is on stabilizing patients, providing advanced life support, and preventing further deterioration until they can be transferred to a specialized unit if needed.
These patients are typically CTAS 1-2.</td><td>1:1</td><td>1:1 ratio minimum when patient is stabilized, however when a patient is being actively resuscitated nursing staff (e.g., code blue or resuscitation team) will provide care to that patient.</td></tr>
<tr><td></td><td>General Acute:
Assessment, diagnosis, treatment, stabilization, and management of patients experiencing acute and sudden injuries and illnesses, or exacerbation of chronic medical conditions that require immediate care.
These patients are typically CTAS 2-3.</td><td>1:2 (CTAS 2)
1:3 (CTAS 3)</td><td>Pediatric General Acute patients should maintain a 1:2 ratio regardless of CTAS score.</td></tr>
</table>

ED/UC (cont.)	**Care Area/Patient Needs**	**Ratio**	**Additional Comments**
	Minor Treatment: Patients with less critical conditions to be seen and treated quickly, allowing the more critical areas of the ED/UC to focus on patients with severe or life-threatening conditions. This area provides rapid assessment and short-term treatment for patients who often no longer require emergency care. *These patients are typically CTAS 4-5.*	**1:4**	
	Short Stay (Observation): Patients that are no longer undifferentiated but must stay in the ED for assessment of stabilization and/or treatment. These patients may or may not require admission.	**1:4**	
	Triage/Waiting Area/Reassessment: A defined area within an ED/UC where patients wait for evaluation, treatment, or admission before and/or after their initial assessment in the triage area. Patients in the waiting area must be regularly reassessed. This area helps manage the flow of patients within the ED/UC, ensuring that those with the most urgent needs are prioritized for immediate care. It is also an area where patients wait for test results, consultation with a specialist, or the availability of treatment rooms.	**See Triage/Waiting Area/ Reassessment Guide below**	

ED/UC (cont.)	**Care Area/Patient Needs**	**Ratio**	**Additional Comments**
	ED/UC Sites with Inpatient Psychiatry Beds: Nurse staffing includes a minimum of one (1) Psychiatric Liaison Nurse (PLN)* on a 24/7 basis, reflective of visit volume.	**1:3**	• Ratio is consistent with mental health ICU and should be maintained while patient remains undifferentiated. • Positions may be labeled Psychiatric Liaison Nurse, Psychiatric Emergency Nurse or Mental Health Liaison Nurse. • *The need for mental health/psychiatric liaison/emergency nurse staffing in sites that do not have inpatient psych beds should be considered on a facility-by-facility basis.
Additional Comments	• Where areas are clearly defined for patients requiring different levels of care, staffing levels should reflect the ratios recommended below. In ED/UC where there are not clearly defined areas, ratios should be considered in terms of patient assignment. (i.e., one nurse should not be assigned to care for more than a maximum of three patients with general acute care needs). • ED/UC nurse staffing includes a Supernumerary CRN 24 hours a day, seven (7) days a week in all large urban and regional acute care centers that have greater than 25,000 annual visits. • ED/UC nurse staffing includes a Supernumerary CRN 12 hours a day, seven (7) days a week in smaller regional and community acute care centers that have 15,000-25,000 annual visits.		

Emergency Department Rural and Northern Framework

Key partners (direct care nurses, nursing leadership, professional practice and Employer) should be consulted to determine most accurate grouping, and safe baseline nurse staffing level, for a facility. Trends in patient acuity and seasonal fluctuations must also be considered.

Group	Description	Baseline Staffing
1: Small Rural & Northern Hospitals with minimal inpatient beds	Diagnostic and Treatment Centres/ Community Health Centres with Emergency Departments (EDs) with **fewer than 3** inpatient beds Example: Snow Lake Health Centre	2 nurses
2: Small Rural & Northern Hospitals	Small rural/northern hospitals with **4** to **10** inpatient beds and **fewer than 5000** annual ED visits. Example: Carberry Health Centre	3 nurses*
3: Rural Hospitals with no Specialty Services	Rural hospital with **11** to **30** beds, and between **and fewer than 10,000** annual ED visits. Example: Virden Health Centre	4 nurses** (assuming base of 11 inpatient beds)
4: Rural Hospital with Greater than One Inpatient Unit	Rural hospitals with more than one inpatient unit, some specialty services and **10,000-15,000** annual ED visits. Example: Gimli Community Health Centre	ED staffing: 3 nurses, inclusive of 1 dedicated triage nurse. Additional staffing required to apply recommended ratios to inpatient units as relevant.

*Rural/Northern EDs may have variable hours. Baseline staffing recommendations are for when ED is open. Staffing requirements may change if ED services are closed.

Baseline staffing should increase by one nurse for every additional **5-6 Inpatient beds

Triage/Waiting Area/Reassessment Guideline

The Table below is a guideline for staffing in triage/waiting area/reassessment. Staffing for these roles may increase with patient volumes, wait times, and acuity levels.

Frontline nurse engagement is strongly encouraged before implementation to determine appropriate staffing levels.

Hospital Groupings based on Annual Visits	**Facilities**	**Recommended Triage/Waiting Room/Reassessment Staffing**
Group A: ≥40,000 Annual visits	Health Science Centre – Adult Health Science Centre – Children's St. Boniface	**3 triage** nurses and **1 additional** triage nurse during peak time* ***Note.*** **Health Science Centre -Adult includes an additional triage nurse for EMS hallway coverage** A minimum of **1 additional** nurse dedicated to waiting area/reassessment. Additional nurses may be required depending on visit volumes and waiting room capacity.
Group B: ~25,000-40,000 Annual Visits	Victoria Hospital Seven Oaks General Hospital Concordia Hospital Grace Hospital Boundary Trails Health Centre Thompson General Hospital Brandon Regional Health Centre	**2 triage** nurses and **1 additional** triage nurse during peak time* A minimum of **1 additional** nurse dedicated to waiting area/reassessment

Hospital Groupings based on Annual Visits (cont.)	Facilities	Recommended Triage/Waiting Room/Reassessment Staffing
Group C: ~15,000-25,000 Annual Visits	Selkirk Regional Health Centre Portage Dist. General Hospital St. Anthony's General Hospital Bethesda Reg Health Centre Dauphin Regional Health Centre	1 triage nurse and 1 additional triage nurse during peak time* A minimum of 1 additional nurse dedicated to waiting area/reassessment
Group D: Fewer than 15,000 Annual Visits	*See Rural and Northern Framework for staffing guidelines for recommended Emergency Department/Facility staffing.*	

*The peak time is to be established by each Emergency Department, according to its daily patient flow fluctuation in consultation with direct care nursing staff

<table>
<tr><th>Unit</th><th>Focused/Specialty Care</th></tr>
<tr><td>Definition</td><td>A multi-day inpatient unit which is organized, operated, and maintained to provide care for:
a specific medical condition; and/or
a specific patient population.
<table>
<tr><th>Included</th><th>Excluded</th></tr>
<tr><td>• Acute stroke
• Coronary care /Cardiac telemetry
• Hematology /Oncology
• Transplant
• Neurosurgery</td><td>• Labour, birth, & postpartum care including care of the newborn
• Perioperative areas (i.e. operating room, post-anesthesia care/recovery unit)
• Intermediate care/stepdown Intensive care (ICUs)
• Cardiac ICU
• Inpatient psychiatry unit
• Alternate level of care (ALC)
• Renal (dialysis)</td></tr>
</table></td></tr>
<tr><th>Ratio</th><th>1:4</th></tr>
<tr><td>Additional Comments</td><td></td></tr>
</table>

<table>
<tr><th>Unit</th><th>Medical/Surgical Combined Unit</th></tr>
<tr><td>Definition</td><td>A multi-day inpatient unit in which either of the following are cared for:
patients with an acute or chronic illness or an injury; and/or
a short stay (observation) patient care area
<table>
<tr><th>Included</th><th>Excluded</th></tr>
<tr><td>• Palliative patients
• Hospice and transitional care/alternative level of care patients
• Remotely monitored telemetry patients</td><td>• Monitored beds
• Critical Care (adult, neonatal, psychiatry)
• Specialty Units (higher level of care but not critical care)
• Maternity
• Emergency
• Inpatient Psychiatry Units
• Rehabilitation Units
• Designated Transitional Care Units
• Designated Palliative and Hospice Units Surgical Services (OR, PARR)
• Ambulatory Units
• Surgical Day Care</td></tr>
</table></td></tr>
<tr><td>Ratio</td><td>1:5-6

<u>Range Guideline:</u>
1:5: Regional facilities
1:6: Community acute facilities</td></tr>
<tr><td>Additional Comments</td><td>Charge Nurse is Supernumerary 24/7
Pre-Implementation Requirements:
Local input</td></tr>
</table>

<table>
<tr><td>Unit</td><td>Surgical Unit</td></tr>
<tr><td>Definition</td><td>A multi-day inpatient unit in which patients are pre-operative and/or recovering from (surgery) surgical intervention.

<table><tr><td>Included</td><td>Excluded</td></tr><tr><td>• See definitions</td><td>• Surgical Services (OR, PARR)
• Surgical Day Care</td></tr></table></td></tr>
<tr><td>Ratio</td><td>1:4-6

<u>Range Guideline:</u>
• 1:4: Large urban facilities with ICUs
• 1:5: Regional facilities
• 1:6: Community acute facilities</td></tr>
<tr><td>Additional Comments</td><td>• Charge Nurse is Supernumerary 24/7 in large urban facilities with ICUs, and 12 hours per day in others.

Pre-Implementation Requirements:
• Local input</td></tr>
</table>

Unit	**Obstetrics/Maternity Units**		
Definition	*See specific care units for definitions and ratios*		
Ratio	***Ratios are based on Care Area/Patient Needs. See definitions and recommended ratios below.***		
	Care Area/Patient Needs	**Ratio**	**Additional Comments**
	Antepartum: A multi-day inpatient unit which is organized, operated, and maintained to care for a patient that is pregnant who requires hospitalization during their pregnancy related to obstetrical complications or care needs for themselves and/or the unborn child(ren).	**1:4**	
	Labour & Delivery: A multi-day inpatient unit which is organized, operated, and maintained to care for a patient that is pregnant and their newborn(s) during labor, childbirth, and the postpartum period.	**1:1**	Charge Nurse is Supernumerary.
	Triage: An inpatient area organized, operated, and maintained to provide emergency obstetrical medical care for pregnant patients at a specified gestation (typically ≥20 weeks) upon entry to the hospital system.	**1:3**	Where triage beds are embedded within the unit, implementation will determine the appropriate ratio, aligned with delivery volumes.

Obstetrics (cont.)	Care Area/Patient Needs	Ratio	Additional Comments
	Postpartum: An inpatient unit which is organized, operated, and maintained to care for postpartum patients and their newborn(s) after delivery, as well as, for patients who are having complications related to their postpartum period.	**1:3-4(dyads)** <u>Range Guideline:</u> 1:3: discretion of unit charge nurse 1:4: if all dyads are medically stable	
	Labour, Delivery, Recovery, and Postpartum Unit: Multi-day inpatient unit where a labouring, delivering or postpartum patients are cared for from admission until discharge, covering all stages of perinatal care, from the initiation of obstetrical care to postpartum recovery. The newborn typically remains with the postpartum patient, as clinically indicated.	**1:1-3**	• CRN/Charge Nurse must be OB trained. • CRN/Charge Nurse may be shared with triage in smaller units. • Implementation should consider labour, delivery, and postpartum ratio guideline, supported by delivery volumes to determine the appropriate ratio, and CRN/Charge Nurse coverage.
Additional Comments			

Unit	**Post Anesthetic Recovery Unit**
Definition	A unit which is organized, operated, and maintained to provide short term care to patients immediately following operative or invasive procedures with administration of anesthesia, analgesia, sedation and/or any surgical procedure. The unit may include patients with varying levels of care needs.
Ratio	**1:2** <u>Exceptions:</u> • 2:1: Critically ill/unstable patient, combative patient or patient whose status has regressed to a life-threatening state. • 1:1: Patient who requires mechanical ventilation, patient who displays respiratory distress, patient with uncontrolled pain, critically ill/stable patient, patient who is eight (8) years of age or younger without family/guardian or support staff present, patient requiring isolation precautions.
Additional Comments	

<table>
<tr><td>Unit</td><td>Special Care/Step-Down Unit</td></tr>
<tr><td>Definition</td><td>Patients requiring higher levels of monitoring or interventions than are available in an inpatient unit. Patients require frequent observation.

<table><tr><td>Included</td><td>Excluded</td></tr><tr><td>• High Observation Units</td><td>• Intensive Care Units</td></tr></table></td></tr>
<tr><td>Ratio</td><td>1:2</td></tr>
<tr><td>Additional Comments</td><td></td></tr>
</table>

Unit	**Transitional Care Unit**
Definition	A designated multi-day inpatient unit for medically stable patients that have finished their acute phase of care but are not ready for discharge.
Ratio	**1:8-10**
Additional Comments	• Where unit is juxtaposed to a personal care home, staffing models should be a consideration for ratios and coverage. • At least two nurses on each shift in units with more than 10 beds.

<table>
<tr><th>Unit</th><th>Neonatal Intensive Care Unit</th></tr>
<tr><td>Definition</td><td>A multi-day inpatient unit which is organized, operated, and maintained to provide specialized care for neonatal patients who have complex, life threatening medical problems requiring urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians. The NICU may include newborns with varying levels of care needs, as described below:

Newborn Care Needs
<table>
<tr><td>Care Level</td><td>Care Needs</td></tr>
<tr><td>Intermediate Care</td><td>Newborns requiring intermediate care</td></tr>
<tr><td>Intensive Care</td><td>Newborns requiring intensive care</td></tr>
</table>
</td></tr>
<tr><td>Ratio</td><td>1:1-3 (all levels of NICU)

<u>Range Guideline:</u>
• 1:1 – Intensive Care
• 1:2-3 – Intermediate Care
• CRN/Charge Nurse discretion</td></tr>
<tr><td>Additional Comments</td><td>• CRN or a Supernumerary Charge Nurse recommended.
• CRN/Charge Nurse may be shared with Labour & Delivery.
• Implementation should consider volumes to determine the appropriate CRN/Charge Nurse coverage.</td></tr>
</table>

Unit	**Palliative Care Unit**
Definition	A designated multi-day inpatient unit which is organized, operated, and maintained to provide complex pain and symptom management. It includes complex discharge planning, and/or emotional, social, practical, spiritual, grief, and bereavement support and care for patients living with acute or advanced life-limiting illness and for patients at the end of life, family/supports affected by a patient's life limiting illness or death.
Ratio	**1:4-6** <u>Range Guideline:</u> • 1:4: Facilities offer highly complex care requiring specialized interventions and support. • 1:5-6: Considered based on patient volumes and less specialized care units versus what size or services the facility offers.
Additional Comments	• Implementation should consider acuity and complexity of the unit to determine the appropriate CRN/ Charge Nurse coverage.

Unit	**Pediatric Medical/Surgical Unit**
Definition	A multi-day inpatient unit which is organized, operated, and maintained to: • deliver comprehensive, interdisciplinary, family centred, age specific, pediatric care for infants, children, and youth newly admitted; • diagnose and provide treatment for pediatric patients with a broad range of low to medium acuity/complexity medical conditions (including psychosocial issues) that require hospitalization, stabilizing and referring/transferring, as necessary.
Ratio	**1:3** <u>Exception:</u> • 1:2 – Monitored beds
Additional Comments	• In Children's hospital, Supernumerary CRN/Charge Nurse 24/7. • Within sites outside of Winnipeg, CRN and Charge Nurse resources may be shared. Implementation should consider acuity and complexity of the unit to determine the appropriate CRN/Charge Nurse coverage. Monitored Beds: • Staffing plans should account for the total number of monitored beds on the ward during implementation.

<table>
<tr><td>Unit</td><td>Pediatric Special Care Unit</td></tr>
<tr><td>Definition</td><td>A multi-day inpatient unit which is organized, operated, and maintained to provide specialized care for pediatric patients who have complex, life threatening medical problems requiring urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians.

<table><tr><td>Included</td><td>Excluded</td></tr><tr><td>• See definition</td><td>• Pediatric Intensive Care Units</td></tr></table></td></tr>
<tr><td>Ratio</td><td>1:2</td></tr>
<tr><td>Additional Comments</td><td>• Supernumerary CRN/Charge Nurse 24/7.</td></tr>
</table>

<table>
<tr><th>Unit</th><th>Rehabilitation Unit</th></tr>
<tr><td>Definition</td><td>A designated multi-day, interdisciplinary inpatient unit which is organized, operated, and maintained to:
• provide rehabilitation of patients following stabilization of their acute medical issue; and
• improve functions of patients with musculoskeletal and neuromuscular conditions due to injury or illness, or following surgery, so that they may be safely discharged.

<table><tr><th>Included</th><th>Excluded</th></tr><tr><td>• See definition</td><td>• Rehabilitation services provided for mental health conditions and/or for drug or alcohol addiction.</td></tr></table></td></tr>
<tr><td>Ratio</td><td>Days/Evening Shift:
• 1:6 with a Supernumerary CRN/Charge Nurse
Night Shift:
• 1:6 Charge Nurse takes an assignment</td></tr>
<tr><td>Additional Comments</td><td>Pre-Implementation Requirements:
• Local input</td></tr>
</table>

<table>
<tr><th>Unit</th><th>Same Day Procedures/Surgeries</th></tr>
<tr><td>Definition</td><td>Services delivered on an outpatient basis, without admission to a hospital or other facility. These services may include diagnostic tests/imaging, treatments, and surgical day care which may include procedural sedation.

<table><tr><th>Included</th><th>Excluded</th></tr><tr><td>• Surgical Day Procedures
• Diagnostic Tests and Imaging
• Pediatric Day Procedures/Surgeries</td><td>• Ambulatory Care Clinics
• Endoscopy
• Post Anesthetic Recovery Unit</td></tr></table></td></tr>
<tr><td>Ratio</td><td>• Adult: 1:4
• Pediatric: Ratio is dependent on the child’s disposition plan. Refer to pediatric ratios by unit.</td></tr>
<tr><td>Additional Comments</td><td>• mNPR are assigned based on patient care area/stretcher.
• Patient assignment based on acuity/patient needs.</td></tr>
</table>

<table>
<tr><td>Unit</td><td>Endoscopy</td></tr>
<tr><td>Definition</td><td>Endoscopy services delivered on an outpatient basis, without admission to a hospital or other facility, which may include procedural sedation.

<table><tr><td>Included</td><td>Excluded</td></tr><tr><td>• See definition</td><td>• Ambulatory Care Clinics
• Surgical Day Procedures
• Diagnostic Tests and Imaging
• Pediatric Day Procedures/Surgeries</td></tr></table></td></tr>
<tr><td>Ratio</td><td>Endoscopy Procedures (in operating/procedure room/endoscopy suite):
• 1.5-2:1 (i.e., 1.5 to 2 nurses for each procedure).
Pre/Post Endoscopy Procedure:
• 1:2-3 (i.e., 1 nurse for every 2-3 stretchers)
Note. Pediatric Post Endoscopy Care takes place in PACU, and the ratio for care is 1:1.</td></tr>
<tr><td>Additional Comments</td><td><u>Range Guidelines:</u>
Endoscopy Procedures: Nurse staffing in the operating/procedure room and endoscopy suite is dependent on the complexity of the procedure, patient acuity, and type/level of sedation. There must be at least one nurse in the procedure room to monitor the patient and administer medication, and another nurse to assist with the procedure. In some circumstances (i.e., low complexity, low acuity, and/or minimal sedation), the second nurse may float between two procedure rooms.

Pre/Post Endoscopy Procedure: Nurse staffing levels required to meet this ratio should be evaluated based on:
• Volume of procedures
• Level/type of sedation
• Complexity of patients and/or procedures, including frequency of emergency procedures
• Transfer of care and discharge instructions needs
• Workload (e.g., scheduled breaks and/or break coverage)</td></tr>
</table>

<table>
<tr><td>Unit</td><td>Renal/Dialysis Programs</td></tr>
<tr><td>Definition</td><td>Services include kidney health clinic care for stages one to five chronic kidney disease as well as in-centre (outpatient) and home dialysis.

<table><tr><td>Included</td><td>Excluded</td></tr><tr><td>• See definition</td><td>• Ambulatory Care Clinics</td></tr></table></td></tr>
<tr><td>Ratio</td><td>Dialysis Treatment:
• Pediatrics: 1:2
• Adults: 1:2.5-3

<u>Range Guideline:</u>
• Higher acuity sites would include an additional nurse for changing acuity and break relief.</td></tr>
<tr><td>Additional Comments</td><td>Clinical: Demand for services, workload and volume in Renal Program be assessed via an analysis of the following for the implementation team:

• Quantity and characteristics of clinic appointments (e.g., new clients)
• Volume of telephone consultations and follow-up care
• Overtime and workload trends that indicate additional staff is necessary
• Time spent on non-nursing duties

Adjustments to nurse staffing within each clinic and/or the maximum number of daily visits will be reflective of this analysis and engagement with frontline nursing staff.

Pre-Implementation Requirements:
• Local input
• Placement on treatment ratio range should be decided on a facility-by-facility basis in close consultation with frontline nursing staff. Once the range is determined the assignment of clients will be at the discretion of the CRN based on clinical/patient needs.</td></tr>
</table>

Appendix C

mNPR Recommendations: Non-Acute Units/Programs

The Sub-Committee recognizes that many long-term care, community health and outpatient programs do not align with acute in-patient mNPR models. Nevertheless, the sub-committee acknowledges the need for staffing improvements and adjustments to client scheduling practices to ensure safe, high-quality, client-centered care and to enhance working conditions for nurses in these settings.

Overarching Recommendations

For all Non-Acute Units/Programs, the Sub-Committee recommends:

1. **Engagement and Shared Governance**
    a. Actively involve frontline nursing staff in decision-making through focus groups and/or participation in future committee meetings related to staffing and scheduling.
2. **Program-Specific Staffing Reviews**
    a. Assess staffing requirements on a facility-by-facility and program/service-by-program/service basis, recognizing the unique characteristics of each service area.
3. **Nurse-Driven Scheduling**
    a. Ensure client visit scheduling is led by nurses to incorporate clinical expertise and experiential knowledge. Special consideration should be given to travel requirements where applicable.
4. **Workload and Demand Assessment**
    a. Factor in demand for services, workload, and patient volume when determining staffing and scheduling in outpatient care areas.
5. **Staff Safety**
    a. Integrate staff safety considerations into all nurse staffing frameworks.

<table>
<tr><td>Unit</td><td>Community Mental Health, Addictions, and Recovery Services/Programs</td></tr>
<tr><td>Definition</td><td>Community Mental Health, Addictions, and Recovery Services/Programs assist people with mental health, addictions, and recovery needs to develop coping and living skills and obtain other community services needed to meet their living needs and personal goals.

Services/programs are provided at many community hospitals and health facilities, as well as via mobile services and virtual care. These services include identification, assessment, treatment and case management services for persons with mental health, addiction, and recovery needs.

<table>
<tr><td>Included</td><td>Excluded</td></tr>
<tr><td>• Crisis Response Centre
• Early Psychosis Prevention & Intervention Service (EPPIS)
• Manitoba Opioid Support & Treatment (MOST)
• Program of Assertive Community Treatment (PACT)
• Flexible Assertive Community Treatment (FACT)
• Rapid Access to Addictions Medicine (RAAM)</td><td>• Inpatient Psychiatry Units
• Crisis Stabilization Units
• Inpatient Withdrawal Units
• Manitoba Adolescent Treatment Centre</td></tr>
</table>
</td></tr>
<tr><td>Ratio</td><td>See additional comments</td></tr>
<tr><td>Additional Comments</td><td>To address demand for services, workload, and non-nursing duties in Community Mental Health, Addictions, and Recovery Services/Programs, the implementation team should use the following actions, guided by analysis of:
• A planned and consistent approach for vacancies due to vacation, leaves, and sick calls.
• Analysis of workload and overtime trends to facilitate funding of additional FTEs.
• Tailored staffing models for each Community Mental Health program (e.g., PACT, FACT, EPPIS, MOST, etc.), prioritizing staff safety (e.g., team visits).</td></tr>
</table>

<table>
<tr><th>Unit</th><th>Long-Term Care</th></tr>
<tr><td>Definition</td><td>Provides personal care services to individuals who can no longer manage independently at home with family support and community services. Nurses provide comprehensive care services for residents, including those with complex and unpredictable health needs. These services include nursing assessment and intervention, administration of prescribed medical treatments, collaboration within the health care team, and participation in the development and implementation of resident care plans.

<table><tr><th>Included</th><th>Excluded</th></tr><tr><td>• Personal Care Homes</td><td>• Transitional Care Units</td></tr></table></td></tr>
<tr><td>Ratio</td><td><u>Day/Evening Shift:</u>
• 1:12-15
<u>Night Shift:</u>
• 1:20-25</td></tr>
<tr><td>Additional Comments</td><td>Recommended ratios for Long-Term Care facilities are provided as ranges. These ranges are based on the goal of 4.2 Hours per Resident Day (HPRD) that Manitoba is currently working towards. With these ranges as a guideline for minimum NPRs, each facility should also consider the following when determining nurse staffing needs:
• Specialized units in Long-term Care (e.g., dementia care; chronic care needs; long-term ventilation). These units will require unique ratios given the care needs of their residents.
• The physical layout of the facility may require additional nursing staff to provide safe, effective, quality resident care.
• Standalone facilities (not juxtaposed with an acute care facility) should have a minimum of 2 nurses on staff 24/7.</td></tr>
</table>

Unit	**Public Health**
Definition	The Public Health Nurse applies public health science and nursing theory to promote, protect, and preserve the health of populations. Services may be directed to individuals, families, groups or communities.
Ratio	***See additional comments***

Additional Comments	To address demand for services, workload, and non-nursing duties in Public Health, the implementation team should use the following actions, guided by analysis of:
	• Standardized and regular needs assessment of the community being served by each public health office, with frontline nurse engagement that reflect:
	  ○ Changing populations and needs of the community
	  ○ Disease trends
	  ○ Emergency response
	  ○ Geographic region covered
	• Analysis of time spent on non-nursing duties
	• A planned and consistent approach for managing vacancies due to vacation, leaves and sick calls.

<table>
<tr><th>Unit</th><th>Home Care</th></tr>
<tr><td>Definition</td><td>Home Care nurses work with individuals and provide assistance to help clients remain in their homes for as long as is safely possible. Home Care nurses conduct comprehensive health assessments and monitor changes in a client's condition; administer prescribed medications, treatments and therapies; provide client and family education; and coordinate care with other healthcare providers.
<table>
<tr><th>Included</th><th>Excluded</th></tr>
<tr><td>• Palliative Home Care
• Home Care Respite Program
• Community Intravenous Program Clinics
• Wound Care Clinics</td><td>• N/A</td></tr>
</table>
</td></tr>
<tr><th>Ratio</th><th>See additional comments</th></tr>
<tr><td>Additional Comments</td><td>The demand for services, workload, and non-nursing duties in Home Care should be assessed via front-line nurse input, in addition to an analysis of the following for the implementation team:

Opportunities for nurses to use clinical judgment and experience (e.g., travel time, client care needs) in visit scheduling
Reassessment of time required for client care activities involving frontline nursing input
A reasonable cap on the visits scheduled per day to address workload challenges, travel time, and patient safety concerns.

A maximum of 6.25 hours of scheduled visits per day to allow time for additional nursing activities (e.g., charting, planning, referrals).
Additional travel time in rural regions must be factored into visit maximum.

An analysis of non-nursing duties (e.g., supply ordering and distribution)

</td></tr>
</table>

<table>
<tr><td>Unit</td><td>Primary Care</td></tr>
<tr><td>Definition</td><td>Nurses assess, treat, and manage health conditions; provide health promotion, illness and injury prevention; help manage chronic disease; provide health education; and coordinate care and resources. Primary care services may be provided in a clinic-based setting.

<table>
<tr><td>Included</td><td>Excluded</td></tr>
<tr><td>• ACCESS Centres
• Walk-in Connected Care Clinics
• Extended Hours Care Clinics
• Mobile Clinics
• QuickCare Clinics
• Minor Injury and Illness Clinics
• MyHealthTeams
• Health Links
• Primary Care Clinics
• Community Clinics</td><td>• N/A</td></tr>
</table>
</td></tr>
<tr><td>Ratio</td><td>See additional comments</td></tr>
<tr><td>Additional Comments</td><td>Due to the variability in client visit volumes and characteristics, and the unique workload associated with each facility or program, each facility/program must engage with frontline nursing staff. Consideration should also be given for the physical layout/capacity of each clinic. Each primary care clinic/program should undergo an evaluation of the following to assess demand for services, workload and volume, with specific analysis of the following:
• Time spent on non-nursing duties
• Volume of visits
• Acuity/complexity of client population
Adjustments to nurse staffing within each clinic/program and/or the maximum number of daily visits will be reflective of this analysis and engagement with frontline nursing staff.</td></tr>
</table>

<table>
<tr><td>Unit</td><td>Outpatient Oncology and Hematology</td></tr>
<tr><td>Definition</td><td>Services include prevention, early detection, multidisciplinary treatment, service navigation, supportive care, and end-of-life care.

<table><tr><td>Included</td><td>Excluded</td></tr><tr><td>• CancerCare Manitoba
• Community CancerCare Programs</td><td>• Inpatient units</td></tr></table></td></tr>
<tr><td>Ratio</td><td>Treatment: 1:3 (one nurse for every three client treatment chairs)</td></tr>
<tr><td>Additional Comments</td><td>Clinic: Demand for services, workload and volume in Outpatient Oncology and Hematology Clinics should be assessed via an analysis of the following for the implementation team:
• Quantity and characteristics of clinic appointments (e.g., new clients)
• Volume of telephone consultations and follow-up care
• Overtime and workload trends that indicate additional staff is necessary
• Time spent on non-nursing duties
• Client waiting lists
Adjustments to nurse staffing within each clinic and/or the maximum number of daily visits will be reflective of this analysis and engagement with frontline nursing staff.</td></tr>
</table>

<table>
<tr><td>Unit</td><td>Ambulatory Care Clinics</td></tr>
<tr><td>Definition</td><td>Services delivered on an outpatient basis, without admission to a hospital or other facility. These services may include assessments, treatments, and follow-up care.

<table>
<tr><th>Included</th><th>Excluded</th></tr>
<tr><td>• Pediatric Ambulatory Care Clinics
• Women's Clinics:
○ Prenatal Clinic
○ Gynecology Clinics
○ Pediatric Gynecology Clinic
○ Acute Care Gynecology Assessment Clinic
○ Early Pregnancy Assessment Clinic (EPAC)
○ Pregnancy Counselling
○ Colposcopy
○ Fetal Assessment</td><td>• Endoscopy
• Surgical day procedures
• Diagnostic tests and imaging
• Wound Care Clinics
• CIVP Clinics
• ACCESS Centres
• Walk-in Connected Care Clinics
• Extended Hours Care Clinics
• Mobile Clinics
• QuickCare Clinics
• Minor Injury and Illness Clinics
• MyHealthTeams
• Health Links
• Primary Care Clinics
• Community Clinics</td></tr>
</table></td></tr>
<tr><td>Ratio</td><td>See additional comments.</td></tr>
<tr><td>Additional Comments</td><td>Due to the variability of client visit volumes and characteristics, each clinic must include engagement with frontline nursing staff. Consideration should also be given for the physical layout/capacity of each clinic. Each ambulatory care clinic should undergo an evaluation of the following to assess demand for services, workload and volume:
• Quantity and characteristics (e.g., complexity) of clinic appointments
• Volume of telephone consultation
• Time spent on activities that are not directly related to in-person clinic visits (e.g., follow-up, lab results).
Adjustments to nurse staffing within each clinic and/or the maximum number of daily visits will be reflective of this analysis and engagement with frontline nursing staff.</td></tr>
</table>

MAY 2026