Our Health, Our Future

Creating Quality Workplaces for Canadian Nurses

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FINAL REPORT OF THE CANADIAN
NURSING ADVISORY COMMITTEE

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CONTENTS

The time is always right
to do what is right.

Dr. Martin Luther King, Jr.
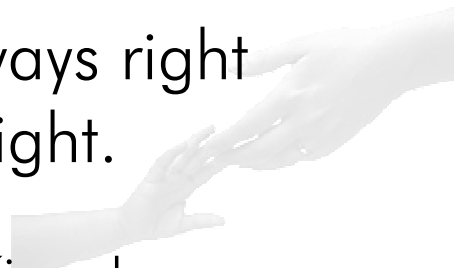
PREFACE AND ACKNOWLEDGEMENTS

There is urgent need to repair the damage done to nursing through a decade of healthcare reform and restructuring. The case for constructive change is compelling. However, simply to endeavour to return to better days will not meet the needs of Canadians for high-quality nursing services as a mainstay of our broader healthcare system.

This report describes in detail why Canada needs more nurses and better working conditions for nurses. It also sets forth a plea for treating nurses with greater respect.

It is a privilege to have been invited to chair the Canadian Nursing Advisory Committee. No Chair has been blessed with as talented a Committee to head. I would like to thank the members of the Canadian Nursing Advisory Committee for their spirited, committed and passionate participation. *Merci beaucoup*. We were aided by the dedication of Michael Villeneuve, who led our staff support with grace, determination and energy. Our six research teams brought forward insight and important evidence to support our conclusions, and Wayne Brighton was pivotal in facilitating all that work. Louise Wood was a great help in producing the final version of the document.

Finally, I hope that our report lends urgency to the recognized problems in Canadian nursing. Actions are required.

Michael B. Decter

PREFACE

TERMINOLOGY

Throughout this report, we have used the terms "nurse" and "nursing" to refer collectively to Canada's three regulated nursing professions:

- Licensed Practical Nurses;
- Registered Psychiatric Nurses; and
- Registered Nurses.

Licensed Practical Nurses are also called Registered Nursing Assistants, Certified Nursing Assistants, and Registered Practical Nurses. We have used the term Licensed Practical Nurse in this report to represent these various titles.

Registered Psychiatric Nurses are regulated only in the four Western provinces, and most work in those provinces.

Registered Nurses and Licensed Practical Nurses work in all provinces and territories.

EXECUTIVE SUMMARY

The *Canadian Nursing Advisory Committee* was created in 2001 in response to the first recommendation of the *Nursing Strategy for Canada*. This strategy, known more commonly as the *National Nursing Strategy*, was developed by the Advisory Committee on Health Human Resources (ACHHR) and approved by Ministers of Health in October 2000.

According to its terms of reference, the primary goal of the Canadian Nursing Advisory Committee was to formulate recommendations for policy direction that would improve the quality of nursing work life at the federal, provincial and territorial levels. The Committee was established for a twelve-month period, with the understanding that its role and mandate would be reviewed at the end of that period.

Following a call for nominations, 16 individuals were appointed to the Committee by the Advisory Committee on Health Human Resources. All Committee members were selected in recognition of their individual knowledge, experience and expertise. Twelve of the 16 members were from non-government organizations and employers, three represented provincial or territorial governments, and one was from the federal government. Nursing representatives were selected from the three nursing professions: Licensed Practical Nurses, Registered Nurses and Registered Psychiatric Nurses. Final Committee membership was approved by the Deputy Ministers and Ministers of Health in March 2001. The Committee Chair was Michael Decter.

The Committee met three times between its founding and March 2002: in June and November 2001, and in March 2002. Each meeting lasted two full days, and each involved discussion and debate regarding the large body of evidence about nursing work life and quality work environments. At these meetings, the Committee also consulted a variety of researchers and other experts. The committee received briefs from the *Canadian Nurses Association*, the *Aboriginal Nurses Association of Canada* and the *Ontario Nurses Association*. As well, several groups and individuals were invited or requested the opportunity to appear before the committee.

To inform discussion and to provide current perspectives on selected issues, the Committee commissioned six research/information projects. The six projects examined current strategies for healthy workplaces, the cost of nurses' absenteeism and overtime, strategies for addressing nursing workload issues, factors relating to nurses' satisfaction in the workplace, focus-group findings on nurses' definitions of respect and autonomy in the workplace, and a discussion

of the organizational structures within which nurses, doctors and patients interact. Experienced researchers known to the Committee were contracted on a short-term basis to carry out the projects. Unfortunately, time constraints and the lack of data about Licensed Practical Nurses and Registered Psychiatric Nurses limited the scope and depth of these six projects. Executive summaries of these research/information projects are provided in this report, and the full research reports themselves are available on request.

Following these meetings, consultations and research activities, the Committee prepared 51 recommendations for submission to the Advisory Committee on Human Health Resources. These recommendations may be grouped into three broad categories:

- those designed to put in place conditions to resolve operational workforce management issues and to maximize the use of available resources. Broadly speaking, these recommendations are designed to help reduce the pace and intensity of nursing work, increase the proportion of nurses working full-time, reduce absenteeism and overtime and maximize nurses' scope of practice.

- those designed to create professional practice environments that will attract and retain a healthy, committed workforce for the 21st century. Key activities associated with this recommendation focus on the importance of respect for all workers in the healthcare system, educating and graduating more nurses at all levels (entry level, masters and doctoral), providing increased funding for education and professional development for both nurses and students, improving education services to rural and remote settings, maximizing classroom and clinical opportunities, and addressing abuse and violence issues in the workplace.

- those designed to monitor activities and generate and disseminate information to support a responsive, educated and committed nursing workforce. These recommendations are concerned mainly with such activities as conducting an annual national survey of nurses' health, developing national Healthy Work Environment Guidelines to create high-quality nursing workplaces, supporting accreditation activities and awards that improve the quality of nursing work life, continuing to study and refine our understanding of nursing workforce information, implementing recommendations of provincial/territorial nursing advisory committees (or equivalent structures) and other strategies under way to improve the working lives of Canadian nurses, and implementing a broad, national campaign to attract and retain a diverse workforce in all nursing roles and at all levels — especially to increase the recruitment and retention of Aboriginal nurses and nursing students.

Taken together, these recommendations address the central issues identified as barriers to a quality workplace for Canadian nurses, namely:

- the need to increase the number of nurses;
- the need to improve the education and maximize the scope of practice of nurses; and
- the need to improve working conditions of nurses.

The implications of *not* acting now to resolve these nursing workforce issues are plain. The regulated nursing professions make up over one-third of the entire Canadian healthcare workforce, and the care nurses provide has direct and significant impact on outcomes for the patients, clients and families the system is designed to serve. Simply put, as nursing goes, so goes the rest of the system. The value of improving nursing working conditions is clear — and the need to act now is urgent.

Background — The Origins of the Canadian Nursing Advisory Committee

Sparked by the effects of budget cuts and health system reform that took place in most Canadian provinces and territories throughout the 1990s, the first years of the 21st century have seen unprecedented interest and activity in health human resources. Numerous reports, studies and strategies on this topic have emerged at every level, from individual employers to provincial and territorial strategies to national system reviews. They all have addressed health human resources in some way, with particular reference to describing and suggesting strategies to resolve current and looming shortages affecting every region of the country and every healthcare discipline (Standing Senate Committee on Social Affairs, Science and Technology, 2002b).

The *Canadian Nursing Advisory Committee* was born of one such strategy. The Committee was created in March 2001 in response to the first recommendation of the *Nursing Strategy for Canada* (Advisory Committee on Health Human Resources, 2000a), more commonly known as the *National Nursing Strategy*. Recognizing mounting concerns about a looming crisis in the Canadian nursing workforce in the late 1990s, the Conference of Deputy Ministers and Ministers of Health directed the *Advisory Committee on Health Human Resources* (ACHHR) "to develop a pan-Canadian strategy for nursing" (ACHHR, 2000a, p.2). Following extensive stakeholder consultation, the ACHHR's *Working Group on Nursing and Unregulated Healthcare Workers* gave life to a national strategy whose purpose was to make recommendations to "achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed and deployed to meet the health needs of Canadians" (ACHHR, 2002a, p.2). The Nursing Strategy for Canada was approved by Ministers of Health in October 2000 (see Appendix A for the executive summary of the Strategy).

Immediately following approval of the Nursing Strategy for Canada, work began on its first recommendation — the creation of a Canadian Nursing Advisory Committee. Drawing on the ideas and advice of stakeholders consulted during the development of the National Nursing Strategy, members of ACHHR's Working Group on Nursing and Unregulated Healthcare Workers generated terms of reference for the Committee (see Appendix B), as well as nomination and selection criteria for members.

BACKGROUND

From the outset, it was agreed that quality of nursing work life demanded immediate attention. According to its terms of reference, the Committee had as its primary goal in its initial mandate the formulation of recommendations "for policy direction to improve quality of nursing work life which would provide a framework and context for work life improvement strategies at the provincial/territorial level" (ACCHR, 2000b). Since the dimensions of the crisis in the Canadian nursing workforce came to be understood more precisely over the past couple of years, a number of governments and healthcare institutions have moved to improve the working lives of Canada's nurses. Some of the changes have been dramatic, and there is no doubt that numerous problems have been eased. However, the very existence of the Canadian Nursing Advisory Committee is an acknowledgement that serious problems remain.

The Canadian Nursing Advisory Committee met three times during 2001-2002. During that time, the Committee commissioned six small research and information projects designed to inform the Committee's deliberations on specific topics (see Appendix C). Details of the Committee's structure and membership are included in Appendixes D and E, respectively. This report summarizes the issues the Committee addressed and presents the recommendations it was mandated to develop.

A Note about Data. Throughout this report, we refer repeatedly to Registered Nurse data in places where we did not refer similarly to Licensed Practical Nurses or Registered Psychiatric Nurses. Our decision to do so was deliberate and based on the available data. We are concerned by the lack of data in general, and we are particularly concerned about the paucity of data on Licensed Practical Nurses and Registered Psychiatric Nurses. We are encouraged by the development of databases for both groups at the Canadian Institute for Health Information (CIHI); unfortunately, those data were not available at the time this report was written. In other sources, such as the Canadian Labour Force Survey, data on nurses other than Registered Nurses are aggregated at such a high level that they do not permit meaningful analysis or allow us to draw conclusions. Therefore we have used what data we could, and we recommend that data be collected and analyzed for all three regulated nursing groups. We also found that most of the relevant nursing human resources studies involved acute care settings, so we used those data. We encourage researchers to replicate their findings in community, long-term and other settings where nurses practise.

THE PROBLEM — WHAT IS CAUSING THE SHORTAGE OF NURSING CARE?

THE PROBLEM

Introduction

Nurses are the cornerstone of a healthcare system that is currently beset by challenges, problems and opportunities. Twenty-four hours a day, seven days a week, whether in community health centres, metropolitan teaching hospitals or isolated nursing stations, nurses are often there first when Canadians are in need of care.

For several years, Canada's governments and healthcare leaders have recognized that the healthcare system faces a crisis related to the nursing workforce: there simply are too few funded nursing care hours for too many nursing care needs. As a result, the nursing positions that are available for duty are overworked and strained. That, in a nutshell, is the problem.

The shortage of nursing care at the point of care has three root causes:

- an actual current shortage of nurses (e.g., a reduced number of seats in nursing education programs and an aging nursing workforce);

- human resources management issues that make it impossible to maximize the productivity of the nurses who are available to work (e.g., high absenteeism, high overtime, high rate of part-time work, high number of non-nursing tasks, and limited scope of practice); and

- insufficient funds to hire the number of nurses needed to deliver the care being demanded.

> Where there is so much racket, there must be something out of kilter.
>
> *Sojourner Truth, 1851*

Working in concert with the rising acuity, intensity and complexity of patient care environments and an erosion of nursing leadership — themselves the result of system downsizing through the 1990s — these three root causes have contributed to relentless workload increases across all types of practice settings where nurses work. This workload has, in turn, reduced satisfaction and morale, contributed to a high rate of absenteeism and threatened the quality of patient care. The cycle set in motion in the 1990s has arguably led to a situation that requires a proactive and deliberate national strategy of intervention if we hope to rescue and renew a very troubled sector of the health system.

Important to decision makers is the notion that we not make the problem unnecessarily complex. Positive change is readily achievable without further study. Even at a national level, some of the solutions are relatively straightforward, and some can be realized within existing funds.

The implications of *not* moving now to resolve nursing workforce issues are plain — the regulated nursing professions make up over one-third of the entire Canadian healthcare workforce. The care nurses provide has direct and

significant impact on outcomes for the patients, clients and families the system is designed to serve. Because of their high numbers in the system, it has often been suggested that as nursing goes, so goes the rest of the system. The implications and value of improving nursing working conditions for multi-professional teams and patient care are clear — and the need to act now is urgent.

The Extent of the Shortage

Nurses are fundamental to the health system, both in their role and in their numbers. While the number of regulated nurses remains high, the devastating impacts of government funding cuts in the 1990s need to be acknowledged. Currently there are about 300,000 Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses working in the Canadian healthcare system (Canadian Institute for Health Information [CIHI], 2001a). Among Registered Nurses, that equals one nurse for every 133 Canadians (CIHI, 2001b) — a drop from a ratio of 1:119 in 1990. The number of Licensed Practical Nurses dropped from some 83,000 in 1992 to about 65,000 in 2000.

Some of these losses came about as a result of reduced numbers of seats in nursing education programs, and some as a result of retiring nurses not being replaced. Further, the prevailing thinking in the 1990s was that to maximize funding, flexibility and nursing care hours, full-time work should be converted to more part-time and casual employment. That shift of employment status across the nursing workforce led in turn to a reduction in nursing care hours. It must also be emphasized that a portion of the loss was due to direct lay-offs of nurses during the 1990s.

> The key for governments, employers and policy makers now is to recognize that if we want nurses and other health professionals to come into the system and stay in it, we have to create and maintain stable and healthy work environments.

We do not know if the number of nurses per capita in 1990 was the right one, and since then, the system has undergone dramatic changes in its structure and operations. However, rising rates of absenteeism, excessive overtime and decaying morale suggest strongly that the number of nurses is too low to deliver the care required.

By how many nurses are we short? The Canadian Federation of Nurses Unions asserts that if Canada were to have the same ratio of nurses to population today as 10 years ago, another 16,000 nurses would have to be added to the system immediately (Connors, 2002). Whether that number is a precise reflection of the current problem is moot. The reality is that we are short of nursing care in every sector, and the shortage will only worsen without action.

A Delicate Balance — Who is Leaving Nursing and Who is Coming In?

Any consideration of the state of nursing in Canada must begin with the acknowledgement that — regardless of cause — there is a real shortage of nurses now, and that the shortage will get worse in the future without determined policy changes. In 1997, Ryten forecast a shortage of between 59,000 and 113,000 Registered Nurses by 2011, and there is ample evidence that the gap between care demands and the supply of nurses has indeed begun to grow (Ryten, 1997).

A 2001 Ontario environmental scan by the Association of Colleges of Applied Arts and Technology suggests cumulative retirement rates to the year 2010 of 48.9% for Head Nurses and Supervisors, meaning that nearly half of this workforce will retire by 2010.

Other cumulative retirement rates related to nursing human resources:

- University Professors, 49.6%

- College Instructors, 37.7%

- Registered Nurses, 37.4%

- Licensed Practical Nurses, 36.1%.

Most problematic is the fact that the nursing workforce is not sufficiently renewing itself. Ahead lies the prospect that the nurses of the baby boom generation are approaching the age at which they will begin to leave the workforce. In 1990, the average age of a nurse was 39; today that average is 43.3 (CIHI, 2001b). Almost half the nursing workforce is more than 45 years of age, and almost 30% of working nurses are older than 50. The average age of nursing educators is nearly 49 (CIHI, 2001b). With many nurses retiring at age 55, the great body of nurses is moving steadily toward retirement. And as that generation leaves the workforce, it takes with it the knowledge, expertise and productivity that are critical to a stable healthcare system and necessary to support and mentor new practitioners.

A related concern is the impact of job insecurity on the nursing workforce. It has been established that a number of recent graduates left the country in search of jobs elsewhere or simply left nursing when they realized they could not get full-time nursing work in Canada. Those who remained took part-time or even full-time jobs for which there was no guarantee of permanence.

Talk of those exiting the system leads naturally to the question of who is coming into nursing. Statistics from schools of registered nursing across the country provide a dramatic indication of the roots and causes of the nursing shortage. In 1990, there were 12,170 admissions to basic entry Registered Nurse programs; by 2000, there were just 8,790 admissions (Canadian Nurses Association, 2002). While there was an increase in admissions and seats for Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses from 2000 to 2002 (O'Brien-Pallas, Meyer, Alksnis, et al., 2002), the initial decline was so steep that it will take some time — and many more admissions — before the shortage is overcome.

In a decade in which the Canadian population increased by 11%, admissions to registered nursing seats decreased by 26%. During the same time period, the number of nursing graduates decreased by 46%. The number of Registered Psychiatric Nurses and Licensed Practical Nurses also decreased notably in the 1990s (see Figure 1).

With fewer and fewer new recruits able to enter nursing, more career choices for all of Canada's young people, and more and more nurses leaving the professions or the country, an even more critical shortage is inevitable unless action is taken. Adding complexity to the situation is the fact that applicants and graduates in nursing education are older than in the past, and so their potential years of service in nursing are reduced from the outset.

Figure 1. Canadian Population vs. Number of Nurses

Left unattended, the number of older nurses exiting from the workforce could simply overwhelm the number of new nurses coming in — and the impact on shortages is plain. There is, however, some good news. The number of qualified applicants continues to exceed the seats available in nursing education programs. Unfortunately, in some parts of the country, fully qualified candidates have had to wait up to three years on waiting lists before beginning nursing studies. Their frustration with a system that acknowledges a nursing shortage is understandable.

An early response in many jurisdictions has been to increase the number of admissions to nursing studies. That will help, but it takes years to graduate nurses, and increased admissions alone will not solve the problem. Moreover, an increase in the number of admissions carries with it an added challenge: clinical placements for students are increasingly difficult to arrange in a downsized system.

To add further confusion, occasional voices have suggested that the solution to the shortage lies in reducing educational qualifications so that more nurses could be graduated more quickly. In the hypothetical situation of a shortage of neurosurgeons or architects or lawyers, would we consider it appropriate to suggest reducing their required training by a year or two? Hardly. The Canadian Nursing Advisory Committee lends its strongest support to the trend for increased education for all categories of nurses and urges abandoning any discussion of rolling back entry-to-practice educational requirements.
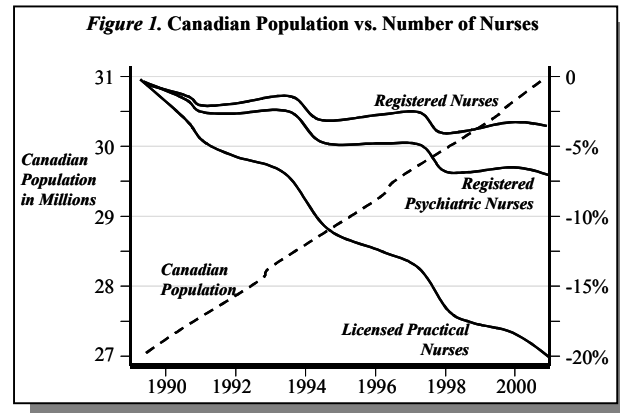
On the Front Line of Canadian Health Care: The Burden of the Shortage

We have a fairly clear picture of who is entering nursing and who is leaving it. Perhaps our greatest challenge therefore lies in understanding how to retain and maximize the skills and productivity of those currently in the system.

To that end, we know that a high level of basic predictability is an important requirement for a healthy workplace (Baumann, O'Brien-Pallas, Armstrong-Stassen, et al., 2001). Glouberman stresses further that the current situation "does not provide much stability to nursing staff … unstable work environments make everyone more jittery and less respectful of each other" (2002, p. 29). The key for governments, employers and policy makers is to recognize that if we want nurses and other health professionals to come into the system and stay in it, we have to create and maintain stable, healthy work environments.

For example, nurses need safe, accessible parking. Nurses in many settings work around the clock; those working on weekends or in the middle of the night have the same need for warm, nutritious food as those who work weekdays. Nurses need responsive, flexible and innovative schedules that allow a female-dominated workforce to balance home and working lives and to meet unpredictable family care needs.

> Nurses are working harder, caring for more individuals, and spending less time with each person. What has shrunk in this changing environment is the amount of time they have to assess, monitor and provide appropriate nursing care as well as be teachers, comforters and communicators.
>
> *Ontario Nursing Task Force Report 2000*

Factors in two main categories warrant attention as we strive to make recommendations that will stabilize healthcare workplaces: *Operational Workforce Management Issues* and *Professional Practice Environments.*

Operational Workforce Management Issues

Operational issues affecting the nursing workforce can be grouped into five key, inter-related areas: a) workload, b) overtime, c) absenteeism, d) employment status and e) scope of practice and non-nursing tasks.

Workload. Increased workload has led inevitably to work *overload*, one of the unwelcome and inescapable features of nursing in the 1990s that has continued into the new century. The evidence of work overload is not difficult to find. Nurses report they are expected to do more than one thing at a time in more than one place at a time; frequently a very sick patient is involved (Viewpoints Research, 2002). New work or more difficult work is imposed within difficult time constraints. Days are described as *rush-rush-rush*, imbued with a feeling of *always catching up* (Viewpoints

Research, 2002), and nurses report leaving patient care needs unmet because they simply have too much to do in the time allowed (Aiken, Clarke, Sloane, et al., 2001). In the words of one report, the result for nursing administrators and nursing staff is "moral distress when they cannot find adequate numbers of qualified staff to deliver safe care" (Marck, Allen & Phillipchuk, 2001).

Fewer nurses doing more jobs in more intense, complex environments means work overload (Aiken et al., 2001; Baumann et al., 2001; O'Brien-Pallas, Thomson, Alksnis & Bruce, 2001). The physical and mental strain of overload brings on the astonishing levels of injury, illness and burnout that have affected nursing employers in recent years. Furthermore, researchers have suggested that nurses suffer the highest levels of stress of all health professionals (Sullivan, Kerr & Ibrahim, 1999).

According to Baumann and colleagues, "research has made it clear that problems with nurses' work and work environments, including stress, heavy workloads, long hours, injury and poor relations with other professions, can affect their physical and psychological health. Research across occupations has shown long periods of job strain affect personal relationships and increase sick time, turnover and inefficiency" (Baumann et al., 2001, p. iv). Work overload requires more overtime in an environment of insufficient staffing, and the strain of that overtime frequently leads in turn to illness and injury among nurses.

In the multitude of reports about the state of nursing and nurses, the interwoven themes of overwork and the frustration of trying to get the job done the way it should be done occur again and again. One report found that, in addition to regular overtime, some nurses were working eight- or twelve-hour shifts without breaks as the only way to get their work done — and still feeling frustrated:

> Despite working longer and harder, however, many nurses are still unsatisfied with the level of care they are able to deliver and are increasingly becoming frustrated by the number of clerical and other non-nursing duties that prevent them from working to high standards of patient care. The implications of increased workload are complex: with too few nurses and too many responsibilities nurses feel torn from the core values and elements of their work, find it difficult to feel proud or satisfied with their work, and experience a drop in productivity and effectiveness. (Thomson, Dunleavy & Bruce, 2002, p.24)

Overtime. In the period immediately after the budget cuts and staff reductions of the 1990s were instituted, there was an apparent increase in basic productivity — the job seemed to get done by fewer people, so in the short term, the workplace was deemed more efficient and productive. Whether total payroll was reduced remains debateable. Studies in Canada and the United States suggest that understaffing leads, in fact, to *higher* costs for employers, often through overtime expenses. In addition, nurses pay high personal costs

when understaffing occurs, and the Canadian public pays too, in the form of higher costs and reduced service quality.

Canadian Registered Nurses work almost *a quarter of a million hours of overtime every week, the equivalent of 7,000 full-time jobs per year* (Canadian Labour and Business Centre [CLBC], 2002). If nurses work too many hours and work with the intensity that is now inevitable in the system, it takes a toll. All nurses, full-time and part-time, suffer startlingly high rates of strains and sprains and back injuries. When patients must be moved by too few nurses, with inadequate (or missing) equipment, and at a time when the nurses may be tired or stressed or both, a high incidence of musculoskeletal injuries is hardly surprising. Recent research suggests an almost perfect correlation between overtime and sick time; furthermore, overtime is highly predictive of increased lost-day injury claim rates among nurses (O'Brien-Pallas, Thomson, Alksnis & Bruce, 2001; Shamian, O'Brien-Pallas, Kerr, et al., 2001).

Absenteeism. The effect of workload and overtime on nurses' health is clear. In any given week, more than 13,000 Registered Nurses — 7.4% of all Registered Nurses — are absent from work because of injury, illness, burnout or disability (CLBC, 2002). According to Canada's *Labour Force Survey*, that rate of absenteeism is 80% higher than the Canadian average (8.1% for nurses, compared with a 4.5% average among 47 other occupational groups) (CLBC, 2002). Absenteeism for Licensed Practical Nurses and Registered Psychiatric Nurses is on top of those numbers, but exact statistics are not yet available for those groups. The most vulnerable segment of the nursing workforce is the older nurses. That nurses are sicker than the average Canadian worker is an irony that should shame all of us who are in leadership and management roles in the healthcare system.

What are the economic implications of this rate of absenteeism? Over the course of a year, *more than 16 million nursing hours are lost to injury and illness — the equivalent of almost 9,000 full-time nursing positions* (CBLC, 2002). It is unrealistic to expect that illness and injury can be eliminated completely. But if the rate of absenteeism among nurses fell just to that of the rest of the labour force, some 3,500 full-time, full-year nursing positions would be regained immediately (CLBC, 2002).

The cost of overtime and absenteeism

- Canadian RNs work almost a quarter of a million hours of overtime every week, the equivalent *of 7,000 full-time jobs per year*

- Over the course of a year, more than 16 million hours are lost to RN injury and illness — the equivalent of almost *9,000 full-time nursing positions*

- The Canadian Labour and Business Centre estimates the cost of overtime, absentee wages and replacement for Registered Nurse absentees to be between *$962 million and $1.5 billion annually.*

If we assume that nurses suffer the same rates of non-work-related illnesses and injuries as other Canadian citizens, it is reasonable to suggest that the excess absenteeism of nurses may be related to the work they do or the settings in which they practise. We may not be able to change the rates of cancer or motor vehicle collisions or surgical illnesses suffered by nurses; we certainly can, however, change the conditions of their practice settings if those are driving up the rates of absenteeism. And if we are not moved by a moral imperative to help nurses, then the cost to the public obliges us to act. We are spending vast sums of money, with absolutely no benefit, that could be used much more effectively in the system.

Employment status. Almost half of the country's nursing workforce is underemployed, with some 45% of nurses working on a part-time or casual (unscheduled) basis (CIHI, 2001b). Having a high proportion of part-time staff can be problematic in any workplace. Most immediately, scheduling is a constant human and financial burden. There is also the cost of overtime or the cost of hiring agency nurses to compensate for an unpredictable workforce. Such costs are a strain on the budgeting of any organization. Another obvious drawback is that it is difficult to achieve the kind of cohesion and teamwork that is required for a workplace to be effective. Finally, this kind of job fragmentation can only confuse patients. It has been calculated that in a three-day stay in hospital, the average patient is exposed to the attention of anywhere up to 80 people — the vast majority of whose names and functions remain a mystery.

> Almost half of the country's nursing work force is under-employed, working on a part-time or casual basis.
>
> If involuntary part-time workers had been converted to full-time workers in 2001, it would have resulted in some 4.7 million additional hours of nursing practice — the equivalent of 2,592 full-time nursing positions.

Many nurses work part-time out of necessity, not choice — they cannot find full-time work. In a state of shortage, the failure to maximize the employment of every possible worker seeking full-time work is both puzzling and troubling. In the mid-1990s, many new and younger nursing graduates were unable to secure full-time work; the few jobs available went to nurses who were older and had more seniority. Rather than biding their time in part-time jobs, some of those young nurses left the country; others simply left nursing. Part-time jobs, float positions and working across multiple locations hinder the new practitioner from advancing from novice to expert at a pace that is both rewarding and required by the system. Across the country, nurses have loudly and repeatedly voiced their frustration with the lack of access to full-time jobs.

One solution to staff shortages is the creation of a "float pool," where nurses work in multiple units or at multiple sites. However, such pools can be difficult to maintain, because nurses generally prefer permanent assignments. If such pools were to be created, the Canadian Nursing Advisory Committee recommends that these *not* be the usual first jobs of new graduates, who we feel require and deserve a more stable learning environment.

Of equal concern is the reality that many nurses choose part-time work because they refuse to put up with the working conditions that accompany full-time work. Maintaining part-time or casual status brings a measure of control to a nurse's working life – in the eyes of many, a reasonable trade for the loss of benefits and job security that come with full-time work. The incentives in nursing are arguably misaligned; the rewards, both financial and personal, often make it more attractive to work on a part-time or casual basis. The part-time nurse enjoys a measure of control not possible with full-time work while still being able to earn lucrative overtime hours.

Changing the way nurses are deployed would provide the foundation for sustainability and succession planning. More young nurses need to work full-time; more experienced (and older) nurses should be allowed to move to part-time work without losing benefits. One immediate solution would be the active recruitment of part-time nurses to take full-time jobs. However, some full-time jobs should also be available to recent graduates who have taken jobs elsewhere or have simply left nursing altogether because they wanted full-time work. From the present 55-45 ratio of full-time to part-time nurses, a shift to 70-30 would provide healthcare organizations with greater stability in their nursing workforces, and would also provide some flexibility to organizations and to those nurses who do not want full-time employment.

> The task of nurses in hospitals is patient care. But every study shows that they spend up to three quarters of their time on work that does not contribute to patient care … This not only destroys productivity; it also destroys motivation and pride.
>
> Whenever a hospital concentrates paper work and assigns it to a floor clerk who does nothing else, nurses' productivity doubles. So does their contentment. They suddenly have time for the work they are trained and hired for: patient care.
>
> Drucker, 1993, p. 90

Scope of practice and non-nursing tasks. As budgets have been cut in healthcare settings, nurses have been caught in the middle of a *speed-up*. Simply put, there are fewer nurses to do more nursing, and nurses are simultaneously expected to pick up non-nursing tasks that were not previously the routine responsibility of nursing staff. Nurses are educated to care for patients, but the shortage of support staff has meant that nurses must attend to ancillary needs while patient care is neglected. Unfortunately those other tasks cannot be ignored — patients need meals delivered, they need to get to operating rooms and they need supplies and equipment — and nurses are doing them.

What message do we send, when, in a time of alleged shortage, we use a well-paid, college- or university-educated professional to deliver meals, clean up spills, search for staff to replace other nurses who call in sick, walk back and forth to blood banks or pharmacy stations, or serve as hospital porters? Is that really how we want to use what we all acknowledge is a precious, shrinking resource? Probably not — but that's what we are allowing to happen.

The reduction of support staff (due to budget cuts) in a variety of healthcare institutions has been carried out to the point that the employment practice is now chronic. This reality not only reduces job satisfaction, but decreases self-esteem, since nurses perceive that administrators do not value the important intellectual contribution they bring to patient care (Baumann et al., 2001). The Canadian Senate report on the healthcare system pointed to this tendency with justifiable concern: "Nurses are an expensive and shrinking resource and we cannot afford to be using them to carry out those non-nursing tasks. If nothing else is done, workload must be addressed in all settings across the system" (2002a, p. 117).

Rather than maximizing all nurses' scopes of practice, we have created a situation where, almost as routine, we expect nurses to reduce their scopes of practice and focus downstream rather than up. We value far too greatly the precious resource of a surgeon to ask her or him to clean the operating room between cases — quite rightly, we would consider that entirely inappropriate. But we send mixed messages to nurses all the time when we ask them to stop the highly skilled work of nursing to carry out non-nursing tasks. We say there is a shortage of nurses, but every day we put nurses in situations where an unwritten but significant part of their job description is that they roll back their scope of practice and put the "thinking" part of nursing on hold while they carry out the work of others. Licensed Practical Nurses, whose education includes the administration of medications, for example, are prevented by employer policies in many jurisdictions from carrying out that aspect of patient care. These decisions do not make sense.

The time has come to put a halt to these employment practices and push forward the practice of every Licensed Practical Nurse in the country, every Registered Psychiatric Nurse, every Registered Nurse and yes, every other health professional. Although the divisions among nurses are established as a result of differing educational programs, it is clear that there is an overlay of rules and attitudes that prevents nurses from practising to the full extent of their qualifications. Some of the shortages that afflict healthcare workplaces could be eliminated if nurses and all other healthcare practitioners were permitted to work to their full scope of practice. We cannot afford to continue on this path, and we can use our precious resources much more wisely than we now do.

Professional Practice Environments

Downsizing and budget cuts across the healthcare system over the past decade had many secondary effects that may seem on the surface less tangible than layoffs of nurses or reduced lengths of stay for patients. Somewhat lost in the fray was the loss of senior leadership in nursing and a loss of meaningful relationships for many nurses with a nursing supervisor who was visible and accessible. Financial support for necessary continuing education was curtailed, and where education opportunities were available, many nurses were unable to take advantage of them because they were needed on the job in the country's

health centres, homes and hospitals. Compounded by verbal and physical abuse from patients, families, and co-workers — themselves all frustrated with their experiences in the healthcare system — nurses report feeling a decayed sense of respect for themselves and their work.

These secondary effects of system downsizing continue to play out in the professional practice environments of nurses today, and they will need to be remedied with just as much vigour as is applied to problems like absenteeism and overtime. The following section discusses these "secondary" effects under four headings: a) leadership, b) education, c) violence and abuse and d) the search for respect.

Leadership. In the early years of restructuring, in an effort to get more done with fewer people and less money, many healthcare employers resorted to cutting out the positions of chief nurse, head nurse, and clinical nursing experts such as clinical nurse specialists. For administrators, that meant reducing the number of managers, expanding the remaining managers' spans of responsibility, and consequently removing costs from the payroll; for nurses, it meant far more.

To give context to the change, managers accounted for 7.7% of the registered nursing workforce in 2000 compared to 10.1% in 1994 (CIHI, 2001a) — a loss of some 5,500 manager positions. Elimination of, or changes to, the positions of chief nurse and head nurse suddenly deprived nurses of a structure of leadership fundamental to the effectiveness, efficiency and culture of nursing.

Senior nurses have always been more than managers who sign pay cheques. In most settings, they have served as mentors, coaches and experts to whom patients, families and nurses could turn and on whom they could rely. That tradition has always has been especially important to novice nurses, who look for that strong leadership and guidance. Numerous studies have demonstrated that the relationship with the immediate supervisor is an important predictor of job satisfaction and intent to stay in the job (Blegen, 1993; Irvine & Evans, 1992; Thomson, Dunleavy & Bruce, 2002). Thomson and colleagues summarized the problem this way: "At a time when nurses need leadership most, the cadre of managers is shrinking", leaving nurses "with little day-to-day support and diminished access to those who are positioned within the hierarchy to advocate on their behalf" (2002, p. 26).

The loss of supervisors and corporate nurses was accompanied by cutbacks in the number of advanced-practice nursing supports, such as nurse educators and clinical specialists. These individuals have traditionally provided a base of support to advanced patient care, exposed nurses to the latest technologies, and integrated research findings and best practices into daily practice. So the losses came from every direction, and in many instances nurses were left feeling very much alone as they took on the task of providing patient care.

At a broader level, these changes to the nursing hierarchy meant that many nurses were excluded from policy making because their representatives were no longer part of the management system. The result, inevitably, was a degree of alienation. Matters were not helped when some nurses found themselves supervised by non-nurses; their complaint was that they were being told how to do their jobs by people who did not understand what nursing was all about.

In many other situations, head nurses became front-line managers with responsibilities so broad they spent their time managing paper and budgets rather than working with the human beings assigned to them. In fact, the satisfaction of managers has become increasingly problematic, and their jobs are seen as so demanding that younger nurses have little interest in taking on those roles; they see the working lives of their managers and want no part of it. The sense of a hands-on, supervisor-employee, coaching, mentoring, supporting role was all but lost in many cases — and lost at great cost to the quality of patient care and team functioning.

As the participation of nurses in organizational decision making was reduced, their own sense of autonomy declined. Nurses began to feel they had lost their place; self-confidence was sometimes replaced with a feeling of powerlessness. The loss of the chief nurses and head nurses left nurses with few natural allies within the system; there was nobody within the realm of management who understood the bigger picture that included the nature of their work, the issues and problems and could put forward their case. As their jobs became more and more difficult, nurses had less and less support. Not surprisingly, nurses lost respect for the system as they felt themselves increasingly under-appreciated. Added responsibility without concomitant increases in authority is rarely an effective strategy.

Education. One of the strongest recurring themes in discussions with nurses across the country is the need for more education after they have entered the professions. This means professional development on paid time, but not during regular shifts — much as many managers and other healthcare professionals are able to access education as part of their paid jobs. It is worth noting that in focus groups conducted across the country, nurses listed subsidized professional development as a priority second only to the desire to be consulted on patient care and changes in the workplace (Viewpoints Research, 2002).

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The need for continuing education seems no longer to be in dispute. Ontario's joint provincial nursing committee acknowledged last year that fiscal restraint and lack of clinical teachers have forced the reduction of support for continuing education. The result is "a gap between nurses' skill sets and employer requirements, particularly in clinical specialty areas" (Baumann et al., 2001). Paid professional development for nurses would seem to be one

of the obvious and fundamental steps to enhance the satisfaction of nurses and, more important, the health of their patients.

But nurses need more than funding; they need to actually be able to take time away from the work setting to update their knowledge and skills, and they need to be replaced during those absences so that healthcare teams are not left short and scrambling to make up the gaps. Automobile manufacturers cannot operate assembly lines effectively with workers missing, any more than grocery stores can operate without cashiers on the job. The product of the organization suffers immediately, and in nursing, the product is human care. The result of operating with insufficient nursing staff is immediate and drastic — no different than in any other business, but arguably far more important in its consequences.

> Productivity in knowledge and service work demands that we build continuous learning into the job and the organization. Knowledge demands continuous learning because it is constantly changing.
>
> Drucker, 1993, p. 92

The education theme also comes up repeatedly in the form of concerns about access to undergraduate and graduate nursing education programs, and the costs of those programs. The loss of seats in nursing education programs since the cutbacks of the 1990s has meant stiff competition among students, and many qualified applicants are turned away every year. Those who are accepted and who complete their studies often graduate with significant debt and little prospect of obtaining full-time employment. There is no mystery in understanding the difficulty nurses face when they want to advance their education to the master's or doctoral level and have to leave their jobs and often their homes to do so. The personal and financial costs can be massive. None of those dynamics make intuitive sense to the public, to nurses or to students in the context of a shortage of nurses and an impending shortage of nurse educators. The good news is that each of those variables can be influenced if there is the political will to change nursing policy in Canada. We can paint a different picture and restructure our thinking around entry level, advanced practice, and continuing education for nurses.

Violence and Abuse. Exposure to verbal, physical, emotional and sexual abuse in the workplace is not new to nursing or unique to Canada. Healthcare workers in the United States are assaulted more frequently in the workplace than any other working group, including police officers (Occupational Safety & Health Administration, 1998), and nurses are more likely to be attacked at work than prison guards or police officers (Kingma, 2001). The International Council of Nurses argues that 72% of nurses don't feel safe from assault in their workplaces, and 95% have been bullied at work.

The majority of reported abuse incidents originate in nurses' interactions with patients and families, but they also involve physicians, managers and other co-workers. In the study by Fernandez and colleagues of a Vancouver Emergency Department (1999), 68% of the employees reported increased frequency of

violence over time, and 60% reported increased severity of violence. More than half (57%) of the staff had been physically assaulted, and 77% were afraid of patients as a result of violence. Important to any discussion of working conditions is the finding that 26% of the staff took days off because of violence, and 75% felt that violence had reduced their job satisfaction.

More recently, data from a study of 43,000 nurses across five countries (Aiken et al., 2001) found that Canadian nurses reported high rates of emotional abuse, threat of assault and actual physical assault. Data on abuse were collected in Alberta and British Columbia, and nearly 40% of Alberta respondents stated that they had experienced at least one incident of emotional abuse in the last five shifts worked. Despite efforts to curtail violence and punish offenders, the numbers have changed little over the past decade. In a study of 603 Canadian nurses in 1994, Graydon and colleagues reported that 33% of the nurses had experienced abuse in the past five working days; most of the abuse was verbal, and most came from patients. In the recent five-country study, more than 60% of nurses agreed or strongly agreed that their employers had put measures in place to reduce violence. Yet the abuse continues at virtually the same rate as reported by Graydon et al. almost a decade ago.

> Nurses are more likely to be attacked at work than prison guards or police officers.
>
> Kingma, 2001

The Search for Respect. While he was the federal minister of health, Allan Rock acknowledged that no group has borne the brunt of healthcare restructuring more than Canada's nurses. He traced the role of nurses far back in Canadian history, noting that for over 350 years, since Jeanne Mance set foot on this land, "nurses have been caring for Canada, now it's time for Canada to show it cares for nurses" (Canadian Nurses Association,1998).

Canadian nurses have indeed contributed significantly to the high level of health that is the envy of nearly every other nation. Curiously though, and perhaps reflecting the cumulative effects of all the factors presented in this report, there is a general belief among those same nurses that they are accorded little respect within the system. Their opinions are not often sought, and, if voiced, those opinions are usually ignored (Baumann et al., 2001). Within management ranks, the nursing viewpoint traditionally was expressed by chief nurses and head nurses, but many of those were casualties of budget cutbacks or organizational restructuring. Nurses have been critical of healthcare employers they see as being increasingly driven by budgetary rather than care-delivery concerns.

Not surprisingly, the end result in Canada and other Western countries that are undergoing similar changes is a disturbing level of dissatisfaction. Aiken and colleagues suggested that one-third of Canadian nurses were dissatisfied with their jobs, and barely one-third thought there were enough nurses to provide high-quality care for their patients (2001).

It is not difficult to persuade Canadians of the need for attention to nurses. Nurses are the part of the system that everyone knows, and nurses top the list of most trusted professionals in nearly every public survey. The very essence of nursing is to provide comfort in a quiet, competent way, which in turn promotes healing in patients, clients and families. And the public knows that. But despite the contributions nurses make, it has seemed in recent years that they have been treated as almost incidental to the system, if not an inconvenience. Their numbers have been reduced, and those who survived the harshness of budget cutting are often expected to do as much work as they and their now-departed colleagues previously did together.

Consultations with nurses across Canada, commissioned for the Canadian Nursing Advisory Committee (Viewpoints Research, 2002), suggest that the vast majority of nurses remain devoted to their professions. But just as evident as that devotion is the broad stream of frustration that runs right through the country's nursing workforce. That frustration involves both how they see themselves and how they believe others see them. At the core of the frustration is what they regard as a lack of respect. It is a lack of respect that seems both personal and professional; however, in the end, the personal and professional become one, because it is the individual nurse who feels undervalued.

That frustration was expressed in focus groups across the country, and it was directed at physicians who are abusive and pay scant heed to what nurses think, administrators who control nurses' lives but know little about patient care, financial managers who cut budgets at the expense of patient care, patients who are violent against nurses, the families of patients who are abusive, and even fellow nurses who are equally frustrated. When the focus group discussions were finished, participating nurses were asked what could be done to increase the respect shown to nurses. The most frequent response was, quite simply, a request that physicians and administrators "consult nurses and act on their recommendations regarding patient care and when considering operational and structural changes in the workplace" (Viewpoints Research, 2002, p. 24). It is a sad reflection on the Canadian healthcare system that the most fervent wish of its nurses is, in effect, that they be taken seriously.

A Global Perspective

For the nursing community, it is scant consolation to realize that there are parallels to their problems in other occupations and industries in Canada and, indeed, throughout the Western world. For much of the past quarter century, there has been an abiding conviction among managers that as much or more work could be done by fewer people than before. For commercial organizations and even public institutions, it became a harsh struggle for survival. Costs had to be reduced, and the most substantial reduction is usually from salaries.

The challenges faced by Canadian nurses are not unique to Canada. Globally, several studies have confirmed that many of the problems are universal (Aiken et al., 2001; Baumann et al., 2001; Duffield & O'Brien-Pallas, 2002), and despite differences in cultures, geography and economics, the problems facing nursing workforces are striking in their consistency. Nurses in most countries report similar symptoms of distress, as do many other healthcare professionals. The recent study of more than 43,000 nurses in more than 700 hospitals in five countries (Canada, the United States, England, Scotland and Germany) suggests that there are fundamental problems in the design of nursing work (Aiken et al., 2001). In every one of the five countries except Germany, at least one-third of the nurses surveyed were dissatisfied with their jobs; the unhappiest of all were those in the United States, a point worth remembering in discussions about the threat of Canadian nurses leaving for jobs there.

The report on the five countries points specifically to the low percentage of younger nurses working in Canada; the report suggests this is a direct result of the downsizing that followed budget cuts across the country. Quite simply, new graduates were unable to find work in hospitals — and the seniority rights negotiated by nurses' unions resulted in a high proportion of relatively junior nurses losing their jobs when hospital staffs were cut to satisfy budget restrictions.

Yet, uniformly across the five countries, only about one-third of the nurses questioned felt that there were enough nurses to provide high-quality care and enough staff to get the work done. Although a slightly higher proportion believed that support services were adequate, less than half the nurses in the five countries believed that the hospital administrations listened to and responded to the concerns of their nurses. Significantly, at least in Canada, dissatisfaction with working conditions did not appear in any way to reflect dissatisfaction with salaries; 69% of the Canadian nurses reported that their salaries are adequate. Not all research supports that conclusion. When focus groups of nurses were asked recently what they would do to improve respect for nurses, support for higher salaries was among the top three priorities (Viewpoints Research, 2002).

The organization of nurses' work in hospitals was also perceived to be a problem. Nurses had to spend time on jobs that did not require their professional training; as a result, they did not complete some of the care activities that are fundamental to nursing. Thus, some nurses delivered and removed more food trays and undertook more housekeeping duties than carried out oral hygiene, skin care or patient teaching.

The survey of the five countries found few encouraging signs: "The current shortage of hospital nurses in Western countries appears destined to worsen over the long term, with nurses' job satisfaction and intent to leave at higher levels, an aging workforce, and an increased tendency for younger nurses to show greater willingness to leave their hospital jobs" (Aiken et al., 2001).

As various studies have shown, dissatisfaction breeds problems far beyond immediate individual unhappiness. The immediate consequence is turnover, which in turn reduces consensus and increases conflict among those who stay by disrupting relationships and work patterns, eroding team relationships and reducing staff morale. Turnover also brings the burden of lost skills and productivity, and the cost of the time that experienced staff must devote to helping newcomers to adapt; if those who leave are not immediately replaced, the burden of their work will fall on those who remain.

In its interim report on the state of the healthcare system in Canada, the Standing Senate Committee on Social Affairs, Science and Technology observed that "10 years of downsizing the Canadian healthcare system have only exacerbated the situation for nurses by producing unhappy patients, horrific workloads for nurses across the system, destruction of organizational loyalty and decaying morale among all healthcare workers" (2002a, p.116). The problems may well be global, but the solutions will have to begin at home.

Beyond Nurses: Patients, Residents, Clients, Families and Other Team Members

The problems of the nursing workforce do not end with nursing. They are made even more pressing when we relate them directly to their unmistakable impact on the patients under nurses' care. A decade of research has established that there is a direct correlation between the ratio of nurses to patients and the health outcomes of those patients (Doran, McGillis Hall, Sidani, et al., 2001; McGillis Hall, Irvine Doran, Baker, et al, 2001; Needleman, Buerhaus, Mattke, et al., 2002; O'Brien-Pallas, Irvine Doran, Murray et al., 2002; O'Brien-Pallas, Irvine Doran, Murray et al., 2001; Prescott, 1993; Tourangeau, Giovannetti, Tu & Wood, 2002).

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At the most basic level, nurses' skill mix and staffing ratios are significant predictors of mortality (Aiken, Sloane & Sochalski, 1998; Aiken, Smith & Lake, 1994; Prescott, 1993). More broadly, a review of studies by Aiken and other researchers, published in *California Nurse* (1999), concluded that higher ratios of RNs to patients were clearly linked "to increased patient satisfaction, quality of life after discharge, knowledge and compliance in treatment, fewer in hospital complications … decreased costs and safer, shorter patient stays" (p. 7). Similarly, Needleman and colleagues (2002) found that a higher proportion of hours of care per day provided by Registered Nurses and a greater absolute number of hours of care per day provided by Registered Nurses were associated with shorter lengths of stay, lower rates of urinary tract infections and upper gastrointestinal bleeding, lower rates of pneumonia, shock or cardiac arrest and *failure to rescue* (defined as death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis).

McGillis Hall and her colleagues found in 2001 that "staff mix was a significant predictor of patient health and quality outcomes, with higher proportions of Registered Nurses and [Licensed Practical Nurses] in the staff mix associated with better health and patient satisfaction outcomes and lower rates of medication errors and wound infections" (p. iv). These findings do not address the collateral issue of the impact on regulated nursing staff of working with and supervising the increased number of unregulated workers (e.g, Health Care Aides, Patient Service Assistants) in the system. But collectively these studies are building a compelling body of evidence suggesting that more nurses, and more satisfied nurses, are associated with healthier and more satisfied patients. It is a concern that goes to the very heart of the healthcare system.

Fortunately the spillover affecting patients and families when nursing practice environments are improved seems to offer similar benefits for other health professionals. The American Nurses Association (ANA) notes that research "fully documents that high-quality nurses is one of the most important attributes in attracting high quality physicians" and asserts that being accredited under their Magnet credentialling program "creates a positive halo effect beyond the nursing services department that permeates the entire healthcare team" (2002).

One of the basic premises of the Magnet Accreditation Program is a practice environment based on collaborative working relationships (ANA, 2002). The American program is hardly alone in its assertion that relationships are key in quality work environments. Even beyond healthcare settings, Lowe and Schellenberg assert, "a healthy and supportive work environment is the crucial factor in creating robust employment relationships. This includes physical, social and psychological aspects of the workplace. Individuals with strong employment relationships tend to have helpful and friendly co-workers, interesting work, assess their workplace as both healthy and safe, are supported in balancing work with their personal life, and have reasonable job demands" (2001, p. xiii). A subsequent Canadian policy paper that made recommendations to create high-quality health workplaces (Koehoorn, Lowe, Rondeau, et al., 2001) focused on four sets of factors that interact to enable or constrain the achievement of positive outcomes for employees, organizations and patients — one of those being employment relationships. The authors used that term to cover issues "from trust and commitment to communication" (p. vi).

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> What is apparent in all this work is the need not to repair *nursing*, but rather to renew and repair *the work environments in which nurses practise*. A growing body of evidence clearly supports the notion that making those changes does a great deal to recruit and retain the best nurses. In addition, it produces healthier and more satisfied patients and attracts and retains other health professionals.

body of evidence clearly supports the notion that making those changes does a great deal to recruit and retain the best nurses. In addition, it produces healthier and more satisfied patients and serves to attract and retain other health professionals who want to work in centres recognized for excellence as healthcare *employers of choice*.

SOLUTIONS: IMPROVING THE WORKING LIVES OF CANADIAN NURSES

SOLUTIONS

Lessons Learned: What are the Workplace Conditions that Retain Nurses, Minimize Turnover and Increase Job Satisfaction?

The factors influencing nursing job satisfaction and retention have been studied intensely and repeatedly for over 20 years. If the factors contributing to the current crisis in nursing have become increasingly well understood, then many of the solutions surely have, for many years, been just as clear. The more important variable, we submit, is the political will (at all levels) to implement the changes and strategies we know are central to creating high-quality workplaces.

After reviewing 23 Canadian nursing workforce studies, the Canadian Nurses Association and Canadian Healthcare Association issued a joint report in 1990 concluding that there was a clear indication of "growing dissatisfaction among nurses over the past decade" with "limited attention given to their concerns." That report alone reviewed nearly 600 recommendations to remedy the problems.

Ten years ago, Irvine and Evans conducted a meta-analysis of 70 studies that identified factors contributing to enhanced nursing job satisfaction and retention. The most significant relationships were found with autonomy, stress, head-nurse leadership, relationship with supervisor, role conflict, job feedback, opportunity for advancement, salary, age of the nurse, job tenure, and work overload (1992). Blegen's analysis a year later (1993) looked at 15,000 nurses across 48 studies and found similarly that job satisfaction was associated most strongly with stress, organizational commitment, communication with supervisor, autonomy, recognition, routinization of work, fairness, locus of control, age, and years of experience.

In 1994, O'Brien-Pallas, Baumann and Villeneuve described factors contributing to nursing job satisfaction, and went on to discuss concepts that could still ground recommendations today:

- Nurses are generally happier when their personality traits and skills match the needs of the job and clinical area.
- Nurses need feedback, praise and learning opportunities at all stages of their careers.
- Many work-life concerns disappear when nurses are provided with the basic equipment and supplies required to do the job.
- Nurses place a high value on direct nursing care and are frustrated by the pervasiveness of non-nursing tasks they are asked to carry out.
- Nurses value direct nursing care, but continue to experience stress dealing with dying patients and death, and meeting the emotional needs of patients and families.

- Consensus has been reached regarding factors having greatest impact on job satisfaction across roles and settings: autonomy, levels of stress, head-nurse leadership and communication, role conflict, feedback and recognition, opportunity for advancement, salary, and routinization of tasks.
- Excellent clinical practice must be rewarded formally if institutions hope to keep senior/experienced clinical nurses in direct practice roles.

The authors noted that work-sampling studies had consistently demonstrated that the least skilled workers in hospitals often spend the greatest amount of time providing direct nursing care. They went on to suggest that "to use one of the most expensive and educated workers on any healthcare team – the staff nurse – to run errands that could be accomplished by lower-skilled workers, computers, telephones or fax machines, can have a devastating effect on job satisfaction" (1994, p. 403). We face precisely the same problem eight years later.

In a provincial study of some 300 Ontario Registered Nurses and Licensed Practical Nurses in 1995, the leading workplace concerns were job security, workload, inadequate staffing, personal safety, and concerns about quality of care (Villeneuve et al., 1995). The authors warned then that the problems of increasing workload and inadequate staffing to provide even basic care had the potential to spiral into destructive working relationships, decreased personal satisfaction and, ultimately, decreased quality of patient care.

And so on goes the list of studies, both large and small, their findings and recommendations building on one another and providing more, but little new, evidence. The most recent major national review of issues, the weighty nursing policy synthesis titled *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, their Patients and the System* (Baumann et al., 2001) again confirmed the kinds of issues that trigger dissatisfaction and turnover among nurses — and offered an extensive menu of policy recommendations targeted to governments, employers, unions, educators, and professional associations to improve the working lives of Canadian nurses. The six studies commissioned for this report found similarly consistent evidence.

We have a very clear understanding of the problem, and we know many of the solutions. Our collective challenge now is to galvanize and maintain the stamina and political will to make changes and see them through to completion.

Work in Progress across the Country

Current challenges facing the nursing professions have not gone unnoticed. Governments, employers, unions, professional associations and other stakeholders across the country have embarked on measures to redress the shortage of nurses — providing financing to increase the number of permanent nursing positions and to attract back into the professions those who have left nursing or left the country.

Across the country, most provinces and territories are planning or have already started to implement nursing human resources strategies that are in line with the main goals of the Nursing Strategy for Canada. By no means exhaustive, the following list provides examples of these kinds of activities:

- Increasing the number of nurses and the number of *full-time* nurses (Manitoba, New Brunswick, Prince Edward Island, Nova Scotia and Ontario).
- Developing strategies to attract non-practising nurses back to nursing (British Columbia, New Brunswick and Prince Edward Island).
- Increasing seats in nursing education programs by more than 10% (most provinces) (O'Brien-Pallas, Meyer, Alksnis, et al., 2002).
- Offering relocation assistance (Prince Edward Island, Nova Scotia and isolated settings such as Labrador and health services operated by Health Canada).
- Discussing and debating scope of practice (Ontario, New Brunswick and Manitoba and Health Canada's First Nations and Inuit Health Branch).
- Establishing quality workplace initiatives and practice programs (Saskatchewan, Ontario, Nova Scotia and British Columbia).
- Establishing a program to forgive student education loans, at a rate of 20% a year, for nursing students who undertake to work in remote areas (British Columbia).
- Introducing programs similar to student co-op programs (Nova Scotia and Prince Edward Island).
- Approving regulations on the creation of nursing councils and encouraging the participation of nurses in decisions about patient care (Quebec).
- Insisting that there be a Chief Nursing Officer in every hospital and nurses in visible leadership positions in other facilities (Ontario).
- Upgrading equipment (Manitoba and British Columbia).
- Increasing funding for continuing education, specialty education, and professional development (Alberta, British Columbia, Nova Scotia and Yukon).

- Improving the accuracy of data relating to nurses and nursing (several jurisdictions).

And of course, beyond nursing, a number of major health system commissions and reports have been undertaken in various provinces (e.g., Saskatchewan, Alberta and Quebec), federally (the Senate Committee) and nationally (the Romanow Commission). These various reports also offer insights into and make recommendations regarding health human resources and nursing. So although problems persist, it must be acknowledged that attention is being paid to the nursing workforce, and progress has been made. What remains a concern to the Canadian Nursing Advisory Committee is that many well-intentioned strategies and activities in so many jurisdictions have not trickled down to the daily working lives of Canada's nurses. Much of this activity will surely pay off in the long term. However, much work remains to be done, and can be done, to improve the working conditions of nurses more immediately.

> My basic principle is that you don't make decisions because they are easy; you don't make them because they are cheap; you don't make them because they're popular; you make them because they're right.
>
> *Theodore M. Hesburgh*

Further Reading

The Nursing Strategy for Canada
http://www.hc-sc.gc.ca/english/nursing/

British Columbia - Strategic Planning and Nursing Directorate
http://www.healthplanning.gov.bc.ca/strategic/

Alberta Health
http://www.gov.ab.ca/home/health/

Saskatchewan Health and Social Services - Nursing Publications
http://www.health.gov.sk.ca/info_center_publications_nurse.html

Manitoba Health – Nursing Recruitment and Retention
http://www.gov.mb.ca/health/nurses/index.html

Ontario Ministry of Health and Long Term Care - Progress Report on the Nursing Task Force
Strategy
http://www.gov.on.ca/MOH/english/pub/ministry/nurserep01/nurse_rep.html

Quebec - Le ministère de la Santé et des Services sociaux
http://www.gouv.qc.ca/Vision/Sante/Sante_fr.html

New Brunswick Health and Wellness – Nursing Resource Strategy
http://www.gnb.ca/0053/en/nursing/index.htm

Nova Scotia Health – Update on the Nursing Strategy April 2002
http://www.gov.ns.ca/finance/budget02/pdfs/backnursingstrategy.pdf

Prince Edward Island Health and Social Services – Nursing Recruitment and Retention Strategy
http://www.gov.pe.ca/hss/recruitment/nursing.php3

Newfoundland and Labrador Health and Community Services – Update on Nursing March
2002
http://www.gov.nf.ca/releases/2002/health/0321n30.htm

Nunavut Health and Social Services
http://www.gov.nu.ca/hss.htm

Northwest Territories Health and Social Services – Nursing Recruitment
http://www.hlthss.gov.nt.ca/careers/index.html

Yukon Territory Health and Social Services - Recruitment
http://www.hss.gov.yk.ca/recruit/

Recommendations

RECOMMENDATIONS

Overview: Recommendations of the Canadian Nursing Advisory Committee

Against a backdrop of conflict and transformation, the Canadian Nursing Advisory Committee waded into its formidable task – to make recommendations to improve the working conditions of Canadian nurses. Consensus was reached quite quickly on the key issues; recommending practical solutions proved a more arduous task.

> Just as the challenges are shared, creative solutions will have to be generated among governments, employers, regulatory and professional organizations, unions, educators, researchers, and front-line nurses themselves. The recommendations that follow are intended to provoke that thinking, support work already underway, and offer new solutions.

Well before the Committee's work was completed, we had learned enough to be seriously alarmed about the state of nurses and nursing in this country. Collectively, we are convinced by the evidence before us that the answer to enhancing patient care quality and productivity lies in improving the working lives of nurses, and indeed of all workers, in the system. To do so will require a combination of short- and long-term strategies. Maintaining the *status quo* is not a feasible option; we are paying far too high a price in the emotional burnout and decayed morale of nurses, startling rates of overtime, illness and absenteeism, and most important, potentially negative patient outcomes.

Committee members gave careful consideration to the large body of work-life research already published, as well as to the six new projects commissioned for this report. The Committee consulted widely with researchers, stakeholders, colleagues and other experts. It was evident that nurses are experiencing complex, historic and global challenges; as such, it would not be appropriate simply to target all recommendations to governments. Just as the challenges are shared, creative solutions will have to be generated among governments, employers, regulatory and professional organizations, unions, educators, researchers, and front-line nurses themselves. The recommendations that follow are intended to provoke that thinking, support work already under way, and offer new solutions. They are consistent with the kinds of policy recommendations underpinning many of the healthy workplace strategies identified by Wagner and her colleagues in their research commissioned for this report (2002).

Throughout the year, *workload, work environments, human resource planning and data, training/education, professional practice environments* and *leadership* were prominent themes in all of the Committee's discussions and debates. All of these issues directly affect the Committee's main mandate — to make recommendations to improve the working lives of Canadian nurses. But as was noted in the Committee's progress report of November 2001, the key issues can perhaps be summarized much more succinctly:

The most significant challenge before us lies in galvanizing the energy, stamina and political will to make the changes we know must be made in three key areas:

- Increasing the number of nurses;
- Improving the education and maximizing the scope of practice of nurses; and
- Improving working conditions of nurses (including improving staffing and reducing workload and role overload).

The Committee therefore made its recommendations in the context of those recurring themes. As was noted earlier, the good news is that a great deal of good work is already under way. The Canadian Nursing Advisory Committee members want to encourage leaders across Canada to build on that energy and on the excellent initiatives being undertaken at national, provincial, territorial, regional and local/organizational levels.

Few of the solutions will be simple or short-term. To accomplish positive outcomes and in the interests of long-term planning, we strongly recommend that governments across the country consider making longterm funding investments in the system and abandon the practice of year-by-year budgeting. We think some of the solutions can be realized within existing funds, but we need to be clear that some reinvestment in the system will be required. It is our shared belief that those investments made today will foster a system and a workforce that are both sustainable and affordable in the long term.

Recommendation I: Put in Place Conditions to Resolve Operational Workforce Management Issues and Maximize the Use of Available Resources

Best practice thinking should guide all activities designed to improve the quality of the work environments where nurses practise. There are excellent examples of innovative strategies and recommendations in place across the country, both within and beyond healthcare settings; the catalogue of innovative workplace strategies (Wagner et al., 2002) that accompanies this report contains many such examples.

We believe there is ample evidence that workload, overtime and absenteeism are inextricably linked with each other and with patient outcomes. Nurses continue to be torn between respecting the codes of ethics and standards of practices they equate with clinical excellence, and the workplace realities that too often make it impossible to achieve them. Employers, governments, unions and nurses must collaborate to promote professional practice environments that allow nurses to follow established standards and practices to provide optimal patient care. We urge all employers to make the time to go through

the process of articulating the characteristics that constitute a quality workplace as a backdrop to designing systems and making change in all of these areas. And as Thomson and colleagues noted, "provincial and federal resources will need to be directed toward the development of accurate and manageable strategies to measure and report on workload" (2002, p. 25).

Workload

1. Employers should work with their managers and front-line nurses to assess and describe existing workloads and contrast them with current staffing patterns and patient/client demands by October 2002. In each work setting, the demands should be contrasted with the supply of nurses, and compared with workload measurement data, where available. Where workload measurement systems do not exist, they should be implemented by June 2003.

2. Employers should be prepared to submit to governments by January 2003 a report of their existing staffing, absenteeism, overtime hours and actual care needs based on patient acuity, intensity and environmental complexity.

   The purpose of this exercise is to compare practices across organizations and ultimately to reduce the pace and intensity of nursing work and improve quality of care. To do so, we must understand the current workload as fully as possible, and then work with governments and employers to put in place the conditions that will foster manageable workloads.

3. Nurse-to-patient ratios should be sufficient to meet the needs of patients and families, consistent with patient/client complexity and acuity, patient turnover and the qualifications of and supports available to the nursing staff by June 2003.

4. Regarding location and availability of functioning equipment, provincial/ territorial and federal governments should fund a one-time cross-country survey of each employer's equipment status versus needs and fund the upgrade now. The project is to be completed by January 2003 with one-time funding.

   Note that a variety of strategies to address workload issues in Canadian settings were identified by Baumann and Underwood in research conducted for the Canadian Nursing Advisory Committee (2002). Further, a catalogue of strategies to create healthy workplaces (including and beyond workload issues) was generated by Wagner and colleagues in their report for the Canadian Nursing Advisory Committee (2002).

Overtime, Absenteeism and Employment Status: Increasing the Number of Available Nursing Care Hours

Maximize Hours of Work of Current Nurses

5. Governments, employers and unions should collaborate to increase the proportion of nurses working full-time to at least 70% of the workforce in all healthcare settings by April 2004, with an improvement of at least 10% to be completed by January 2003.

6. All employers should implement targeted programs by April 2003 that will examine the reasons for absenteeism and strive to reduce absenteeism to the equivalent of the national average for full-time workers by April 2004.

7. Where overtime hours are being worked, employers should work with their managers and front-line staff to minimize and, where possible, eliminate, overtime hours by January 2003.

8. Where relevant, employers should consider overstaffing by a small margin in anticipation of absences; this strategy is known to result in decreased overall cost compared to traditional staffing methods.

9. Employers and unions should develop and implement ways of addressing contingency staffing.

Retain Older Workers

10. Governments and employer organizations should work with nurse leaders and unions to provide phased-in retirement programs for older nurses, allowing them to do some work without negatively affecting pension benefits, by January 2004.

11. Employers should work with nurses and unions to provide, by January 2003, work opportunities (e.g., coaching, mentoring, teaching), equipment (e.g., electric lifts) and human resources (e.g., porters) that are sensitive to the needs of older workers and will allow them to participate in the workforce for longer.

Innovative, Responsive Scheduling

12. Employers and unions should collaborate to design, by April 2004, innovative schedules, hours of work and job-sharing arrangements that offer flexibility to the individual, meet the collective staffing needs of their work settings and respect nurses' time off work.

13. Governments, employers, unions and regulating bodies should agree to abolish mandatory overtime immediately.

14. Employers and unions should examine and modify practices that impede timely filling of vacant positions.

Salaries, Benefits and Collective Agreements

15. As they are negotiated, collective agreements and employer-driven policies should be reviewed and revised to reflect innovations in work, education and technology; changing work demands; new realities of the world of work; the needs of contemporary nurses; and the changing expectations of professional caregivers coming into the workforce in the new century.

16. Competitive salaries and benefits, which are critical to retaining the current and next generation of nurses, should continue to be attractive.

Reduce Non-Nursing Tasks and Maximize Scope of Practice

17. All employers should employ sufficient numbers of staff to provide support functions (clerical, environmental, food services, porters) to allow nurses to focus fully on the direct care needs of patients and clients.

18. Federal, provincial and territorial governments should lead a national review of nursing scope of practice as it interrelates with that of physicians and other healthcare workers.

19. All employers should abandon the practice of regulating nursing practice and should put in place policies that will allow each Registered Nurse, Licensed Practical Nurse and Registered Psychiatric Nurse to function to the maximum of her or his professional practice abilities according to the respective provincial/territorial licensing body.

    Regulators are urged to work with nurses, employers, unions, educators and governments to maximize the scopes of practice of Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses in all settings and jurisdictions, as appropriate, given the acuity and complexity of patients, residents, clients, and/or families in the setting.

Recommendation II: Create Professional Practice Environments that Will Attract and Retain a Healthy, Committed Workforce for the 21st Century

Just as important as sound corporate practices is the establishment of professional practice environments that are so appealing and rewarding that they will attract and retain the best health practitioners from all disciplines. Key in such settings are respect, autonomy, leadership and maximized scopes of practice for nurses in all roles and in all settings. Nurses

need to be consulted, to have their opinions solicited and recommendations followed, and to have real control over their professional practice decisions.

For nurses to exercise control over practice, employers need to ensure there are possibilities for nurses to be meaningfully involved in decision making from the point of service through to the corporate and even regional level. Employers must put conditions in place so that nurses have time in the workplace that is dedicated to contributing to practice, management and policy decisions that benefit the employer and patient care. We recognize that nurses too must take advantage of opportunities to be involved in professional practice decisions; by the same token, employers must support professional activities that enhance workplace functioning. One option is to establish a professional practice council — a recognized cost to any organization, but one that we suggest more than pays for itself in the contributions it allows nurses to make to the corporate and professional environments.

In the light of factors such as the high absenteeism of Canadian nurses — and the reality that the number of qualified applicants continues to far outnumber the available seats in nursing education programs — we are convinced that Canada is fully capable of providing the bulk of a self-sufficient, self-sustaining nursing workforce. While actions must be taken in the short term to increase the number of nurses, it is just as important to develop and monitor, on an ongoing basis, a national plan to co-ordinate the number of nurses entering the professions (new graduates, immigrants, nurses returning to the professions), the number exiting (through retirement, emigration or career changes) and demands for nurses across the country based on population and health patterns.

Leadership

A Call for Respect

20. Given the powerful need for a return to respectful thinking and behaviour across the healthcare system, all federal, provincial and territorial Ministers and Deputy Ministers of Health should issue a strong statement on the importance of respect for all workers in the system (including managers, corporate leaders and students). This statement should specify the expectations for each and every person working in the healthcare system.

Managers

21. The number of first-line managers should be sufficient to allow reasonable levels of contact with nurses in the setting. In settings where the majority of staff are nurses, the first-line manager should be an experienced nurse with strong leadership abilities.

We encourage employers to examine and assess the growing body of literature suggesting the characteristics of a reasonable, manageable span of control for nurse managers and directors that allows them to complete assigned functions and be present to meet nurses' and patients' needs. Changes should be completed by April 2003.

22. First-line managers should be supported with human (e.g., clerical) and technical resources that allow them to do the required work within reasonable hours of work. Programs should be in place by April 2003.

23. Recognizing that not enough nurses are moving into management and leadership positions, employers, educators and governments should work with nurses to build in succession planning, including moving nurses through management experiences and into formal leadership positions.

Education

Educate and Graduate More Nurses

24. The preliminary recommendations of the Standing Senate Committee on Social Affairs, Science and Technology (Volume 5, 2002) should be supported. These recommendations call on the federal government to work with the provinces and territories to ensure that nursing education programs receive enough additional funding to expand their enrolment. Given that the shortage of nurses is so acute, these recommendations also suggest waiving nursing tuition fees for the next four years.

> *A note about seats and number of nurses.* The Canadian Nursing Advisory Committee recognizes the challenges inherent in determining the right number of nurses for any jurisdiction. In planning nursing human resources, the committee suggests that the following principles be considered:
>
> - In determining numbers of nurses, provinces/territories are strongly urged to educate the bulk of nurses to meet their own nursing care needs in the long term.
>
> - The number of seats in schools of nursing *for all categories of nurses* must be adjusted in consideration of maximized scopes of practice of all regulated categories of nurses and maximized scopes of practice of other health professionals in an evolving healthcare system.
>
> - The results of nursing human resources projection models being developed through the Nursing Strategy for Canada and the National Sector/Occupational Study of Nursing should be considered in setting growth targets for the nursing professions.

25. As part of a co-ordinated, national nursing education plan, governments should work with schools of nursing, as well as with employers who are able to provide clinical placements for nursing students, to increase the number of new, first-year seats in schools of nursing for Registered Nurses by 25% (roughly 1,100 new seats) in September 2004. This number is above and beyond the 10% recommended in the *Nursing Strategy for Canada*.

26. The number of Registered Nurse seats should be adjusted upward by a further 20% in each of the subsequent four years.

27. Seats in graduate (master's and doctoral) programs should be adjusted upward in response to workforce studies that will examine and make recommendations about the nursing professoriate for Canada, as well as in response to the National Nursing Education Strategy being developed by the Canadian Association of University Schools of Nursing. The number of nurse educators should be increased proportionately to the number of new undergraduate admissions and graduates.

Funds for Nurses and Students

28. Governments should work with employers and unions to provide funding each year for 10 years, for each full-time nurse in the country, to be used for work-related professional development (e.g., specialty certification). Programs must be in place by June 2003.

    • Nurses working less than full-time should be offered proportional funding based on hours worked in the previous year.

    • These funds should be in addition to any existing training opportunities (e.g., orientation and inservice activities) or education required by the employer to do the present job, and should be indexed to inflation.

29. Student loans should be forgiven on a prorated basis for nurses who agree to work in hard-to-staff settings, as determined by provincial/territorial and federal governments. This program should be implemented immediately on an urgent basis, with full implementation by September 2003.

30. Employers should work with their managers, nurses and unions to devise schedules and nurse replacement strategies that allow nurses to take full advantage of education opportunities and guarantee their replacement in the work setting during education leaves.

31. To expand the research and teaching capacity of the country, provincial/ territorial and federal governments should collaborate to create and support, by September 2004, a Millennium Nursing Scholarship Fund that will provide bursaries equivalent to 50% of tuition for any Registered Nurse, Licensed Practical Nurse or Registered Psychiatric Nurse in the country studying in a master's or doctoral program, by September 2004. The committee recognizes that non-Registered Nurses would have to study in non-nursing programs such as education, for which there are master's and doctoral programs that would be appropriate.

Maximizing Classroom and Clinical Opportunities

32. Employers should work with universities and colleges to maximize links for students and faculty, including cross-appointments of nurses at every level, by January 2003.

33. Educators should collaborate with employers to offer creative clinical experiences for students and maximize readiness for the work world by September 2004.

34. Provincial/territorial governments should collaborate with schools of nursing and employers to fund, design, maintain and evaluate the infrastructure necessary to support clinical and other nursing education; a plan should be developed and submitted to governments by June 2003.

Improve Education Services to Rural and Remote Settings

35. Provincial/territorial and federal governments should collaborate with schools of nursing to maximize technological (e.g., distance education) and in-person opportunities for nurses working in rural and remote settings, including nurses working in Aboriginal communities, by September 2003.

Violence and Abuse

36. The Canadian Nursing Advisory Committee supports the International Council of Nurses and condemns acts of abuse and violence perpetrated against any person, including other healthcare professionals, patients, children, the elderly and other private citizens. Nurses are particularly at risk, and thus attention should continue to be placed on eliminating all forms of abuse and violence against nursing personnel.

37. All settings employing nurses should implement and enforce a zero-tolerance policy toward violence, abuse and harassment in the workplace by January 2003.

38. Employers, educators, nurses, governments, regulators and the public should collaborate with police and security experts to design safer work environments, follow up infractions and punish offenders.

39. Employers should invite police involvement in the orientation of new staff, as well as encourage the reverse – the involvement of nurses in the education of police and security forces who encounter healthcare situations.

Recommendation III: Monitor Activities and Generate and Disseminate Information to Support a Responsive, Educated and Committed Nursing Workforce

To implement, monitor and evaluate the recommendations in this report, as well as other related, national activities (e.g., the Nursing Strategy for Canada) a number of strategies should be initiated at a broader, system level. These recommendations are intended to support ongoing nursing and health human resources policy development at the provincial/territorial, federal and national levels:

Work and Health

40. The federal government should fund an annual national survey of nurses' health, to continue at least until the illness, absenteeism and injury rate of nurses has been reduced to the national average for Canadian workers.

41. Federal and provincial/territorial governments should provide one-time funding for the development of national *Healthy Work Environment Guidelines* that would offer clear instructions to employers wanting to create high-quality nursing workplaces that would be considered "the workplace of choice" by nurses.

Accreditation

42. Federal and provincial/territorial governments should collaborate with the Canadian Council on Health Services Accreditation and employers to support accreditation activities that will monitor and improve the quality of nursing work life.

43. A special Accreditation Award should be created for employers that achieve excellence as *nursing workplaces of choice*. To be accredited at all, each employer would have to meet basic criteria that would include a reduction in absenteeism and overtime, increases in the proportion of staff working full time and other similar measures. Health Canada is urged to work with the Canadian Council on Health Service Accreditation and the Canadian Healthcare Association to develop and fund the award program.

Ongoing Monitoring

44. Federal and provincial/territorial governments should collaborate with the Advisory Committee on Health Human Resources to monitor the implementation of the recommendations of the Canadian Nursing Advisory Committee. Among many options, the Advisory Committee on Health Human Resources may wish to a) extend the mandate of the

present Committee as it stands, b) extend the Committee but revolve the membership or c) transition the Canadian Nursing Advisory Committee to an issue-based task force under their new structure.

- Any future committee(s) may wish to involve or consult with the federal and provincial/territorial chief nurses and heads of provincial/territorial nursing advisory committees (or similar structures).

- We suggest that such a committee meet twice a year for a further two years to monitor implementation of the recommendations in this report and co-ordinate them with related activities such as the Nursing Strategy for Canada and the National Occupational/Sector Study of Nursing. A related purpose would be to provide some national *corporate memory* by tracking policy decisions so that we maximize opportunities, provide feedback to policy makers and not repeat past mistakes.

Research and Information

45. Researchers should continue to study and refine their understanding of nursing workforce information. In particular, the focus should be on the following:

- Licensed Practical Nurses and Registered Psychiatric Nurses;
- Workload measurement;
- The ratio of nurses to patients and effects on quality of care;
- The effects of shift length on nurses and patients;
- The dynamics of overtime, absenteeism and turnover;
- The impact of relationships between nursing human resources and patient outcomes, including economic impacts;
- Skill mix;
- Management information systems;
- Development and refinement of indicators of quality of work life and nurse-sensitive quality outcomes for patients; and
- Refinement of human resources planning methods that consider the needs of populations, take into account the manner in which nursing resources are managed and deployed, and are linked to population, provider and health outcomes.

46. Nursing policy makers, researchers, educators and professional associations should work closely with the Canadian Institute for Health Information (CIHI), the Canadian Institutes of Health Research (CIHR), the Canadian Health Services Research Foundation (CHSRF), the CHSRF/CIHI Chair of Nursing Human Resources, and Statistics

Canada to develop information about knowledge needed for further work.

The System

47. Governments, employers, unions, educators and professional associations across the country should support the implementation of the recommendations of provincial/territorial nursing advisory committees (or equivalent structures) and other strategies under way to improve the working lives of Canadian nurses.

48. Federal and provincial/territorial governments should fund Chief Nurse positions, position nurses in senior policy positions, and support ongoing funding for nursing advisory committees or similar structures.

49. Governments across the country should make long-term (multi-year) funding investments in the health and education systems. These investments should be stable, sustainable and adequate.

50. Governments should make particular investments in nurses working in rural and remote settings. These investments should be grounded in the triple goals of recruitment, retention and improved working conditions in rural and remote settings.

51. Federal, provincial and territorial governments should work with professional associations, employers, unions and educators to fund and implement a broad national campaign to attract and retain a diverse workforce (based, for example, on gender, culture and ethnicity) in all nursing roles and at all levels, and especially to fund a national task force to increase the recruitment and retention of Aboriginal nurses and nursing students.

CONCLUSION

F or too many years, Canadians have fretted about the state of their revered healthcare system. They have watched and listened eagerly while every aspect of health care - whether medical, political or organizational - has been studied and debated endlessly. Such is the importance of the system that governments in every part of the country and of every political stripe become distinctly uneasy when it is suggested that they are not sufficiently sensitive to the state of the healthcare system. So it stands as a curious national indictment that, after so many years, so many acknowledged problems remain unresolved in nursing.

Of Canadians' commitment there is no doubt. A succession of public opinion polls confirms their profound loyalty to the healthcare system, or at least to the ideal of a publicly funded system. Because it is a public system, the attachment is that much more proprietary and personal — to the degree that an impressive number of Canadians regard medicare as a measure of our nationality, something that makes Canadians distinct as a people.

Despite the public debate in recent years, most public opinion polls indicate that Canadians are broadly satisfied with the state of their healthcare system. But to put that in perspective, when *Ipsos-Reid* began asking Canadians to evaluate the healthcare system and its quality in May 1991, 26% rated it as excellent; in January 2002 just 4% said so. During the same period, the number of Canadians rating the healthcare system as fair, poor or very poor had climbed from 13% to 33% (Ipsos-Reid 2002a). In a May 2002 poll, more than half of respondents stated that they expect their provincial health services to worsen in the future; the leading reason for saying so (35%) was health system human resources shortages (Ipsos-Reid 2002b). Just as spending on healthcare passes the $100 billion mark for the first time (CIHI 2002), public confidence in the system has been shaken. If public satisfaction is to be regained and maintained, the problems of nurses and nursing must be addressed.

The most important response to the work of the Canadian Nursing Advisory Committee will be acceptance and implementation of the recommendations provided in this report. Only urgent action will improve the situation.

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Agency for Healthcare Research and Quality
http://www.ahrq.gov

American Nurses Association, Inc. (including American Nurses Credentialling Center)
http://www.ana.org

Association of Canadian Community Colleges
http://www.accc.ca

Association of Universities and Colleges of Canada
http://www.aucc.ca

Canadian Association of Schools of Nursing
http://www.causn.org/

Canadian Council on Health Services Accreditation
http://www.cchsa.ca

Canadian Federation of Nurses Unions
http://www.nursesunions.ca/

Canadian Health Services Research Foundation
http://www.chsrf.ca

Canadian Institute for Health Information
http://www.cihi.ca

Canadian Nursing Index (links to nursing resources)
http://www.nursingindex.com/

Canadian Nursing Students Association
http://www.cnsa.ca/

Canadian Nurses Association
http://www.cna-nurses.ca

Canadian Practical Nurses Association
http://www.cpna.ca/

Canadian RN Directory
http://www.canadianrn.com/directory/govt.htm

Comprehensive Health Care Disciplines and Education Links
http://www-hsl.mcmaster.ca/tomflem/nurses.html

Extensive Links to Policy Research Organizations
http://policyresearch.schoolnet.ca/community/index-e.htm

Heath Canada (includes good links to each provincial/territorial government's health web site)
http://www.hc-sc.gc.ca

International Council of Nurses
http://www.icn.ch/

Institute for Work and Health
http://www.iwh.on.ca/

Johnson & Johnson's Nursing Recruitment Campaign
www.discovernursing.com

Nursing Effectiveness, Utilization and Outcomes Unit (University of Toronto and McMaster University)
http://www.fhs.mcmaster.ca/nru/

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions
http://www.bhpr.hrsa.gov/

APPENDICES

Appendix A:
Executive Summary of The Nursing Strategy for Canada

Canada is experiencing a crisis in nursing. This is a view expressed across the country, both in the health system and among the general public. While there are many different perspectives on why this is and what the most promising solutions are, there is significant agreement that the current shortage of nurses is getting worse and that left unchecked, this situation will lead to a deterioration in the quality of the nation's health care system.

In response to these concerns, the Conference of Deputy Ministers/Ministers of Health directed the Advisory Committee on Health Human Resources (ACHHR) to develop a pan-Canadian strategy for nursing. Recognizing the complexity of the issue, they also directed the ACCHR to ensure meaningful consultation with the relevant stakeholders.

The initial document, *Towards a Nursing Strategy for Canada: A Consultation Paper for Stakeholders*, was developed by the Working Group on Nursing Resources and Unregulated Health Care Workers (WGNR), a sub-committee of the Advisory Committee on Health Human Resources, in March, 2000. The purpose of this document was to solicit advice and feedback from the many nursing workforce stakeholders prior to developing a nursing strategy for Canada.

This consultation paper identified that the goal of a Canada-wide nursing strategy is to achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed and deployed to meet the health needs of Canadian residents. The document identified the key nursing workforce issues related to this goal, including: the need for detailed and accurate information and relevant research to support the development of improved human resource planning; increased educational capacity; improved opportunities for clinical experience and workplace support for students and new grads; significant changes in the workplace to improve the quality of nurses' working lives; and better utilization of all nurses.

This initial paper explored the many different perspectives held on these issues by the various stakeholders to establish a common understanding of the complexity of this issue. It also posed twelve action strategies, developed by the WGNR, for consideration.

Ninety-four formal responses were received from a wide variety of stakeholders, including professional regulatory bodies, associations and unions representing all three nursing groups, educators, employers and government. These responses guided the development of the final document, *A Nursing Strategy for Canada*.

Feedback from the Stakeholders
Stakeholder responses included wide support for the development of a unifying and multi-stakeholder advisory committee to address the most pressing nursing workforce issues and to provide support for provinces and territories as they address these issues within their respective jurisdictions. As well, there was support for the development of similar bodies in provinces and territories where such integrated planning and policy development does not already occur.

APPENDICES

Stakeholders throughout the healthcare system recognized the need to increase and improve nurse workforce planning. To do so, there was support for the collection of more comprehensive data on nursing groups. As well, there was support for ensuring a strong and coordinated national research agenda to ensure evidence on which to develop needed policy.

While the provincial/territorial jurisdiction over health and education was recognized, there was also support for the federal government to take a lead role in the development of better health human resource data to establish improved future projections for nursing supply and demand. Many respondents noted that it was time to expand beyond the simple supply models that have guided health human resource planning to date.

While there was strong support for increases to education and training capacity for all three nursing groups, the majority of respondents suggested that the recommended 10% increase across Canada in registered nursing seats over two years may be too conservative. Many respondents also commented that increases to nursing education capacity should be determined through improved human resource planning that includes the full spectrum of nursing practice and takes changes in health care practice, population health and demographics into consideration. There was a strong message from the associations representing Licensed Practical Nurses and Registered Psychiatric Nurses that these planning activities need to be inclusive of their members.

Many respondents also emphasized the need to ensure that this increased nursing school capacity be supported by adequate clinical placements and that both post-grad support and full-time employment be ensured for these new graduates in order to retain them in the profession and within the health system.

Registered nursing professional regulatory bodies and many groups representing Registered Nurses offered strong support for the introduction of the new competencies. However, there were also concerns expressed that the impact of the introduction of these polices must be assessed and care taken to avoid unintentional short-term reductions of Registered Nurses. Also, it was emphasized that the educational needs of the existing workforce must be addressed, particularly for continuing education to increase competencies and for specialty training.

While the professional regulatory bodies expressed the need to respect their statutory responsibility for scope of practice and competencies, there was strong support for the need to examine the full spectrum of nursing practice. It was widely recognized that all nurses should be utilized to the fullest extent of their competencies to meet the health needs of the public and that there is a need to determine optimal nurse mix and use of non-nursing personnel.

Many stakeholders suggested that solutions to the current shortage of nurses needed to be both pragmatic and innovative. Even with concerted efforts, the social, demographic and fiscal realities of this new century are resulting in a major structural change to the nursing workforce that cannot be resolved by traditional supply strategies. Accordingly, many respondents emphasized the need for better management of the current workforce. Many jurisdictions report serious difficulties in recruiting nurses, although their individual needs range widely, from casual to specialty-trained nurses. Retention of nurses, both in positions and in the profession itself, was also identified as a serious problem.

Improving the quality of the work life of nurses was identified repeatedly as key in addressing these issues. Improving the quality of the work life has many different aspects, and given the diversity of the nursing workforce there is no single solution. However, strong support was offered for increased continuing education that includes:

- Portability and laddering opportunities;

- Flexible scheduling;

- Increased nursing management leadership and support at the clinical level;

- Improved nurse/patient ratios to address workload concerns;

- Reduction in non-nursing duties; and

- Reduced "casualization."

Finally, there was a call for action: there is a strong belief that the current shortages in nursing and the dissatisfaction of nurses will not improve without quick and decisive and unified action from policy makers and funders.

Strategies for Change

As a result of this stakeholder feedback, the initial document was revised to create *The Nursing Strategy for Canada.* Eleven strategies for change were proposed, organized according to the following key issues:

- Unified action;

- Improved data, research and human resource planning;

- Appropriate education; and

- Improved deployment and retention strategies.

These strategies were proposed with the understanding that further development and implementation of each strategy would require the unifying efforts of all stakeholders. Lead responsibility and suggested timelines were identified for each strategy.

Strategy 1

The federal government and provincial/territorial governments immediately establish a multi-stakeholder Canadian Nursing Advisory Committee (CNAC) to address priority issues as identified by the Advisory Committee on Health Human Resources (ACHHR) and the Working Group on Nursing Resources and Unregulated Health Care Workers (WGNR). The key focus for CNAC for 2000/01 will be improving the quality of work life for nurses and providing advice to support the implementation of other strategies of the Nursing Strategy for Canada.

Strategy 2

A Nursing Advisory Committee (NAC) be established (where an equivalent body does not exist) by each province and territory to support the development of strategies for improved nurse human resource planning and management within each jurisdiction.

Strategy 3

The federal/provincial/territorial governments encourage the efforts of the Canadian Institute for Health Information (CIHI) and other organizations to develop the information required for the effective planning and evaluation of nursing resources.

Strategy 4

The ACHHR work with major research funders to identify gaps in current research, profile workforce planning issues for new research funding, and recommend improved mechanisms for the dissemination of these research results to policy makers and managers.

Strategy 5

The federal government provide leadership to ensure the development of improved projections for nursing supply/demand requirements to the year 2015.

Strategy 6

A communications strategy be developed with the goal of increasing the public's awareness of nursing as a positive career choice and increasing the number of qualified applicants to nursing schools.

Strategy 7

The number of nursing education seats be increased Canada-wide by at least 10 percent over 1998/1999 levels over the next 2 years (2000/2002), and increases in following years be based upon improved demand projections and provincial/territorial need and capability.

Strategy 8

Each provincial/territorial NAC or equivalent body develop a comprehensive strategy to determine what types of nursing human resources are required and for which practice settings, based on an analysis of the needs of the population, the health system as a whole, and the skills and capacities of all types of nurses.

Strategy 9

Each provincial/territorial NAC or equivalent body develop a five-year provincial/territorial Nursing Education Plan based on the comprehensive strategy proposed in Strategy 8.

Strategy 10

Provincial/territorial NACs (or equivalent body) identify and support the implementation of retention strategies for their respective workforces that focus on improving the quality of the work lives of nurses.

Strategy 11

Provincial/territorial NACs (or equivalent body) examine opportunities to encourage nurses to re-enter the workforce.

The full report of the Nursing Strategy for Canada is available at:
http://www.hc-sc.gc.ca/english/for_you/nursing/index.htm

Appendix B: Canadian Nursing Advisory Committee Terms of Reference

Purpose

The Committee will provide informed advice to the Conference of Deputy Ministers of Health through the Advisory Committee on Health Human Resources (ACHHR), related to and in support of implementation of the strategies outlined in The Nursing Strategy for Canada, October 2000. Priority will be given to providing recommendations for policy direction to improve quality of work life for nurses.

Responsibilities

- To formulate recommendations for policy direction to improve quality of nursing work life which would provide a framework and context for work life improvement strategies at the provincial/territorial level.

- To provide a written report to the Conference of Deputy Ministers of Health presenting the recommendations for policy direction with evidence-based rationale and the framework for action.

- To present recommendations and/or advice for effective implementation of other strategies outlined in The Nursing Strategy for Canada as requested by ACHHR.

- To establish effective linkages with relevant groups, committees and bodies to ensure co-ordination of efforts and inform the work of this Committee.

- To advise on other issues which may be referred to the Committee by the ACHHR.

Timeframe

The Canadian Nursing Advisory Committee will be established for a twelve-month period. The future role and mandate will be reviewed at the end of this period relative to ongoing requirements.

Membership

The Canadian Nursing Advisory Committee will have a maximum of 16 members. Members are appointed to the Committee by the ACHHR in recognition of their individual knowledge, experience and expertise as defined in the Criteria for Nominations. The membership will be broadly reflective of:

- Individuals with either nursing or non-nursing background;

- Nursing professions (i.e., registered nursing, registered psychiatric nursing and practical nursing);

- Geographic distribution, (i.e., regional and urban/rural/remote);

- Practice settings (acute, community, and long-term care); and

- Perspectives (clinical, administration/employer, education, research, labour, government).

Four members will be from federal, provincial or territorial governments.

Chair
The Chair of the Committee will be appointed by the Chair of ACHHR from the membership of CNAC.

Terms of Membership
Committee members are expected to be available for all meetings and teleconferences. There will be at least three meetings during the year, each lasting two days, in addition to monthly teleconferences.

Committee members are expected to protect and maintain as confidential any classified or privileged information divulged to them in the work of the Committee.

Committee members will be reimbursed at the government rate for travel, accommodation and per diem expenses for attendance at face-to-face meetings and other pre-approved expenses.

Reporting
The Chair of the Canadian Nursing Advisory Committee will meet with and/or report quarterly to the ACHHR. The Committee will provide a final report to the Conference of Deputy Ministers of Health within one year of the establishment of the Committee.

Secretariat Support
Health Canada will provide secretariat support. This includes the preparation of agendas in consultation with the Chair and other members as appropriate, preparation of meeting notes and making arrangements for teleconferences, meeting rooms and hospitality.

Budget
There will be an operating budget for the one-year term of the Committee. This budget will cover meeting and travel expenses, translation, contract research and report writing.

Appendix C:
Canadian Nursing Advisory Committee
Executive Summaries of Commissioned Research Projects

Electronic versions of all six commissioned research projects will be available on request following the release of the final report of the Canadian Nursing Advisory Committee. The six commissioned reports are as follows:

- *A Catalogue: Current Strategies for Healthy Workplaces*
  Susan Wagner, University of Saskatchewan, Saskatoon, Principal Investigator

- *Full-time Equivalents and Financial Costs Associated with Absenteeism, Overtime, and Involuntary Part-time Employment in the Nursing Profession*
  Canadian Labour and Business Centre (Arlene Worstman, Principal Investigator)

- *Innovation and Strategies for Addressing Nursing Workload Issues*
  Andrea Baumann, McMaster University, Principal Investigator

- *Nurse Job Satisfaction - Factors Relating to Nurse Satisfaction in the Workplace*
  Donna Thomson, University of Toronto, Principal Investigator

- *Nurses' Definitions of Respect and Autonomy in the Workplace: Summary of Focus Groups with Canadian Nurses*
  Ginny Devine, Viewpoints Research, Principal Investigator

- *Structures, Power and Respect: The Nurse's Dilemma*
  Sholom Glouberman, Baycrest Centre for Geriatric Care, Principal Investigator

A Catalogue: Current Strategies for Healthy Workplaces

P. Susan Wagner, S. Bookey-Bassett, L. Clement-Gallien, J. Bulter

Executive Summary

This broadly based catalogue describes current healthy workplace strategies being used in Canada and internationally which are perceived to have positive effects on the quality of work life. Forty-five health and non-health organizations are represented. The strategies include flexible work arrangements, family care initiatives, leave and compensation, legislation, health and wellness, physical work environment and safety practices, supportive organizational culture, and union and management support and initiatives. Specific strategies within each category are defined. Mechanisms for workplace assessment and improvement are described, including some quality programs related to nursing care delivery and healthcare environments. The catalogue includes over five dozen current examples of innovative strategies with organizational contact information. Each example includes the organizational profile, the context, how the strategy was implemented, and the results. Examples of the value-added impact of 'bundling' several healthy workplace strategies in the same setting are given.

The term "healthy workplace strategy" was not as well understood by organizations as "quality workplace strategy." There were likely many more initiatives which could be classified as quality workplace strategies but were not identified as such by the employer representative. The strategies perceived as having a positive effect on staff are often very basic initiatives which seem to be common sense. The core commitment demonstrated by the employer is valuing people and respecting individual employees rather than focusing on tasks. This project found three different levels of commitment to healthy workplaces, at the top management level, at the middle management level, and at the level of staff. The longevity of some strategies was related to all three levels coming together to support the strategy. In order to earn credibility with employees, senior management must be seen to 'walk the talk' in interactions with staff and decisions about the organization.

Implications: For Practice

- Workplace strategies which contribute to quality work environments must be documented and celebrated, including successful union-management collaborative ventures.

- Both employers and employees need to demonstrate sustained commitment to healthy workplace strategies to become 'workplaces of choice'.

- Factors contributing to successful implementation of healthy workplace strategies in this project confirmed those identified by the Canadian Labour Market and Productivity Centre (1997a). They include:

  o Choice for both worker and employer.

  o Certainty and predictability for employer and employee.

  o Addressing quality of life issues had payoffs for company and employee.

  o Working within the constraints.

  o Trade-offs between (job) security and productivity (profits) are important.

  o Agreed-upon processes: joint approaches work best.

  o Education and preparation of culture of change for managers and workers.

  o Governments may have a role in support of both business and labour (p.62).

Implications: For Research

- The relationship of employee and client or service factors to organizational outcomes needs more study.

- Detailed case studies are needed to understand more about the implementation process which is part of the learning and behavioral change in an organization.

- More sensitive tools to assess workplace quality and measure the effects of specific workplace strategies are needed.

- More complete and accurate human resource data both within and across organizations is needed to evaluate the effects of particular strategies.

Implications: For Policy

- Mechanisms should be created to share current healthy workplace strategies, data and knowledge across organizations and sectors.

- Celebration of workplace quality and excellence should occur more often.

- Unions, employers and governments should jointly create mechanisms and processes through which existing collective agreements and legislation can be adapted to support the creation of more high-quality workplace environments.

- Organizations considering restructuring or downsizing should involve employees in the planning of organizational changes and job redesign.

- Research-granting organizations should be encouraged to maintain their priority for the study of human resources issues.

- Both federal and provincial governments should consider legislation which will support and encourage alternative working arrangements and the maintenance of work-life balance for all categories of employees.

Implications: For Nursing

- A strategy and mechanisms for the ongoing collection and dissemination of nursing workforce and workplace information should be developed.

- Widespread accessibility of the information should drive decisions about the mechanisms selected for dissemination, whether web-based, print or personal contact.

- Linkages should be negotiated and established among nursing organizations and with human resource information centres for occupations and workplace environments which share attributes similar to nursing.

- Print materials on nursing human resource issues and healthy nursing workplaces should be created and widely distributed.

This project has collected over five dozen examples of healthy workplace strategies currently used in a wide variety of organizations. Through communication and celebration of positive workplace initiatives, there is hope for stimulating interest and providing guidance to both employees and employers who wish to create more supportive workplace environments. Gradually the increased use and acceptability of these strategies by employers, unions and governments will lead to a better work-life balance for Canadian employees.

Full-Time Equivalents and Financial Costs Associated with Absenteeism, Overtime, and Involuntary Part-Time Employment in the Nursing Profession

Arlene Wortsman and Clarence Lochhead, Canadian Labour and Business Centre (CLBC)

Executive Summary

In light of the current and looming shortage of nurses in Canada, *The Nursing Strategy for Canada* was developed to strengthen and maximize nursing human resources by implementing broad, planned evidence-based and long-term recruitment and retention initiatives. Within that strategy, the *Canadian Nursing Advisory Committee (CNAC)* was established to make recommendations for improving the quality of work life for Canadian nurses. To support its work, the committee commissioned a number of studies to increase its understanding of a select group of issues. Key among these are the financial costs of overtime, use of agency nurses, absenteeism and turnover.

The primary objective of this study was to provide quantitative estimates as to the extent and costs associated with absenteeism, overtime and involuntary part-time employment. In addition, the research examines issues of turnover and the use of agency nurses within the nursing profession.

Methodology

The research draws primarily upon the public-use microdata files of Statistics Canada's Labour Force Survey (LFS). In this analysis all 12 monthly LFS surveys for the calendar year 2001 were used to produce estimates of overtime, absenteeism, and part-time or temporary employment of nurses. Within the LFS public-use microdata file, there are three broad categories of health occupation that pertain to nurses. These are:

- Nurse Supervisors and Registered Nurses;
- Technical and Related Occupations in Health (includes LNAs, LPNs, RNAs); and
- Assisting Occupation in support of Health Services (includes Nurses Aides, Nursing Attendants and Nursing Orderlies).

Only the first of these categories, *Nurse Supervisors and Registered Nurses*, is considered. While information on the employment characteristics of other nurses, particularly LNAs, LPNs and RNAs, is of importance to CNAC, the broad occupational groups provided with the LFS microdata file do not allow for their inclusion in this analysis.

In 2001 an estimated 236,700 individuals were employed as Nursing Supervisors or Registered Nurses. This does not include the approximately 1,900 Nursing Supervisors and Registered Nurses who were unemployed or the 7,500 who were not in the labour force.

The vast majority of employed Nursing Supervisors and Registered Nurses (96%) work in the health and social assistance sector. The estimated number of nurses in this sector is 227,400. Of that number, 186,100 are public employees, while 39,000 are private employees and 2,300 are self-employed. For purposes of this study the sample has been limited to employed Nursing Supervisors and Registered Nurses who are public employees in the health and social assistance sector. This represents 78.6% of all employed Nursing Supervisors and Registered Nurses.

As a supplement to the LFS analysis, the research also includes a case study of Queensway-Carleton Hospital, a 201-bed, full-service community hospital. Interviews were conducted with

representatives of the Ontario Nurses' Association, the Nurse Manager of the Surgical Unit, the Team Leader of the Staffing Office, and a representative of the Human Resource Office to examine issues of overtime, absenteeism, turnover and the use of agency nurses.

Publicly Employed RNs: An Overview of Selected Characteristics:

- Approximately 82% of publicly employed Registered Nurses are found in four provinces: Ontario (31%), Quebec (25%), British Columbia (15%) and Alberta (10%).

- Most Registered Nurses and Nursing Supervisors are female (93%). Quebec has the highest proportion of male nurses (10%).

- Of nurses who are employees in the public healthcare sector, 44% are aged 45 and over, 27% are aged 50 or older, and 11% are 55 or older.

Among provinces, British Columbia has the oldest nursing workforce: 34% of its public healthcare sector nurses are aged 50 or older.

The LFS indicates that 26% of publicly employed RNs in the health and social assistance sector are part-time workers (less than 30 hours per week). This is a much lower rate of part-time employment than that given by CIHI, using the Registered Nurses Database (RNDB), which indicates that 41% of RNs are part-time workers. The discrepancy is the result of different methods of determining part-time status.

Overtime

The Incidence of Overtime. Among publicly employed Nursing Supervisors and Registered Nurses in the health and social assistance sector, an average of 38,400, or 24%, worked paid or unpaid overtime in any given week of 2001. This is somewhat higher than the incidence of overtime among the rest of the employed labour force, which is 20.5%.

In every province, the incidence of overtime is higher among publicly employed RNs than it is in the rest of the employed labour force. Nurses in Quebec have the lowest rate of overtime (19.7%) while nurses in Alberta have the highest (31%).

Nursing Supervisors and Registered Nurses are more likely to work paid overtime than unpaid overtime. This is the opposite of the pattern found among the rest of the employed labour force.

Publicly employed RNs under 35 years of age are the least likely to work overtime (21%), while RNs aged 45 to 49 are the most likely to work overtime (29%). Across all age groups, overtime work is a common experience that pertains to at least one in four nurses each week.

Amount of Overtime. Each week, an estimated 38,400 Nursing Supervisors and Registered Nurses work an average of 6.4 hours of overtime, including both paid and unpaid overtime.

The total overtime hours (both paid and unpaid) amount to more than 240,000 hours per week, and 12.7 million hours per year. This is equivalent to just over 7,000 full-time, full-year positions.

The largest share of overtime hours (72%) is remunerated through either pay or time in lieu. The estimated 9.2 million hours of paid overtime translate into the equivalent of 5,070 full-time, full-year jobs.

The wage costs of overtime in 2001 are estimated to fall between $252.3 million and $430.8 million.

Temporary Absence Due to Illness and Injury

An estimated 13,700 (7.4%) of all publicly employed nurses are absent each week because of illness or injury. The rate of absence due to illness and injury is highest among RNs aged 55 and over. RNs working full-time have a rate of absence due to illness and injury that is 80% higher than the rate found among the overall full-time labour force (8.1% compared with 4.5%).

Compared to 47 broad categories of occupations, Nursing Supervisors and Registered Nurses have a higher rate of temporary absences due to illness and injury than any other group.

Lost hours due to illness and injury are estimated to total 311,364 hours per week (22.7 hours per absent nurse). It is further estimated that during 2001, a total of 16.2 million hours, the equivalent of 8,956 full-time, full-year nursing positions, was lost to illness and injury.

If the rate of absenteeism among nurses were at the same level as that of the overall full-time employed population (4.5%) the average number of RNs absent each week would fall to approximately 8,400 from 13,700 – a reduction of 5,300 nurses absent each week. 6.3 million hours, or the equivalent of 3,481 full-time, full-year positions, could be regained through a reduction in illness-related absenteeism.

The Cost of Absence Due to Illness and Injury. Absentee wage costs amount to an estimated $325 to $440 million per year. Replacement costs associated with illness and injury-related absenteeism could potentially range from $325 million to $660 million per year.

Replacement costs could be significantly reduced by as much as $126 to $257 million per year if the rate of nurses' illness- and injury-related absenteeism was in line with that of other full-time employed Canadian workers. These costs would constitute direct savings to employers and could be used for additional staffing needs.

Involuntary Part-Time Employment

Twenty-six percent of publicly employed nurses work part-time. Of those nurses that worked part-time, fifteen percent are involuntary part-time workers; that is, they could not find full-time work.

Involuntary part-time RNs work an average of 22 hours per week. If these involuntary part-time workers had been converted to full-time workers in 2001, it would have resulted in some 4.7 million additional hours of nursing practice in that year - the equivalent of 2,592 full-time nursing positions.

Limitations of the Study and Future Work

The study was originally undertaken to attempt to estimate the number of full-time equivalent positions that could be created if nurses employed on a casual basis and agency nurse hours were converted to full-time positions. Given the limitations of the LFS in addressing the issue of casual or agency nurses, this is clearly an area which requires further work.

Case Study Results

The limited case study of the Queensway-Carleton Hospital did confirm that hospitals are expending considerable dollars on overtime and on the purchase of nursing services. The case study does support the argument that it would be more efficient and productive to apply those dollars to increased resources within the hospital.

Innovation and Strategies for Addressing Nursing Workload

Andrea Baumann and Jane Underwood

Executive Summary

A major challenge for the Canadian nursing profession is to recruit and retain nurses in the wide variety of workplaces where nurses are currently employed. The Canadian Nursing Advisory Committee was formed to advise the Conference of Deputy Ministers of Health through the Advisory Committee on Health Human Resources. The issues to be addressed arise from *The Nursing Strategy for Canada* (Advisory Committee on Health Human Resources, 2000) with a priority on policy recommendations which will improve the work life of nurses. In partial fulfilment of this mandate, the Committee has asked the Nursing Effectiveness Utilization and Outcomes Research Unit (McMaster site) to investigate strategies to address nursing workload.

The objectives of this study were to determine:

- What is meant by nursing workload, what nurses mean by work overload;

- Staffing, staffing mix and how workload is managed in high quality work environments; and

- What strategies are effective for improving nursing workload issues.

Conclusion

In keeping with the policy recommendations by the Canadian Health Services Research Foundation (CHSRF) report on *Commitment and Care* (Baumann *et al.*, 2001), there are obvious strategies that can improve the work overload that many Canadian nurses are experiencing. The reports from the very small sample of informants for this study, along with the literature reports, are very encouraging. Realistic hiring, which takes into account the time that nurses will be away for various reasons, is important to ensure real time staff coverage for patient care. In addition, creatively paying attention to staff mix, encouraging self-scheduling with appropriate supports, continued improvement of workload measure tools and using the technological innovation that is available can all mitigate workload pressure. Strategic co-operation based on good communication is an important component of any workload strategy. The combination of service and research expertise is showing promise using participatory action research.

Policy Recommendations

Budget for staff realistically
- Incorporate forecast factors such as estimates for staff turnover, recruitment periods and leaves of absence in full-time equivalency staff budgets for nurses.

Workload measurement tools
- Evaluate workload measurement tools.

- Include qualitative contingency factors in workload measurement formulae.

    o Elicit the qualitative factors and confirm those factors through internal workload analysis committees.

Support self-scheduling

- Include training about mechanics, negotiation skills and guideline development in self-scheduling programs.

Technology
- Maximize technological opportunity for supporting nursing workload.

Support nurses' solutions to workload issues
- Conduct open seminars within work settings to share strategies amongst nurses.

Patient-centred care
- Implement strategies that involve patients and their families in their care.

Human resources management
- Pay close attention to human resource retention strategies.

- Provide education to support nurses to gain experience and become more effective quickly.

Use qualitative and quantitative methods (including participatory action research) to further study:
- Optimal lengths of shifts;

- Optimal skill mix of nursing teams based on the type of patient care required; and

- Comparative studies to determine the strategies that have the most positive impact on nursing workload.

Nurse Job Satisfaction — Factors Relating to Nurse Satisfaction in the Workplace

Donna Thomson, Jodene Dunleavy, Shirliana Bruce

Executive Summary

Researchers are accumulating strong evidence about nurses' growing dissatisfaction with their work and the ability of healthcare systems to attract and retain nurses in a climate of nursing shortages. This report expands on this evidence by illustrating the points at which job and workplace characteristics intersect with measures of job satisfaction among a group of nurses reporting very high levels or very low levels of satisfaction. Qualitative findings deepen our understanding of this issue. Dissatisfied nurses were approximately 60% more likely to report that there are too few nurses to get the work done, 50% more likely to report that there are too few support services to allow them to spend time with their patients, and 40% more likely to report an increase in patient loads between 1997 and 1998. The qualitative data gives an overall impression of a decline in the quality of working conditions for RNs, unstable work environments (low morale, strained relationships), reduced quality of patient care and inadequate support for education and training. "Very dissatisfied" nurses are two and a half times more likely to report a deterioration of patient care in their hospital, more likely to rate recognition, levels of autonomy, leadership, and support from unit and hospital administrators as unsatisfactory and to report significantly higher rates of emotional and physical fatigue.

After many years of watching working conditions deteriorate under mandated change, nurses have become disillusioned and feel powerless when it comes to voicing their concerns or having agency in an effort to improve conditions. Many nurses have a great deal of hope, but little trust, in moving front-line nurse and patient needs from the periphery to the centre of decision making in their institutions. In today's environment, two very clear messages emerge: too much workload and too little leadership.

Nurses' Definitions of Respect and Autonomy in the Workplace: Summary of Focus Groups with Canadian Nurses

Ginny Devine, Lesley Turnbull

On behalf of the Canadian Nursing Advisory Committee, Viewpoints Research conducted qualitative research with nurses to explore their views regarding respect at work – what defines respect and how a respectful work environment, or lack thereof, impacts their overall job satisfaction and work life. To meet the requirements of this project, six focus groups were held, two each in Winnipeg, Toronto and Vancouver in December 2001 and January 2002.

The vast majority of nurses participating in the groups said that, generally speaking, they like, even love, their jobs. However, most added a qualifier to their positive responses, indicating that they often experience high levels of frustration and stress on the job. Nurses from Toronto's hospitals expressed the greatest satisfaction and happiness with their work, while many Vancouver nurses, despite proclaiming they like their jobs, offered a distinctly negative view of their working environments. The Vancouver nurses, for the most part, do not believe they are treated with respect on the job, while Winnipeg and Toronto nurses do feel that in general, they are afforded respect in their workplaces.

- Nurses who work in the community or medical units, which operate on a multi-disciplinary model emphasizing communication and teamwork, indicated feeling a great amount of respect from their colleagues.

- Lack of respect for nurses is often evident in operational and human resource policies set by administrators and managers who don't recognize that nurses are highly educated professionals with personal responsibilities as well as work related ones.

- The consensus among the groups was that the younger generation of physicians is more respectful of nurses than previous generations. It was also suggested that recent nursing graduates have a greater level of self-confidence than their predecessors and expect to be respected by other professionals with whom they work. Nurses stated that physicians in particular specialties, like cardiology and surgery, were less likely to show respect for nurses.

- Virtually all nurses described their workloads as being frequently overwhelming because of understaffing, preventing them from providing their patients with an adequate standard of care. This situation, which ultimately sees nurses spending time doing non-professional work or work no one else is there to do, shows disrespect for both patients and nurses, participants said.

- There was universal criticism of budget decisions that negatively impact patient care and patient safety and of the fact that those decisions are often made without any consultation with nurses on the front lines. Participants felt that this showed disrespect for nurses' experience, skills and education.

- Nurses are dismayed by the tendency of hospital administrators to make operational and structural changes in their workplaces without soliciting feedback from the nurses or, alternatively, by asking their opinions but then ignoring them. Further, they believe physicians' opinions are given credence, while frequently theirs are not.

- Many nurses suggested that it was critical that staff nurses have representation on key hospital committees.

- Being managed by people who have no nursing background is considered a significant problem by many nurses, who believe these managers do not understand or appreciate their concerns related to patient care and operational issues. Expecting

nurses to be able to work in any area, no matter how specialized and no matter what their training, was cited as a reflection of this lack of understanding, as were round-the-clock visiting hours.

- Nurses who work in specialty areas or in community health appear to enjoy more autonomy on the job than do general duty nurses. They also report feeling more respected by their peers, physicians and other members of their healthcare teams.

- Nurses feel that the inadequate salaries and meagre pay differentials allotted for higher education and supervisory responsibilities indicate a lack of respect for the professions. The dearth of subsidized professional development opportunities also signifies a lack of respect for the professions. Expecting nurses to attend training sessions on lunch hours or to advance their nursing education on their own time is also a significant issue for nurses.

- Another sign of disrespect cited is the expectation that nurses should always be available to work overtime and extra shifts, regardless of personal circumstances.

- Nurses say that relying on excessive overtime and on relief and agency staff to take up the slack is not a sustainable solution to staff shortages. They believe this policy is detrimental to patient safety and results in nurse burnout, which manifests itself in retention and recruitment problems.

- A lack of comfortable staff lounges for nurses, combined with not ensuring that nurses working nights and weekends have access to the same amenities, services and support staff as their nine-to-five colleagues, is considered disrespectful.

- Nurses say that management does not provide sufficient recognition of their contributions, either in the form of verbal praise or concrete rewards for their efforts. Even small tokens of appreciation such as free coffee and cookies on Fridays or modest seasonal celebrations would help nurses feel they are respected.

- Nurses noted that when management takes anything less than a zero tolerance approach to the verbal and physical abuse of nurses, it suggests to them that abuse is considered an occupational hazard rather than a serious offence.

- Educating physicians, other medical professionals, administrators, patients, families, the general public and government decision makers about nursing and the important role nurses play in the healthcare system was often cited as a crucial step in enhancing the level of respect for nurses and for the professions. Using the media to convey this message was recommended.

- Nurses realize that they themselves must do more to show respect toward one another and to support one another on the job. Participants believe that their nursing unions and professional associations have a key role to play in ensuring that happens.

Recommendations

During this research project, nurses made numerous recommendations on ways to increase the level of respect afforded them in their work life. There was a strong consensus among the participants that pointed to four main areas that healthcare employers should concentrate on to improve the level of respect for nurses in Canada. The four priority recommendations are:

- Increase the level of involvement of nurses in decisions about patient care and when considering operational and structural changes in the workplace, including representation on hospital and government committees.

- Increase basic salaries and provide better compensation for supervisory and specialty positions and for higher education.

- Provide subsidized professional development and training opportunities on paid time, but not during regular shifts.

- Maintain the appropriate level of patient care by hiring more staff.

Structures, Power and Respect: The Nurse's Dilemma

Sholom Glouberman

Executive Summary

The modern nurse is caught in the throes of change. Medicine has increasingly made her into an administrative specialist, while her heritage is that of bedside care for the individual patient. From her leaders, she is under pressure to become a professional, while the physician and she herself are apt to doubt her qualifications as a professional. She is a woman who finds herself in a work situation where the most prestigious positions routinely go to men. She ranks low in occupational prestige and financial rewards. All this has been described and documented again and again. The conflict inherent in the nurse's situation could doubtless be elaborated even further than the existing studies have already done, but more useful insight can be gathered by taking a look at how the nurse fits into the movement to apply rational knowledge in modern medicine (Katz 1969, p. 54).

Introduction

Although a great deal has changed in the past 30 years, the difficulties described above remain. Nursing leaders' desire to professionalize the nursing role stands in opposition to the need for more basic bedside care. A deeply felt inequity between how doctors and nurses are valued persists. It is mirrored in the disparity of pay. The average nurse earns about one-third as much as the average medical specialist. The inequity is less evident but equally felt in terms of the relative value ascribed to nursing knowledge as opposed to physician knowledge. For the vast majority of nurses, these tensions occur in the context of institutions, especially the acute care hospital. In hospitals, where almost 70% of nurses work, the perennial struggle between doctors and nurses over the "division of medical labour" is joined by other players, including various healthcare workers and hospital administrators. This, coupled with reduced resources, results in increased tensions and greater complexity.

In this paper, we will explore the structures within which these various players interact with each other and with patients, how their roles are perceived and how their work is performed. We will try to clarify some of these issues and provide some possible directions for the future.

Objectives

Our objectives are to describe the potential organizational structures and roles that could facilitate increased respect and professional autonomy associated with nurses' work. We will suggest steps that could be taken to achieve such a proposed organizational structure, and identify potential barriers to the process. We will identify how the core values of differing professional groups conflict and potentially redirect attention from the mission of healthcare, namely to support the needs of the patient and family and to provide an organizational context which values communication and collaboration.

Our Research Questions

How do organizational structures interact with healthcare professionals?
Professional and organizational boundaries form obstacles and opportunities to the co-ordination of work and to collaboration among professionals. We will approach this question in relation to the work performed by the various professionals in relationship with each other and patients.

How do people understand "respect"?

The lack of clarity about what constitutes "respect" in the workplace setting is in part a function of the widely differing perspectives on the nature of health care work by the various agents in the health care system. Much of our work is in the clarification of differing views about such concepts.

What are tangible policies to change the situation?
It is clear that there are some standards and policies that are in place about workplace roles and responsibilities of all participants in the health field. A literature review would help identify those that need to be strengthened.

How do we position these issues so that you have robust ways to think about them?
It is most important to consider how correcting the issues you describe is critical to reinvigorating public confidence in Canadian medicare. Finding ways to think that allow for this connection to be transparent is a challenging question.

How can we describe them to help you with your final report(s)?
We believe that identifying and reinforcing the links between nursing and the rest of the healthcare system will be an important way forward.

We recognize the relevance of the questions proposed and would add several other questions that elaborate on yours:

- How much are the issues related to structures?

- How much are they related to lack of respect?

- How much are they related to crippling workloads?

- Are there other relevant factors that lead to current nursing problems?

- What are some policy interventions by nursing organizations, by government and by other professions that could change the situation?

Appendix D:
Canadian Nursing Advisory Committee Structure

Membership
To meet the goals set out for the Canadian Nursing Advisory Committee, the right team had to be assembled. Early on, it was determined that, rather than being made up of representatives of various organizations, the Canadian Nursing Advisory Committee should bring together nurses and other experts who had experience in and knowledge of quality of work life and quality work environments, regardless of their organizational affiliations. Members would be appointed because of their knowledge and what they could contribute to the Committee, not simply to represent a sector or an organization.

In response to the call for nominations, 114 names were submitted to the ACHHR. A process was put in place to select Committee members that would reflect the enormous diversity of the country in its geography, linguistics and cultures, the diversity of the regulated nursing groups, nursing roles and practice settings, and be inclusive, as appropriate, of non-nurse experts who could help in the process.

The appointment process resulted in a 16-member committee with 12 non-government members, three members from provincial or territorial governments, and one from the federal government. Participation by government representatives was seen as essential, because any recommendations ultimately would impact on governments across the country. Their input as the process unfolded was important. However, the government representatives also would be required to have a solid understanding of work life and quality work environments, and to participate as active members of the Committee (as opposed to serving in observer roles).

The final membership (see Appendix E) list was approved by the Deputy Ministers and Ministers in March 2001 and the membership announced to the public shortly thereafter.

Committee Meetings
The Committee met for the first time in June 2001, in Toronto, Ontario. Subsequent meetings were held in November 2001 (St. John's, Newfoundland) and March 2002 (Vancouver, British Columbia), each meeting lasting two full days. In all the meetings, the Committee discussed and debated the large body of evidence about nursing work life and quality work environments, and consulted a variety of researchers and other experts. Over the year, the group's thinking moved from a *problem* focus – identification of the key work life and workplace problems - to suggesting the list of recommendations that grounds this report. The Committee received briefs from the *Canadian Nurses Association*, the *Aboriginal Nurses Association of Canada* and the *Ontario Nurses Association*. As well, several groups and individuals were invited, or requested the opportunity, to appear before the committee (see Appendix F).

Research
To inform the committee and provide current perspectives on selected issues, six research/information projects were commissioned by the Canadian Nursing Advisory Committee (see Appendix C). Time constraints limited the scope and depth of these projects. Experienced researchers known to the committee were contracted on a short-term basis to carry out the projects. Final reports of those studies will be published in an addendum to this report; their executive summaries are included in Appendix C.

Appendix E:
Canadian Nursing Advisory Committee Membership

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Appendix F:
Canadian Nursing Advisory Committee Guests and Presenters

Toronto – June 2001
Heather Crawford, Vice President and Chief Nursing Officer
Health Sciences Centre
Winnipeg, Manitoba

Phyllis Giovannetti, Professor and Associate Dean (Research, Partnerships & Faculty Development)
Faculty of Nursing, University of Alberta
Edmonton, Alberta

André Picard, Author, Public Health Reporter
Globe and Mail
Montreal, Quebec

Shirlee Sharkey, President and Chief Executive Officer
St. Elizabeth Health Care
President
Registered Nurses Association of Ontario
Toronto, Ontario

Thomas F. Ward, Deputy Minister
Department of Health, Nova Scotia and Chair, Advisory Committee on Health Human Resources
Halifax, Nova Scotia

St. John's – November 2001
Jeanette Andrews, Executive Director
Association of Registered Nurses of Newfoundland and Labrador
St. John's, Newfoundland

Regina Coady, Chair
Working Group on Nursing & Unregulated Healthcare Workers
Advisory Committee on Health Human Resources
St. John's, Newfoundland

Diane Irvine Doran, Associate Professor
Faculty of Nursing, University of Toronto
Toronto, Ontario

Paul Fischer, Executive Director
Council for Licensed Practical Nurses of Newfoundland and Labrador
St. John's, Newfoundland

Heather K. Spence Laschinger, Professor and Associate Dean
University of Western Ontario
London, Ontario

Melanie Lavoie-Tremblay
Laval University
Quebec City, Quebec

Susan Wagner, Professor
University of Saskatchewan
Saskatoon, Saskatchewan

Vancouver – March 2002

Laurel Brunke, Executive Director
Registered Nurses Association of British Columbia
Vancouver, British Columbia

Sholom Glouberman (by phone)
Baycrest Centre for Geriatric Care
Toronto, Ontario

Elma Heidemann (by phone), Executive Director
Canadian Council on Health Services Accreditation
Ottawa, Ontario

Bonnie Lance, President
Registered Nurses Association of British Columbia
Vancouver, British Columbia

Clarence Lockhead, Economist
Canadian Labour and Business Centre
Ottawa, Ontario

Debra McPherson, President
British Columbia Nurses Union
Vancouver, British Columbia

Anne Sutherland-Boal, Chief Nurse
British Columbia Health
Victoria, British Columbia

Donna Thomson (by phone)
Faculty of Nursing, University of Toronto
Toronto, Ontario

Leslie Turnbull
Viewpoints Research
Winnipeg, Manitoba

Jane Underwood, Assistant Professor
School of Nursing, McMaster University
Hamilton, Ontario

Evelyn Voyageur
Aboriginal Nurses Association of Canada
British Columbia

Susan Wagner, Professor
University of Saskatchewan
Saskatoon, Saskatchewan

We pride ourselves in this country upon being progressive, yet we are compelled to work from twenty to twenty-two hours out of the twenty-four … There is something radically wrong in a civilized system that breaks nurses down in health in an average of ten years and this is especially unjust to a class of workers whose lives are spent in the alleviation of suffering in others.

Letter to the Editor
The American Journal of Nursing
May 1902
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