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CANADIAN FEDERATION OF NURSES UNIONS

EMPOWERING NURSES, ENHANCING CARE:

Lessons on safe staffing and nurse-patient ratios from Ireland and the United Kingdom

Current evidence report

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Canadian Federation of Nurses Unions

The CFNU is Canada's largest nurses' organization, representing frontline unionized nurses and nursing students in every sector of health care — from home care and LTC to community and acute care — and advocating on key priorities to strengthen public health care across the country.

Land acknowledgement

From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis and First Nations Peoples that call this land home. The Canadian Federation of Nurses Unions is located on the traditional unceded territory of the Algonquin Anishnaabeg People. As settlers and visitors, we feel it's important to acknowledge the importance of these lands, which we each call home. We do this to reaffirm our commitment and responsibility to improve relationships between nations, to work towards healing the wounds of colonialism and to improve our own understanding of local Indigenous Peoples and their cultures.

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Manitoba nurses Union
A COMMITMENT TO CARING

Table of contents

President's message

Do we have a shortage of nurses — or a shortage of nurses willing to work short-staffed?

Our health care system has been understaffed for far too long, and this is pushing nurses out the door. It is time to ask ourselves if we have a nursing shortage — or a shortage of nurses willing to work under the unsafe and unsustainable conditions that have become the norm.

A survey of our CFNU members shows that four in ten nurses intend to leave their job, the profession, or retire in the next year.[1] Staffing levels and workload were identified by our members as top reasons they would consider leaving their jobs. Clearly the workload has become too much for many nurses, and they are seeking opportunities outside of public health care, such as with private nursing agencies, which is unsustainable for our public health care system.

We have been advocating nurse-patient ratios (NPR) since at least 2005 when we published our first report calling for NPRs. The evidence was there then but it has continued growing each year with more jurisdictions seeing the immense value of mandating ratios. Again in 2012, we looked at the impacts of nursing workload on patient care and found that high workload leads to poor patient outcomes, including mortality, hospital acquired infections, medication errors and more. In 2016, CFNU's National Executive Board met with the New Zealand Nurses Organisation to see their method of safe staffing in action, bringing a renewed sense of determination to make ratios happen in Canada. After many years of hard work, we are starting to see the needle move, with agreements to implement ratios in British Columbia and Nova Scotia in 2023, and again in 2024 a letter of intent was signed to begin the process of bringing NPRs to Manitoba.

Safe NPRs are critical for ensuring safe patient care as they are so tightly correlated. Reducing the number of patients each nurse must care for means that patients are getting the care they deserve, and the risk of negative outcomes falls. Research from countries with mandatory staffing ratios in place demonstrates that a greater number of nurses saves lives, reduces hospital length of stay, decreases the likelihood of readmission and is less likely to injure or emotionally exhaust nurses, leading to less turnover.[2,3,4,5] Health Canada's *Nursing Retention Toolkit* highlights safe staffing practices as one of its core themes that affect nurse retention.[6]

Nursing ratios already exist everywhere. On any given unit, there is a number of patients to care for and a number of nurses that are staffed to provide that care. Mandating safe NPRs ensures that the ratio is evidence-informed and not just informed by historical staffing levels, or by the finance department. The status quo has not been working, so it is time to make a change, and NPRs is an evidence-informed change that can be made to ensure nurse well-being, improve patient outcomes and retain nurses. We need nursing to be a great job that nurses can stay in for their whole career. Ensuring their workloads are reasonable through mandating minimum NPRs can reduce rates of burnout and help to pull us out of the shortage of nurses willing to work under these conditions by retaining more nurses over the long term, which results in better patient care.

The CFNU continues to push forward this critical issue by hosting national and international nursing leaders at the Nurse-Patient Ratios Summit in November 2024 to share knowledge and begin building a path towards spreading and scaling NPRs across Canada.

In solidarity,

Linda Silas, CFNU President

Background

In spring 2024, members of the CFNU's National Executive Board along with two researchers travelled to the Republic of Ireland, Northern Ireland (N.I.), Wales, Scotland and England to meet with nurses' unions, researchers, government officials, employers, regulators and frontline nurses to discuss how frameworks for safe staffing and NPRs have been implemented in their countries.

The CFNU has been advocating for NPRs for decades, even prior to publishing the discussion paper *Enhancement of Patient Safety through Formal Nurse-Patient Ratios* in 2005 written by Dr. Gail Tomblin Murphy.[7] Since then, the research has grown, resulting in strong academic evidence base and many examples of real-world policy change. A broad body of research underscores the critical impact that staffing levels have on nurse well-being and patient care outcomes. Studies indicate that additional patients assigned to a nurse are associated with increased emotional exhaustion and a higher risk of burnout. In contrast, jurisdictions with minimum nurse staffing regulations, such as California and Australia, have observed numerous benefits, including enhanced job satisfaction, better patient safety ratings, reduced occupational injuries, and fewer patient and family complaints.

Over the years, several nurses' unions have taken the ask of implementing NPR to bargaining tables, but it took until 2023 for the British Columbia Nurses' Union (BCNU) and the Nova Scotia Nurses' Union (NSNU) to finally get commitments to implement NPRs. The BCNU is funded by the provincial government to jointly develop service area-specific mandatory NPRs in conjunction with health care employers. The process started with medical and surgical inpatient units and will progress through all other areas. In Nova Scotia, acute care health employers are now contractually required to staff units with a minimum number of nursing hours per patient day, fulfilled by a specific number of registered nurses and licensed practical nurses according to the number of patients and their specific needs, which is being referred to as "ratios plus."

Purpose

Nurses have long claimed that understaffing is one of the primary reasons they would consider leaving the profession. As recently as 2024, the CFNU reported that this was a primary reason 40% of members were considering leaving their job or profession. This tour aimed to address direct-care nurses' concerns by exploring international solutions for safe NPR. Key objectives included meeting with various nursing and health care stakeholders, visiting frontline nurses to understand the impact of staffing ratios, examining different staffing frameworks, and gathering insights to inform discussions at the CFNU's NPR Summit in fall 2024.

Value statements

Darlene Jackson

PRESIDENT OF MANITOBA NURSES UNION

"Hearing the gains made in the UK regarding NPRs was very encouraging, however, we can learn so much from their experiences when we develop our own NPR's. I think the fact that the majority of health care programs are nurse-led in the UK is so important. No one knows better than nurses what patients' needs are, and I believe directly involving frontline nurses in the development of NPRs is the key to success."

Janet Hazelton

PRESIDENT OF NOVA SCOTIA NURSES' UNION

"Participating in this study tour with the CFNU came at the perfect time for NSNU. After achieving NPRs based on nursing hours of care, the insights from the tour helped NSNU learn from other jurisdictions before implementing our own system. A key takeaway was the importance of staffing units with enough "headroom" to account for nurses' time off, as seen in many UK models. Another critical point was ensuring public awareness of staffing levels on each unit. Posting expected nurse numbers for each unit, along with current staffing levels, is essential to promoting transparency and managing expectations. Families deserve to know if nurses are adequately resourced to meet patient needs."

Value statements

Paula Doucet

PRESIDENT OF NEW BRUNSWICK NURSES UNION

"Being a part of CFNU's National Executive Board presented me with the opportunity to learn from international partnerships with INMO and RCN. We were astounded that there were no vacancies at the Beaumont Hospital in Dublin, Ireland, and they truly support their entire staff on their education journey to whatever designation they aspire to be, from student nurse to advanced practice nurse. Although Northern Ireland does not currently have nurse-patient ratios in place, they are fully committed to securing safe nurse staffing, and their priority within this continues to be to hold their governments to account for the delivery of the measures needed to provide the level and quality of health care that their members want to deliver. This tour brought valuable insight into how we can make it work in New Brunswick."

Adriane Gear

PRESIDENT OF BRITISH COLUMBIA NURSES' UNION

"It was an amazing experience to visit Wales, Scotland and London to learn about their safe staffing strategies. Each jurisdiction shared an innovative solution that contributed to improved recruitment and retention of nurses. It was fascinating to tour hospitals and observe the policies in action. Highlights included visiting an emergency department with a specialized geriatric sub-unit and a student hub ward at the Western General Hospital. I also enjoyed meeting with the RCN Scotland Employment Relations and learning about their industrial relations model and successes. I would like to thank the RCN for welcoming us and providing informative presentations. It was a pleasure to share information on BC's nurse-led policy agreement on minimum NPRs and learn from each other."

Value statements

Danielle Larivee

VICE-PRESIDENT OF UNITED NURSES OF ALBERTA

"Many thanks to our hosts for their efforts to show us how safe staffing frameworks have made a dramatic difference to health care, even if they aren't perfect. The proof was in the pudding! Safe staffing levels clearly increased the quality of care for patients, while also increasing job satisfaction and decreasing burnout for nurses. Safe staffing levels matter and are so important to fight for. I was also impressed to see that they built in extra FTE to account for planned and unplanned absences — an approach Alberta needs to follow. The strong voice of nurses in their health care systems and governments leads to cross-party commitment, to an evidence-based approach, to addressing safe staffing levels. It seems to me that they were able to achieve that by having a nurse at the top of the civil service — the voice of nurses is strong there "from the ward to the board". Making sure that nurses are at the right tables could be part of succeeding in our own fight."

Tracy Zambory

PRESIDENT OF SASKATCHEWAN UNION OF NURSES

"I would like to thank all the hosts and speakers that met with us and discussed their experiences with safe staffing. I saw that nurses' unions play a key role in achieving NPRs, and governments will do nothing without that pressure. That pressure is starting to be exerted at a global level now. We will take into consideration many pieces of what we saw, when determining what will work at home. We observed the benefits of having ratios embedded in legislation, which appears to make them much more difficult to turn away from. An interesting approach that we saw was requiring institutions to implement ratios before they can be accredited by the government. I would also like to bring home the respect that we saw for nurses' professional judgement. Their voices were being listened to in decision-making processes, which was very refreshing to see. I would like to acknowledge the generosity, openness to share and in-depth discussions that made that possible. I am very grateful to have had this experience."

Value statements

Barbara Brookins

PRESIDENT OF PRINCE EDWARD ISLAND NURSES' UNION

"The tour provided valuable insights through presentations from nursing leaders, frontline nurses, employers, regulatory bodies and educational institutions. Key findings highlighted the critical need for increased staffing levels, with recommendations suggesting a 23-24% rise to accommodate both planned and unplanned absences. A notable example was witnessed in an emergency department that previously faced a 45% vacancy rate, which has since been resolved through proactive staffing strategies. The tour also showcased the effectiveness of tools like Trendcare, demonstrating their role in resource allocation and validating staffing needs. Moreover, the emphasis on continuous education, including accessible "open university" opportunities for all staff, underscored the importance of upskilling and recognizing expertise among frontline nurses. Engaging with speakers and frontline nurses was enlightening and the tour fostered a collaborative environment where challenges and solutions were openly shared."

Republic of Ireland

HOSTS: Phil Ní Sheaghdha – INMO General Secretary; Tony Fitzpatrick – INMO Director of Professional Services; Edward Matthews – INMO Deputy General Secretary

SPEAKERS: Karen Greene – Deputy Chief Nursing Officer (CNO), Ray Healy – Nursing and Midwifery Board of Ireland (NMBI) Director of registration; Johnathan Drennan – University College Dublin, Professor of Nursing; Deidre Mulligan – Area Director NMPDU Dublin and North East / ONMSD Workforce Planning Lead; Aisling McCaughey – NMPDU Officer; Sinead Connoly – Director of Nursing; Yvonne Ryan – Strategic Nursing Workforce Lead; Maeve Foster – RN, Beaumont Hospital

IRELAND'S HEALTH CARE SYSTEM — Ireland has a two-tier health care system, with private services typically funded by private insurance.[8] The Department of Health oversees health policy and funds the Health Services Executive (HSE), the public health care operator and largest employer in Ireland. The HSE also handles strategic workforce planning. Sláintecare, the Department's 10-year plan, aims for universal health care by increasing community care, reducing wait times, creating regional health areas, limiting privatized care in public hospitals and implementing nationwide e-health systems[9].

NURSING IN THE REPUBLIC OF IRELAND — Ireland has four categories of registered nurses: general, children's, psychiatric and intellectual disabilities nurses. Additional roles, such as public health nurses, advanced nurse practitioners, nurse prescribers and nurse tutors, require further education. In 2023, there were 79,489 practicing nurses and midwives, a 5% increase from the previous year, with a 27% rise in new registrants, including domestic and international recruits.[10] Over half (51.8%) of practicing nurses in 2023 were internationally educated, primarily from India, the UK and the Philippines.

UNION — IRISH NURSES AND MIDWIVES ORGANISATION (INMO) — INMO is a registered trade union and professional organization representing over 47,000 nurses and midwives in Ireland. Unionization is not compulsory in Ireland; therefore, much effort goes to recruitment. INMO sits on the Irish congress of trade unions, which collectively bargain on behalf of all public sector health services. INMO represents nurses in both the public and private sector, though there is a higher concentration of membership in the public sector.[11]

IRELAND'S SAFE STAFFING APPROACH — *The Framework for Safe Staffing and Skill Mix (*the *Framework)* is Ireland's approach to measuring safe staffing. It is a set of guidelines to be funded by the government and implemented by the Health Services Executive (HSE). The *Framework* applies to both registered nurses and health care assistant (HCA) roles. Ireland began its journey to safe staffing measurement in 2014 with the creation of a national *Taskforce for Safe Nurse Staffing and Skill Mix*, bringing together key stakeholders, including INMO, the Department of Health, the Health Services Executive (HSE), the Irish Association of Directors of Nursing and academic researchers. The *Taskforce* led the project and developed the *Framework*. The *Framework* is built on evidence gathered from a publicly funded research program commissioned by the *Taskforce*. The research was conducted by independent scholars and was followed by the creation of evidence-based policies that were grounded in that research.

The *Framework* uses the calculation of nursing hours per patient day (NHPPD) in conjunction with professional judgement to determine the final staffing establishment. This assesses how many nurses are required based on the number of patients and type of ward, and determines the number of whole-time-equivalent funded registered nurse and HCA positions to be hired to staff wards. Implementation of the *Framework* was set out in three phases. The first phase focused on data collection and building a framework for medical and surgical care in adult hospitals. The next phase aimed to expand the framework to emergency departments (ED) and injury units (IU), which included evaluation of the framework at four pilot sites between 2017 and 2021. A third phase, that was ongoing at the time of the tour, continued expanding the framework to non-acute

settings, including long-term residential care for older adults (phase 3(i)) and general community care (phase 3(ii)).[12,13]

EVALUATION AND ACCOUNTABILITY — Hospitals are at varying stages of implementing the *Framework*, with no dedicated budget, enforceable timeline or penalties for non-adherence. Nurse managers are responsible for monitoring safe staffing and skill mix, but higher-level accountability is needed to ensure adherence and escalate concerns. The *Framework* has been rolled out as pilots with evaluation and reporting; expanding it will require ongoing funding, ownership policies and ongoing evaluation. Several progress reports have been published for Phase 1, covering outcomes such as "care left undone" events (CLUEs), staffing recommendations and nurse-sensitive outcome indicators. Phase 2 focused on emergency departments, while Phase 3 is evaluating long-term residential care and general community care settings. The *Framework* is designed to lead to measurable improvements in staff, patient and organizational outcomes. In Phase 1 (adult medical and surgical settings), staffing levels increased, patient-to-staff ratios improved, job satisfaction rose, missed meal breaks decreased and agency usage dropped significantly, with some sites reducing agency reliance by up to 95%. Phase 2 (emergency departments) showed similar positive results, with a lower NPR, shorter triage times, reduced wait times and improved staff satisfaction. Phase 3 is still in the early stages, with preliminary data indicating improved care quality at sites with staffing adjustments. Overall, early results suggest positive outcomes, though more data is needed for comprehensive evaluation.[14,15,16,17]

NEXT STEPS — The next steps focus on expanding the *Framework* to non-acute and community care settings through Phase 3. Phase 3(i) pilot projects in long-term residential care are ongoing, while Phase 3(ii) for general community care is in progress. A key goal is to strengthen the nursing workforce to fully staff and sustain the *Framework*. INMO is advocating for legislating the framework to enhance accountability, transparency, and ensure hospitals adhere to safe staffing standards. They also support expressing safe staffing as NPR, making it easier for nurses to validate and escalate concerns.[18] INMO's 2024 survey revealed that 76% of nurses believe current staffing does not meet clinical demands, with 92% concerned about patient safety.[19] The union continues to campaign for the full implementation and support of the *Framework* to improve outcomes and support nurses.

The United Kingdom — The Royal College of Nursing (RCN)

In the UK, nurses and midwives are represented by the RCN, which is both a trade union and professional organization. The RCN is a four-nation organization with around 500,000 members. Within the RCN, there is a section specific to each of the four nations — England, Northern Ireland, Scotland and Wales.

Northern Ireland (N.I.)

HOSTS: Rita Devlin – Executive Director of RCN Northern Ireland; Ruth Thompson – Associate Director, Nursing Policy and Practice, RCN Northern Ireland

SPEAKERS: Elaine Connoly – Director of Adult Social Care, Care Homes and Domiciliary Care RQIA; Karen Scarlett – Assistant Director Care Homes RQIA; Maria McIlgorm – Chief Nursing Officer; Katy Rennick – Deputy Chief Nursing Officer, Department of Health Northern Ireland; Heather Reid – Interim Director of Nursing, Midwifery and Allied Health Professionals, Public Health Agency; Siobhan Donald, Assistant Director of Nursing – Workforce, Health in Criminal Justice, Primary, Acute and Secondary Care, Public Health Agency; Brenda Creaney – Executive Director of Nursing, Royal Victoria Hospital; Paula Forrest – Deputy Director of Nursing, Workforce, Education, Regulation and Informatics, Royal Victoria Hospital; Linsey Sheerin – Divisional Nurse, Unscheduled Care, Royal Victoria Hospital; Olga O'Neill, Director of Critical Care, Royal Victoria Hospital; Jennifer Welsh – Chief Executive, Northern HSC Trust; Tracie Flemming – Assistant Director of Nursing Workforce and Regulation, Northern HSC Trust; Caroline Diamond – Assistant Director of Women's Services and Head of Midwifery, Northern HSC Trust

N.I. HEALTH CARE SYSTEM — Health and Social Care (HSC) is the N.I. branch of the National Health Service (NHS), the general term for the collective health systems across the United Kingdom. N.I. integrates Health and Social Care service funded from a single budget via UK treasury block grant. Most health and social care services are cost-free at the point of access. Health services are organized in 5 hospital trusts and 1 ambulance trust working within geographical boundaries.

NURSING IN N.I. — Over a quarter of HSC staff in N.I. are nurses and midwives. Registered nurses are the only class of nurses in N.I., specializing in one of four streams. Nurses generally start out in pay band 5 on the *Agenda for Change* and increase in bands as they gain more training and education, though RCN N.I. is fighting for nurses to start higher on the pay band scale.

N.I. SAFE STAFFING APPROACH — The *Delivering Care: Nurse Staffing in Northern Ireland* framework is a policy framework from the Department of Health and Social Care, outlining the policy for safe staffing in N.I. The framework sets out nurse-patient ranges specific to clinical settings aiming to support safe staffing and provide safe high-quality care. The program is led by the Chief Nursing Officer (CNO), who is a government representative, with professional agreement. Staffing ranges allow for flexibility as demand changes leaving room for professional judgement. Phase one of the framework applies to nurses and unregulated nursing assistants and outlines typical staffing ranges that apply to inpatient medical-surgical wards. The ranges outline the number of nurses required to staff a ward with a given number of beds. The "funded establishment" is the number of nurses hired to staff a ward. Placement within the acuity range correlates with a pre-determined allocation of funded hours that includes a 24% "headroom" allowance for planned and unplanned absences.[20] Telford's (1979) professional judgement method is used along with an acuity measuring tool to triangulate evidence and determine where a ward sits within the safe staffing range.[21] Given the funded establishment, professional judgement from nursing management is used to schedule staffing day-to-day within a budget.

The SafeCare Live electronic rostering system is a nurse-facing acuity measurement tool that collects data on the nursing workforce and patient acuity. The system requires a 95% compliance rate, and head nurses can adjust the inputs, indicating higher need if necessary. The system uses data to inform safe staffing ratios. All N.I. has the same nurse rostering system, allowing a big picture of workforce planning across the country.

SKILL MIX — On medical-surgical wards, there was a skill mix of 70% registered nurses and 30% unregulated nursing assistants, depending on the ward.[22] In emergency departments, the recommended skill mix was higher, with 80% RNs and 20% nursing assistants, and recommendations on including senior nurses such as advanced nurse practitioners and emergency nurse practitioners on the roster. When possible, within the budget, at least one advanced practice nurse (band 6 or 7) was recommended to be on each shift. The mix of band 6 and 7 nurses depends on professional judgement.[23] Despite having the framework, the skill mix frequently dropped below the appropriate ratio in practice.

The framework recommends that the ward manager be 100% supervisory and super-numerary to the staff complement, meaning they should not have a patient load.

In practice, this policy is not always adhered to, and ward managers end up taking on patient loads.

EVALUATION AND ACCOUNTABILITY — N.I. does not audit or externally enforce safe staffing requirements. Health and Social Care trusts are expected to take account of staffing ranges and uphold the framework recommendations.[24] Nursing management uses key performance indicators (KPIs) to evaluate the impact of the *Delivering Care* policy framework on patient outcomes. These indicators include falls, length of stay, pressure sores, omitted or delayed medication, patient experience and use of temporary workforce, among others. The presence of KPIs may indicate a need to adjust the *Delivering Care* funded establishment. RCN N.I. holds the Department of Health and N.I. executive accountable to provide the necessary resources and support for safe staffing. One of RCN N.I. strike asks in 2020 was to ensure there was safe staffing. The government has taken actions towards creating safe staffing legislation and started policy consultations because of this work.[25]

NEXT STEPS — The case is being built to support the implementation of a more robust safe staffing framework. Currently, a consultation on the principles that will form the basis of safe staffing legislation is out for feedback in N.I. A commitment to introduce safe staffing legislation was part of RCN N.I.'s strike asks in 2020, and it is expected to be introduced to the Northern Irish Assembly 2025.[26] For now, N.I. needs to build up the case for recruitment and retention of staff to enable delivery of safe care to patients. More data is needed to effectively define community needs and determine the appropriate nursing establishment that fulfills them.

Wales

HOST: Helen Whyley – Executive Director RCN Wales

SPEAKERS: SUE TRANKA — Chief Nursing Officer, Wales; Nicola Williams – Executive Director of Nursing Velindre Trust and Chair of Executive Directors of Nurses Group for Wales; Professor Jayne Cutter – Head of the School of Health and Social Care, Swansea University; Professor Danny Kelly – Royal College of Nursing Wales Chair of Research

WALES' HEALTH CARE SYSTEM — The Welsh health system is devolved from the UK government. Health services are provided by NHS Wales and are free to citizens. NHS Wales is funded through block funding to the Welsh government from the UK government. There are 7 local health boards that plan and deliver NHS services to a given geographical area and 3 NHS trusts delivering ambulance, specialist care and public health. There were nearly 38,000 nursing, midwifery and health visiting staff in Wales in 2023.[27,28]

WALES' SAFE STAFFING APPROACH — Wales was the first country in the UK and the European Union to legislate safe nursing protocols under *the Nurse Staffing Levels (Wales) Act 2016*.[29] The desire to implement safe staffing policy came from the recognition that the quality of care was inadequate, and this stemmed from insufficient staffing and skill mix.

The push for safe staffing policies arose from recognizing that inadequate care quality was largely due to insufficient staffing and skill mix. Resolutions calling for enforceable UK-wide safe staffing policies were passed at the 2006 and 2011 RCN congresses, with RCN Wales leading campaigns to keep the issue prominent. In 2014, strong evidence from RCN Wales convinced the Welsh government to introduce safe staffing legislation, which became law in 2016. This legislation required trusts and health boards to maintain appropriate nurse staffing levels through careful calculation and monitoring. The Chief Nursing Officer's office, with input from RCN Wales, developed statutory guidance for implementation. Initially applied to inpatient medical and surgical wards in 2018,

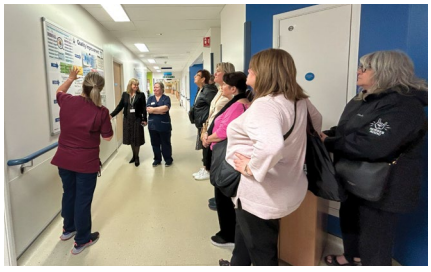
the *Act* led to increased staffing levels, as reflected in RCN Wales' 2019 *Progress and Challenge* report. The *Act* was expanded in 2021 to cover children's wards. Staffing levels are determined using nurse managers' judgment, nurse-sensitive indicators and patient acuity, with a 26.9% buffer to account for planned and unplanned leave. These levels are reassessed every six months, with interim adjustments typically made by hiring health care support workers, who are more readily available and cost-effective.

SKILL MIX — *The Welsh Act* does not set out a ratio of registered nurses to unregulated health care support workers (HCSWs) in their staffing calculations. The number of health care support workers to include as part of the staffing establishment is left up to professional judgement as stated in section 38(vii) of the statutory guidance for the *Act*. Care delegated from RNs to HCSWs or other health care workers can be considered part of the calculation for nursing hours.[30] Statutory guidance for the *Act* appoints ward managers to supernumerary positions meaning they should not carry a patient load.

OUTCOMES — The clearest outcome from the legislation is that there is now accountability for staffing and quality of care at the government level. The NHS must report their compliance with nurse staffing levels to the government, which ensures a chain of accountability. There has also been a shift in the discussion where it is not possible to discuss patient safety without also addressing sufficient ratios. This legislation empowers nurses to share their voices at the executive level of decision-making.

EVALUATION AND ACCOUNTABILITY — Twice yearly the staff establishment itself is re-evaluated using acuity, dependency and quality indicators to determine if adjustments need to be made to staffing levels. A robust digital staffing assessment system is seen as a critical step for tracking and evaluating implementation and impact. Health boards were in the process of scoping effective existing tools to provide more robust data. Section 25E of the *Act* requires health boards to report their compliance with the other sections of the *Act*. Every three years they must report to the Welsh government on their adherence to the duties in the *Act*, including outcomes, efforts to maintain staffing and adherence to staffing levels.[31]

NEXT STEPS — After seven years of the *Nurse Staffing Levels (Wales) Act 2016* additional operational guidance was required to realize the full potential of the legislation as nurses were still being left with unsafe workloads and held responsible for things going wrong due to unsafe staffing. RCN Wales was campaigning for the *Act* to be fully implemented in community and inpatient mental health units. Nurse retention and recruitment with the goal of stabilizing the nursing workforce was also critical for the maintenance and continued expansion of the *Act*. RCN Wales also wants the government and health boards to have explicit consequences for noncompliance with the *Act*, improving effectiveness.[32]


Scotland

HOST: Eileen McKenna, Associate Director, Nursing, Policy and Professional Practice

SPEAKERS: Norman Provan – Associate Director, Employment Relations RCN Scotland; Philip Coghill – Scotland Lead Pay, Terms And Conditions, RCN Scotland; Anne Armstong – Interim Chief Nursing Officer, Scottish Government; Kathryn Brechin – Professional Advisor, Scottish government; Hannah Watson – Unit Head, Scottish government; Caroline Craig – Associate Director, Healthcare Staffing and EiC, Healthcare Improvement Scotland

SCOTLAND'S HEALTH CARE SYSTEM — Scotland receives a block grant for devolved services from the UK parliament, including the health care services provided by the NHS. Health is a devolved role for the Scottish government, and the Scottish parliament autonomously funds and operates NHS Scotland,[33] the national public health care provider. There are 14 regional NHS boards, 7 special boards and 1 public health board that arrange and administer health services.

NURSING IN SCOTLAND — Registered nurses (RNs) are the only designation allowed to practice in Scotland. In the UK, RNs enter one of four nursing specialties in their undergraduate training. RNs are generally supported on wards by unregulated nursing support workers (NSWs). Nursing associates (NAs), which are like licensed practical nurses in Canada, are not employed in Scotland as there is a concern that they will contribute to substitution in favour of saving money. This substitution is already being seen in Scotland, with NSWs substituted in positions that should be filled by RNs to provide safe care.[34] RCN Scotland is the trade union and professional organization representing nurses in Scotland.

SCOTLAND'S SAFE STAFFING APPROACH — The *Health and Care (Staffing) (Scotland) Act 2019* was first announced at the 2016 RCN Congress by the Scottish First Minister and passed after three years, with significant influence from RCN Scotland, eventually meeting 85% of their recommendations. The *Act* was first passed during a minority government, so all parties were able to work together to push the bill through parliament. Though the *Act* was passed mid-2019, implementation was delayed due to the COVID-19 pandemic. It came into force April 1, 2024, just over two months prior to the tour.[35]

The *Act* sets out duties the government must fulfill to provide safe nurse staffing levels for health and social care in Scotland.[36] The government is obliged to work collaboratively with trade unions and professional bodies to design and implement the final framework. The *Act* applies to multiple clinical professionals, including registered nurses, clinical nurse specialists, registered midwives and medical practitioners. The primary objective of the *Act* is to improve patient safety and outcomes. Improved staff well-being and retention is seen as a secondary outcome of the policy.

With the new *Act*, the NHS and care providers have a legal duty to have appropriate number of staff with the necessary skills and qualifications to provide safe care, including using the "common staffing method" for all areas of care with established staffing tools. Plans to identify risks and escalate concerns are required in cases of inadequate staffing.[37] Clinical advice for staffing decisions, allocated time for training and limited reliance on staffing agencies is also required. The guidance covers real-time staffing and future workforce planning, using staffing tools, professional judgement and organizational context to determine baseline staffing levels. An additional 22.5% "headroom" is added to account for expected and unexpected absences. In situations where a ward is below ratio, management decides if it is safe to work, with evidence of professional judgement explaining the reason. Severe and recurrent risks must be addressed by the health board to remain in compliance with their duty to provide adequate safe staffing.

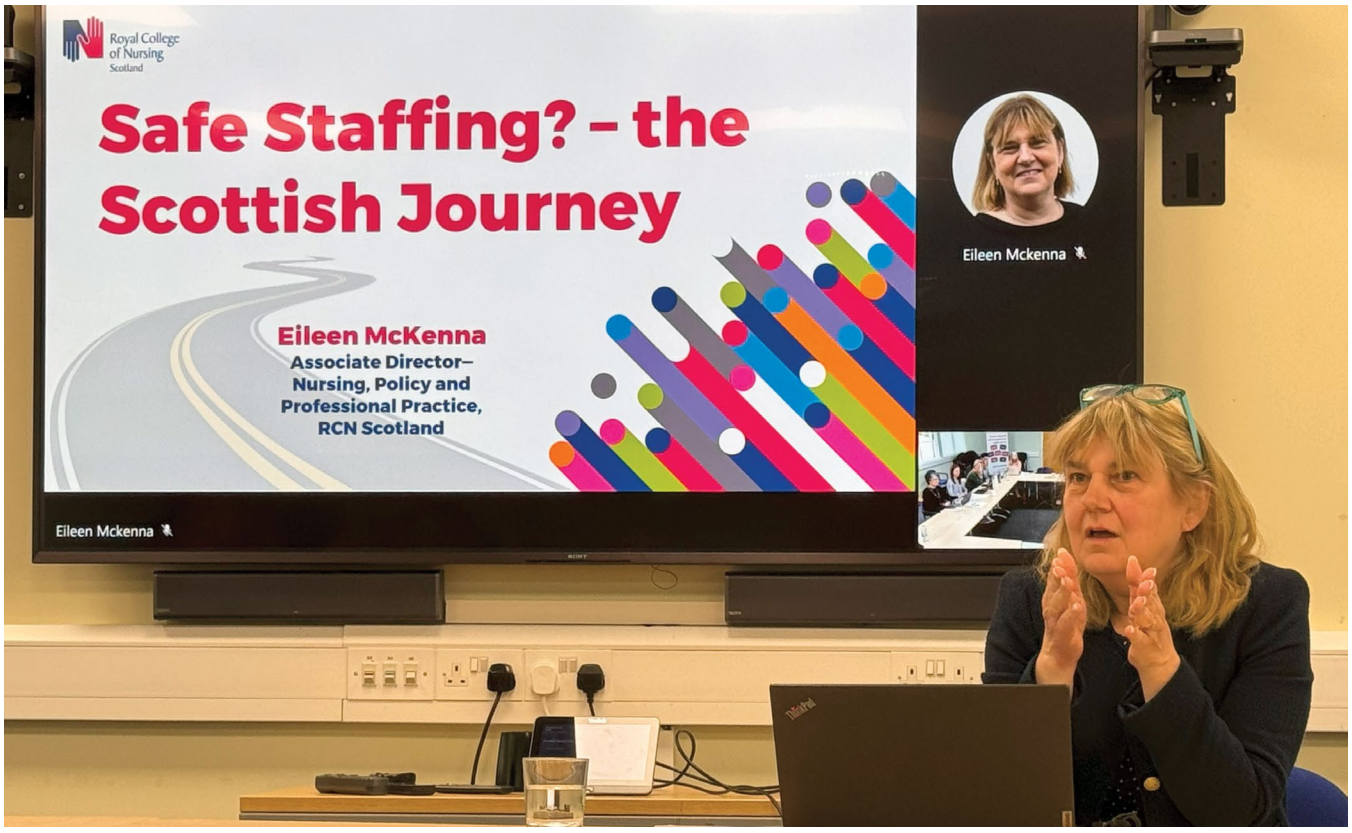
SKILL MIX — Skill mix is not explicitly stated in the *Act* or accompanying statutory guidance, citing the need for flexibility and innovation. This is concerning because substitution of registered nurses for less expensive care providers comes at the expense of patient safety.[38] While RCN Scotland was unsuccessful in securing a 100% supervisory senior charge nurse role in the *Act*, sufficient time and resources for clinical nurse managers to effectively perform their duties is indicated.[39] Senior charge nurse members are encouraged by RCN Scotland to use the legislation to ensure time to manage and lead their team is protected.

ACCOUNTABILITY — Health boards have the duty to provide quarterly compliance reports and a yearly report on the impacts of the legislation to the Scottish government, which is then taken to the Scottish parliament.[40,41] With the legal requirement to ensure there is a sufficient supply of RNs, the Scottish government is in a position to support and fund retention and recruitment initiatives. This places much of the burden of providing safe care with the government and employers, removing it from individual staff.[42,43]

Healthcare Improvement Scotland (HIS) is an arm's-length government agency responsible for monitoring and evaluating health, including evaluating the impact of the *Safe Staffing Act*. Information on adverse events, missed care, reports of concerns and other quality and workforce data can be requested by HIS, highlighting significant concerns and areas for improvement.

NEXT STEPS — A review of existing staffing tools and an assessment of where additional tools should be developed is underway by Healthcare Improvement Scotland, RCN Scotland and other unions. Proposed workforce planning tools must be calibrated and assessed for reliability and validity before implementation. This evidence will make it easier to support requests for changes to staffing calculations. Actions to stabilize the nursing workforce, including recruitment and retention, remain a key area of advocacy and action to improve the Scottish health care system.

RCN Scotland continues to monitor the implementation of the *Act*, providing guidance and scrutiny to ensure it is fully realized. They proposed an annual parliamentary debate on the topic to ensure it remains politically relevant, propose necessary amendments and ensure that the *Act* remains upheld.[44]



England

HOSTS: Nicola Ranger – General Secretary and Chief Executive, RCN; Patricia Marquis – Executive Director, RCN; Christine Callendar – Head of Nursing Practice, RCN; Charli Hadden – Policy Manager, RCN; Emma Selim – Communications Manager, RCN; Emma Laws – Senior Strategic Campaigns Officer, RCN; Stephanie Goodwin – Head of Organizing, RCN; Carli Whittaker – Head of Nursing, RCN

SPEAKERS: Lynn Woolsey – Deputy Chief Nurse, Workforce, Professional Practice and Quality, RCN; Wendy Preston – Head of Nursing Workforce, RCN; Lena Johnson – Professional lead, Nursing Workforce, RCN; Christine Callendar – Head of Nursing Practice, RCN; Callum Metcalfe-O'Shea – Professional Lead for Long-Term Conditions, RCN; Claire Sutton – Transformation Lead, Independent Health and Social Care Sector, RCN; Lynn Woolsey – Deputy Chief Nurse, Workforce, Professional Practice and Quality, RCN; Marcus Wootton – Associate Director, International, RCN; Emily McWhirter – Associate Director, Leadership, RCN; Patricia Hughes – Associate Director, Nursing Practice, RCN

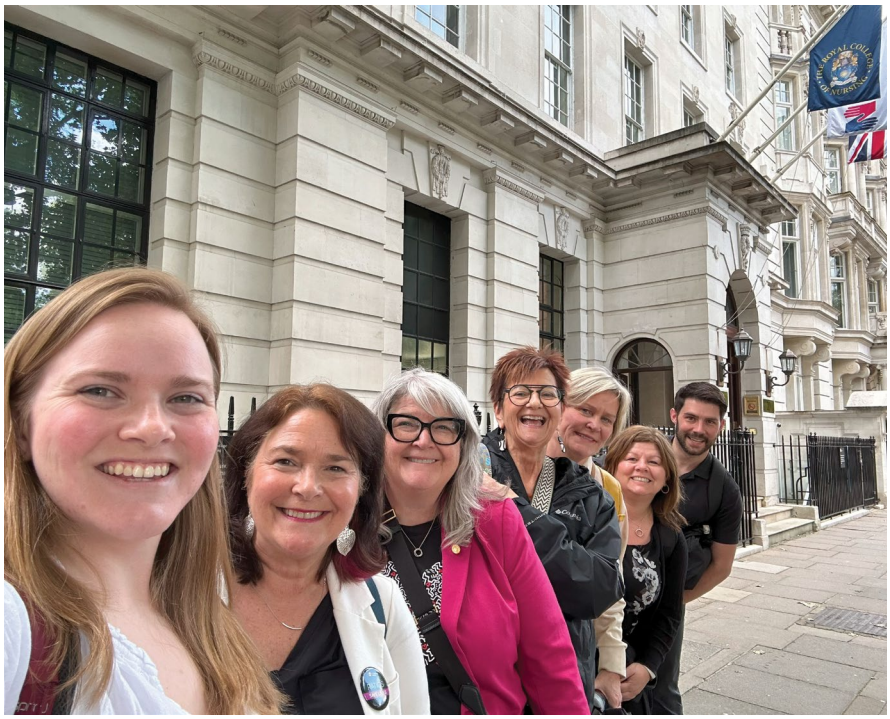
ENGLAND'S HEALTH CARE SYSTEM — The National Health Service (NHS) England has provided universal health services free of charge in England since 1948. The government owns health care assets such as NHS hospitals and creates policies for governance and administration of health services.[45]

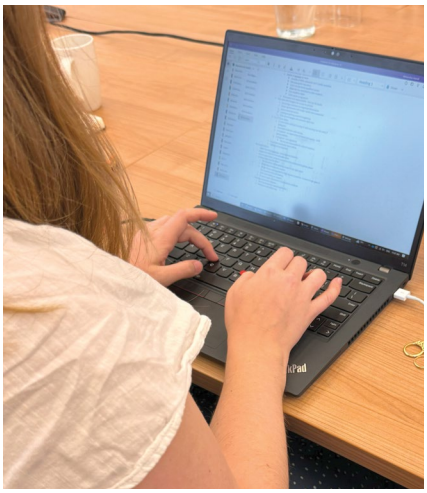
ENGLAND'S ROAD TO SAFE STAFFING — England does not currently have a mandated safe staffing framework or legislation, but the RCN is advocating and building the groundwork for safe staffing legislation. In July 2014, the National Institute for Health and Care Excellence (NICE) developed guidelines for staffing adult inpatient wards across the UK. As a national organization that produces best practice guidance for health care practitioners, NICE based its recommendations on the best available evidence at

the time. The guidelines provided clear directives for nurse and hospital management, focusing on safe staffing. Similar to frameworks later developed in the UK and Ireland, the NICE guidelines were influenced by findings from the Mid Staffordshire report and other inquiries into NHS care quality, which revealed widespread understaffing. The guidelines emphasized patient-centered care, recommending that staffing levels be based on patient needs. They also introduced key concepts, such as evidence-based staffing establishment and ensuring an appropriate skill mix to meet those needs. These ideas set the groundwork for similar concepts that were carried through in later frameworks.[46]

The NICE guidelines were influential in subsequent staffing policies; however, it is evident that the guidelines alone were not sufficient to make the kinds of changes that were necessary to improve outcomes. The guidelines are not enforceable and lack a systemic method for implementation. Ten years after the NICE guidelines were introduced, RCN's *Last Shift Report*, that asks nurses how their last shift went, found more than two thirds of respondents reported having below the recommended number of nurses on their last shift. Evidently, the guidelines are not enough, and substantive action must be taken to ensure safe staffing in England for patients and nurses alike.[47]

RCN SAFE STAFFING CAMPAIGN — The RCN is running the *Staffing for Safe and Effective Care in England* campaign to lobby the government for sufficient resources to fund and legislate safe staffing in England. The campaign calls for increased investment in domestic workforce supply by funding education and training, while recognizing the role that internationally educated nurses currently occupy in the workforce. They also call for the government to set out a legal duty to ensure safe staffing is written into law like in Wales and Scotland. The campaign allows nurses to make statements about staffing conditions at their workplace to increase visibility and amplify their voices so substantive changes can be made.[48]



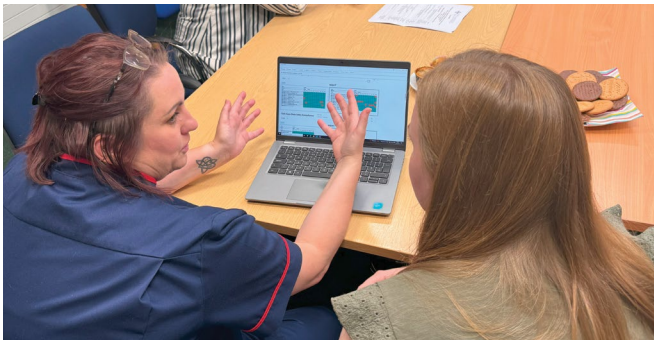


Key takeaways

DRIVERS OF SAFE STAFFING POLICY — The Mid Staffordshire report was commonly cited as a driver of safe staffing policy in both Ireland and the UK. It was an independent review of unacceptable standards at an NHS hospital. This report shone a light on the potential consequences of inadequate staffing and failing to prioritize quality of care. The Mid Staffordshire report continues to have a significant impact on transformational change within the NHS and in many ways opened the political window for safe staffing guidelines and legislation. The need for improvement to care quality through safe staffing and patient-centered care was also identified in several local strategic guidance frameworks, which fed into advocacy for transformational change such as policy mandates and legislation.

At the same time, global research into the correlation between inadequate staffing and poor patient outcomes had amassed a body of evidence that was becoming difficult to ignore. This body of evidence underpinned the first attempts at safe staffing made in the UK and Ireland with prominent researchers in this field, such as Linda Aiken from the United States, frequently being cited in initial policy frameworks. The creation of the NICE guidelines in 2014 brought together best practice evidence and set out standards that contributed to the eventual safe staffing frameworks and legislation that exist today.

EVIDENCE-BASED SAFE STAFFING AND NPR — There were several safe staffing approaches across the countries that were visited, with even greater diversity worldwide, but the goals of safe staffing and NPR are aligned. Implementing safe staffing measures is a deliberate decision to ensure that nurses are set up with the appropriate number of care hours and support to provide safe and effective care to patients. In most cases, prior to safe staffing policies, staffing levels evolved from historical staffing trends which may have been heavily influenced by finance departments and not based on evidence. This left wards chronically understaffed, leading to insufficient care, staff burnout and moral distress when nurses cannot provide the care they know patients need. An overwhelming body of international academic evidence supports more skilled nursing care per patient to mitigate negative patient outcomes. All the safe staffing policies that were explored on the tour leveraged evidence to support their policy decisions and demonstrate why they were necessary.



Evidence was used not only to create the initial frameworks but also was used or will be used to evaluate and fine-tune the policies. Data collection and evaluation was built into all the frameworks in different ways. This evidence creates standards for evaluation of performance and sets up a system for accountability. Evaluations can be used to advocate for additional support and changes to continue to improve the system. Measurable outcomes show efficacy and build a case for decision-makers to continue supporting safe staffing policies.

MANDATED FRAMEWORKS OR LEGISLATION — Mandated frameworks for safe staffing are present in the Republic of Ireland and Northen Ireland, whereas safe staffing is legislated in Wales and Scotland. Wales was the first country in the UK and the European Union to legislate safe staffing in 2016, with Scotland just a few years after in 2019, although it took until 2024 for Scotland's *Act* to come into force.

Frameworks are a step toward safe staffing, but they lack accountability, downloading responsibility to individual hospitals, nurse managers and even nurses. While they help build knowledge and make a case for scaling the guidelines, progress is often slow and dependent on voluntary effort. In Ireland, the framework has been under study for years through pilot projects, with additional phases only beginning to spread across the country after extensive research and multiple reports. In N.I., the framework is upheld by local trusts, but there is no robust pathway for evaluation and accountability. In the Republic of Ireland, nurse managers are responsible for implementation, and accountability stops with them, even though larger system issues often influence non-adherence. Without legislation, there is no guarantee that the government will continue to invest in or expand the framework, leaving safe staffing vulnerable to shifting priorities and de-prioritization.

Legislation provides clear directives for the government and its agencies to ensure safe staffing, establishing a chain of accountability. Mandatory reporting ensures guidelines are followed, with mechanisms in place to escalate incidents of non-adherence to authorities capable of providing additional resources and support. Governments may also be more inclined to back related policies, such as student support and immigration, that contribute to maintaining adequate staffing levels. By enshrining safe staffing in legislation, as in Wales and Scotland, the responsibility lies with decision-makers who have the power to implement changes. This makes it easier to request additional resources and ensures a coordinated system-wide approach to fulfilling the obligations of safe staffing, from workforce planning to policy alignment.

CALCULATING SAFE STAFFING — The frameworks and acts in the Republic of Ireland, N.I., Wales and Scotland calculated the *funded establishment*, which is the number of whole-time-equivalent staff that are hired to provide nursing care in a particular setting or ward. In all the frameworks that were explored, the funded establishment was determined by collecting data on observed patient needs combined with professional judgement and other organizational factors. Some of the calculations were quite complex and would require several levels of discussions, data analysis and approval, while others were more straightforward. Nursing care looks different between sectors and settings so diverse methods were appropriate for different wards.

Conclusion

We would like to extend a big thank-you to all the wonderful hosts and speakers that supported the knowledge exchange during this study tour. Seeing safe staffing practices in various stages of development and hearing diverse perspectives on the process provide a unique insight for the CFNU tour delegates. The knowledge gained will undoubtedly guide developments and campaigns for safe staffing and NPR nationally and in provinces across Canada. With several tour delegates in the process of advocating nurse-patient ratios or in the process of consulting on the implementation of such ratios, learning from those who are in different stages of their implementation process was invaluable.

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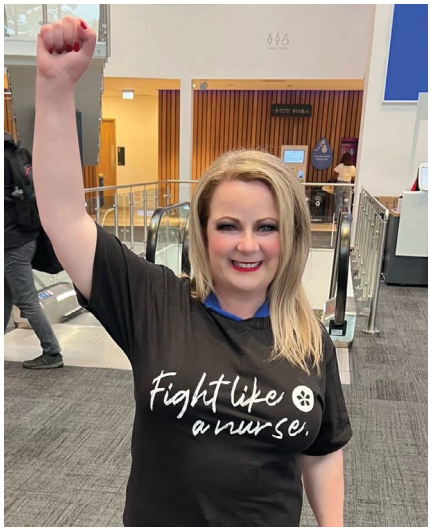
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