Where Policy Meets the Nursing Front Line:

A Framework for Determining Appropriateness for a Safe, Sustainable Health System

August 2014

Published by:
The Canadian Federation of Nurses Unions
www.cfnu.ca
2841 Riverside Drive
Ottawa, Ontario K1V 8X7
613-526-4661

Project manager: Linda Silas
Project team: Arlene Wortsman, Oxana Genina, Katarina Oestreich
Researched and written by: Janet Davies and Carol Reichert

August 2014

Design and layout by Madeleine Gagné of Communicarium
Printed and bound in Canada by Imprimerie Plantagenet Printing

Table of Contents

The Canadian Federation of Nurses Unions (CFNU)

The Canadian Federation of Nurses Unions represents close to 200,000 nurses and student nurses. Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

Letter to the Premiers










Dear Honourable Premiers,

On behalf of the close to 200,000 nurses represented by the Canadian Federation of Nurses Unions (CFNU), we are pleased to present our latest policy brief *Where Policy Meets the Nursing Front Line: A Framework for Determining Appropriateness for a Safe, Sustainable Health System*.

Premiers, we applaud the positive work the Council of the Federation has undertaken through the Health Care Innovation Working Group and the Pan-Canadian Pricing Alliance. Since its inception in 2003, and the signing of the Canada Health Accord in 2004, the Council of the Federation has continued to work on behalf of all Canadians to improve our health care system.

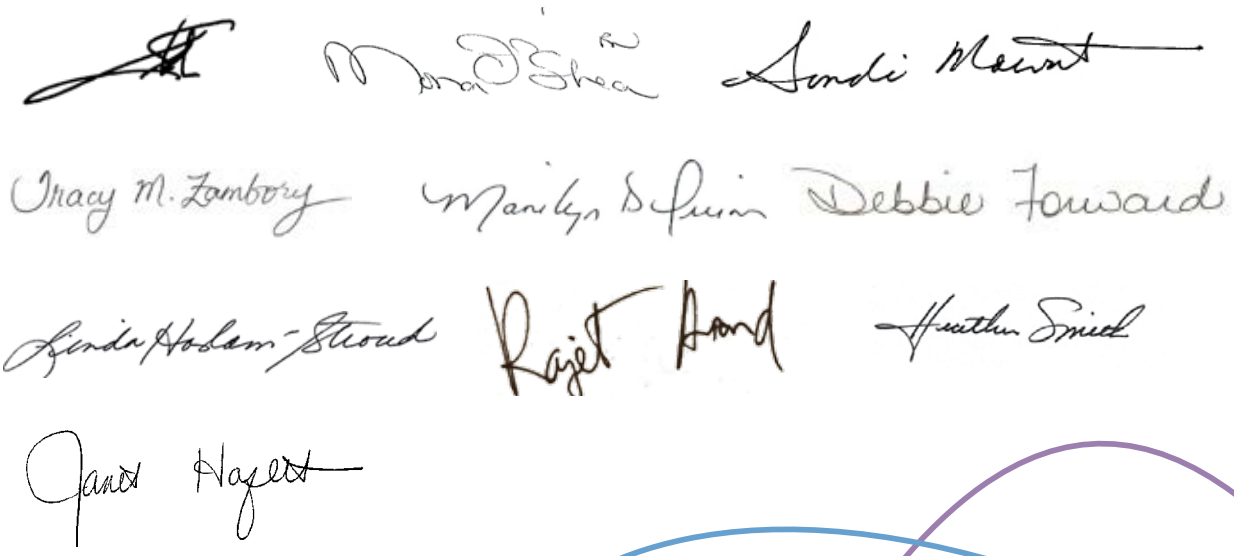
With the end of the Health Accord, the Council of the Federation has taken on even greater significance for the future of our health care system and nurses recognize the importance of your efforts and want to contribute our energy and expertise.

As a representative of the front line of health care, the CFNU has a message for provincial/territorial leaders:

1. First, we must unite in opposition to the federal government's continued erosion of health care funding to the provinces. The decline in funding has resulted (and will continue to result) in negative health outcomes for all Canadians, leading to a dramatic loss of nurses for our treasured health care system.
2. We must stand together to develop and implement a national pharmacare program in this country, a measure which could save up to $11.4 billion annually, money which could be reinvested in our health care system.

3. Health care leaders must support and improve frontline patient care in all sectors of our health system. Direct staffing decisions must be made based on patient needs, best practices and evidence-based research, rather than resulting from ill-conceived budget cuts.
4. A long-term National Health Human Resources Plan needs to be developed that includes a more equitable and efficient distribution of nurses, support for the current workforce through safe staffing and safer workplace measures to safeguard patient safety, and initiatives that ensure permanent stable employment for new graduates.
5. Finally, frontline nurses have proven to be key partners with premiers in the past, and they have demonstrated the effectiveness of nurse-led innovations within the public system. We are prepared to plan, innovate, and implement initiatives, but to do so, frontline nurses must be included as partners in future discussions on system design and innovation if leaders want to implement successful long-term, effective solutions.

Sincerely,




RN

Executive Summary

The Canadian Federation of Nurses Unions, which represents frontline nurses across Canada, offers the following to further productive discussions inclusive of all stakeholders/decision makers.

The Council of the Federation has directed that decisions about transforming the health care system be guided by the concept of appropriateness.

Based on a review of international literature and interviews with frontline nurses, the Canadian Federation of Nurses Unions (CFNU) has concluded that appropriateness encompasses the following elements:

1. PATIENTS: their well-being; their care; their dignity as Persons

- Focus on patient-driven changes.
- Strong health systems are "people-centred".
- Design delivery methods to facilitate people's access to health services.
- Safe and effective care can be provided in the public system, with positive patient outcomes, in community and ambulatory settings.
- Focus on promoting health: there is a substantial body of evidence showing that the majority of health care expenditures are spent on conditions that are largely preventable. Investing in promoting health could yield billions in annual savings, while providing better access to prescription drugs through universal pharmacare could save $3 billion to just over $11 billion per year.

- Focus on aging in place through a different approach to seniors care: integrated chronic disease management, including comprehensive health literacy and caregiver supports.
- Delivery and access to care should be through nurse practitioners, registered nurses, doctors, and other health care professionals, based on patients' needs and working collaboratively as a team.

EXAMPLES

- Enhance population health outcomes through electronic technology.
- Strengthen the role of nurses as patient advocates.
- Increase the number of nurse-led health care clinics within the community, i.e., in shopping malls closer to where people live and work, within a publicly funded, administered and delivered health care system.
- Outreach and pre-screening of at-risk populations (e.g., First Nations).

2. POLICY: a health care system supported by evidence-based long-term strategic policies

- The structures, policies, and processes that make up the health system are interrelated: changing one element affects some or all other elements.
- No single change alone in policy/practice will transform the health system.
- A systems approach with a range of concurrent, sequential, and mutually reinforcing changes is needed.
- Long-term health human resources planning must take into consideration staffing inefficiencies (turnover, excessive overtime, absenteeism due to own illness or disability, etc.), the numbers of individuals at, or nearing retirement, and new graduate numbers.
- Achieve wage parity across all health care sectors.
- Coordination improves health care systems' productivity and effectiveness.
- Frontline health care workers recognize the impact of system changes on patients – they must be included in decision making processes.
- Health care decisions must be made with the full participation of every stakeholder, including nurses, patients and their families.

EXAMPLE

- Cuts to the National Health Service (NHS) England public health care system, focused solely on budgetary constraints, led to a dramatic reduction in nurse staffing levels and nurses' replacement with unregulated care providers. The result: substandard care, patient neglect, and high patient mortality rates, and a high profile public inquiry resulted in the Francis Report which serves as a wake-up call for Canadians.

3. PRACTICE: build on the frontline knowledge of health care workers in every sector

- Safe staffing policies need to be implemented to better achieve positive patient health outcomes.
- Creating an environment where nurses and other health care professionals are engaged to think creatively about making changes, have ideas, and be part of the process improves patient safety and satisfaction.
- Engaging frontline providers offers cost savings, and greater staff satisfaction and retention.
- The various re-engineering tools must recognize the value, and require the inclusion and meaningful engagement of frontline workers, and should be directed towards improving the quality of the work environment, not delivery of care.
- A focus on innovation must draw on the collective knowledge and experience of frontline health care professionals.

EXAMPLE

- In 2008-2009, Health Canada funded CFNU's Research to Action Project with 10 provincial pilots in which nurses implemented specific activities (e.g., mentoring, leadership and orientation). An evaluation revealed a 10% reduction in overtime, absenteeism and turnover costs, and a 147% increase in the number of nurses reporting a high level of leadership and support.

4. PUBLIC ACCOUNTABILITY

- The role and responsibilities of the federal government must be clear, present and visible.
- Evaluation and public reporting of the impacts of changes contributes to public confidence in the system.
- New delivery methods require re-thinking evidence-based performance measures and governance structures.
- Patients and their families must be a strong voice within our health care system.

EXAMPLES

- On a provincial basis, data needs to be collected, analyzed and reported on new nurse graduates' permanent employment, nurse retirements, and supply and demand projections to ensure that a current, accurate picture of the Health Human Resources (HHR) data is available.
- Standardized patient adverse events data need to be collected, reported and acted upon in a timely manner. These data should be transparent and publicly accessible.
- Data related to nursing care delivery, such as staffing levels and staff mix, must be publicly available to ensure organizational transparency and accountability. Unit-based patient adverse events data must be linked to nursing care delivery data.

5. PROVINCIAL/TERRITORIAL ENGAGEMENT

- Given that much of the health care workforce, including nurses, are unionized, successful transformations must involve both employers and employees engaged in dialogue, working directly with provincial nurses unions and employer organizations.
- Nurses are on the front lines of health care. Nurses must be with provincial/territorial leaders to guide, inform and reinforce decision making.
- Provincial/territorial governments must continue to encourage the federal government to assume its role in health care by providing appropriate funding and national leadership.

EXAMPLE

- Creation of the Health Accord brought the federal and provincial/territorial governments together with health care stakeholders in a unique collaboration to tackle major challenges within the health care system. In the spirit of this Accord, drawing on the knowledge and experience of frontline health care workers, the provinces need to engage with nurses as partners in health system reform to reduce the cost of staffing inefficiencies (turnover, excessive overtime, absenteeism due to own illness or disability, etc.), to close gaps in the continuum of care, as well as to introduce measures that would save billions per year, while improving patient health outcomes (promoting health, national pharmacare, etc.).

The Council of the Federation has directed that decisions about transforming the health system be guided by the concept of appropriateness. The CFNU believes that the following are the key elements of appropriateness:

- **Patients**: evidence related to patient health outcomes.
- **Policy**: coherent and coordinated policy, processes and practices across the system.
- **Practice**: engage provider knowledge from hands-on practice.
- **Public accountability**: publicly available data, information, and evaluation.
- **Provincial/territorial engagement**: as the health care front line, nurses must be with provincial/territorial leaders guiding, informing, and reinforcing decision making.

The CFNU strongly recommends that to accomplish a key objective of Canada's Premiers – a safe, accessible and sustainable health care system for all Canadians – all decision makers must include the front line of health care with the meaningful representation and engagement of nurses unions and employers' representatives as an integral part of the Council of Federation health care innovation consultation process. We all must adopt these elements as a framework for assessing the appropriateness of transformation initiatives.

"Canada's challenge ahead is to adjust priorities appropriately, ensuring our funding follows the needs of those who require care at home and within the community."

John Abbott
Chief Executive Officer
Health Council of Canada

Introduction

Public opinion polls in Canada continue to reflect concerns about the health system. International comparisons show that Canadians encounter problems accessing health services. Canada ranks 10th among 17 peer countries in terms of the health of its population.[1] Further, there are gaps in the health system.[2] For example, primary care services in Canada lag behind those in similar countries.

Escalating health care costs are an issue across the globe. Many countries are working to make their health systems fiscally sustainable. Attention is directed at innovations to enhance efficiency in the health sector. Research has identified efficiencies from new models of care, operational upgrades, investments in information and other technology, as well as the introduction of accountability. Implementing changes to operations, practices, and policy can be expected to provide positive results in terms of health outcomes, patient satisfaction, and staff retention.[3]

Governments in Canada have tasked commissions and expert working groups to propose measures to strengthen the health system. Under the banner of the Council of the Federation, provincial and territorial governments are currently working to redesign and transform the health system to achieve the triple aim of: better health, better care, and better value. Their efforts provide the basis for modifying some of the aspects of the system: they focus attention on how, where, and by whom health services are delivered. The Council has directed that decisions about the delivery of health services must be guided by the concept of appropriateness. As cited by the Canadian Foundation for Healthcare Improvement[4], the Council of the Federation offered the following definition of appropriateness:

> *In the context of health care, appropriateness is the proper or correct use of health services, products and resources. Inappropriate care, in contrast, can involve overuse, underuse and/or misuse of health services, products and resources. Appropriateness is primarily determined by analyses of the evidence of clinical effectiveness, safety, economic implications, and other health system impacts. The practical application of appropriateness is made when these analyses are qualified by (a) clinician judgment, particularly in typical circumstances, and (b) societal and ethical principles and values, including patient preferences.*

For the Canadian Federation of Nurses Unions (CFNU) this definition comprises patients as well as frontline providers. It also acknowledges the interconnectedness of the health system. The definition is robust; it creates the foundation for conceptualizing and assessing innovations:

- **EFFECTIVENESS** incorporates the idea of positive patient and population health outcomes. It depends on the evaluation and measurement of outcomes.
- **RESOURCES** includes staff who deliver care.
- **CLINICAL JUDGEMENT** allows for the reality of ever-evolving knowledge.
- **HEALTH SYSTEM IMPACTS** connotes links among the services, products and resources of the health system.
- **SOCIETAL** speaks to relevance to population health; "societal" also connotes inclusiveness and the concept of equity, whether geographic or related to health services or health status.

The CFNU believes that the successful and sustainable transformation of the health system depends on evaluating proposed changes to the system against each of these elements. The CFNU believes that transparency and public accountability for all proposed changes are essential elements to ensure that providers, including nurses, patients and their families have a strong voice within our health care system to ensure its continued integrity. The CFNU has developed a framework to support the operationalization of the definition of appropriateness.

The Framework

Based on a review of international literature and interviews with frontline nurses, the Canadian Federation of Nurses Unions (CFNU) has concluded that appropriateness encompasses the following concepts:

1. PATIENTS: their well-being; their care; their dignity as Persons

- Focus on patient-driven changes.
- Strong health systems are "people-centred".
- Design delivery methods to facilitate people's access to health services.
- Safe and effective care can be provided in the public system, with positive patient outcomes, in community and ambulatory settings.
- Focus on promoting health: there is a substantial body of evidence showing that the majority of health care expenditures are spent on conditions that are largely preventable. Investing in promoting health could yield billions[5] in annual savings, while providing better access to prescription drugs through universal pharmacare could save $3 billion to just over $11 billion per year.[6]
- Focus on aging in place through a different approach to seniors care: integrated chronic disease management, including comprehensive health literacy and caregiver supports.
- Delivery and access to care should be through nurse practitioners, registered nurses, doctors, and other health care professionals, based on patients' needs and working collaboratively as a team.

EXAMPLES

- Enhance population health outcomes through electronic technology.
- Strengthen the role of nurses as patient advocates.

- Increase the number of nurse-led health care clinics within the community, i.e., in shopping malls closer to where people live and work, within a publicly funded, administered and delivered health care system.
- Outreach and pre-screening of at-risk populations (e.g., First Nations).

2. POLICY: a health care system supported by evidence-based long-term strategic policies

- The structures, policies, and processes that make up the health system are interrelated: changing one element affects some or all other elements.
- No single change alone in policy/practice will transform the health system.
- A systems approach with a range of concurrent, sequential, and mutually reinforcing changes is needed.
- Long-term health human resources planning must take into consideration staffing inefficiencies (turnover, excessive overtime, absenteeism due to own illness or disability, etc.[7]), the numbers of individuals at, or nearing retirement, and new graduate numbers.
- Achieve wage parity across all health care sectors.
- Coordination improves health care systems' productivity and effectiveness.
- Frontline health care workers recognize the impact of system changes on patients – they must be included in decision making processes.
- Health care decisions must be made with the full participation of every stakeholder, including nurses, patients and their families.

EXAMPLE

- Cuts to the National Health Service (NHS) England public health care system, focused solely on budgetary constraints, led to a dramatic reduction in nurse staffing levels and nurses' replacement with unregulated care providers. The result: substandard care, patient neglect, and high patient mortality rates, and a high profile public inquiry resulted in the Francis Report which serves as a wake-up call for Canadians.

3. PRACTICE: build on the frontline knowledge of health care workers in every sector

- Safe staffing policies need to be implemented to better achieve positive patient health outcomes.
- Creating an environment where nurses and other health care professionals are engaged to think creatively about making changes, have ideas, and be part of the process improves patient safety and satisfaction.
- Engaging frontline providers offers cost savings, and greater staff satisfaction and retention.
- The various re-engineering tools must recognize the value, and require the inclusion and meaningful engagement of frontline workers, and should be directed towards improving the quality of the work environment, not delivery of care.

- A focus on innovation must draw on the collective knowledge and experience of frontline health care professionals.

EXAMPLE

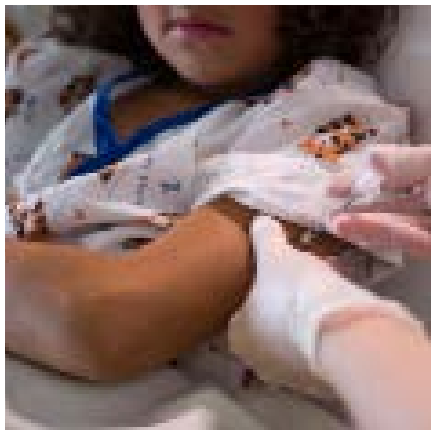
- In 2008-2009, Health Canada funded CFNU's Research to Action Project with 10 provincial pilots in which nurses implemented specific activities (e.g., mentoring, leadership and orientation). An evaluation revealed a 10% reduction in overtime, absenteeism and turnover costs, and a 147% increase in the number of nurses reporting a high level of leadership and support.[8]

4. PUBLIC ACCOUNTABILITY

- The role and responsibilities of the federal government must be clear, present and visible.
- Evaluation and public reporting of the impacts of changes contributes to public confidence in the system.
- New delivery methods require re-thinking evidence-based performance measures and governance structures.
- Patients and their families must be a strong voice within our health care system.

EXAMPLES

- On a provincial basis, data needs to be collected, analyzed and reported on new nurse graduates' permanent employment, nurse retirements, and supply and demand projections to ensure that a current, accurate picture of the Health Human Resources (HHR) data is available.
- Standardized patient adverse events data need to be collected, reported and acted upon in a timely manner. These data should be transparent and publicly accessible.
- Data related to nursing care delivery, such as staffing levels and staff mix, must be publicly available to ensure organizational transparency and accountability. Unit-based patient adverse events data must be linked to nursing care delivery data.




5. PROVINCIAL/TERRITORIAL ENGAGEMENT

- Given that much of the health care workforce, including nurses, are unionized, successful transformations must involve both employers and employees engaged in dialogue, working directly with provincial nurses unions and employer organizations.
- Nurses are on the front lines of health care. Nurses must be with provincial/territorial leaders to guide, inform and reinforce decision making.
- Provincial/territorial governments must continue to encourage the federal government to assume its role in health care by providing appropriate funding and national leadership.

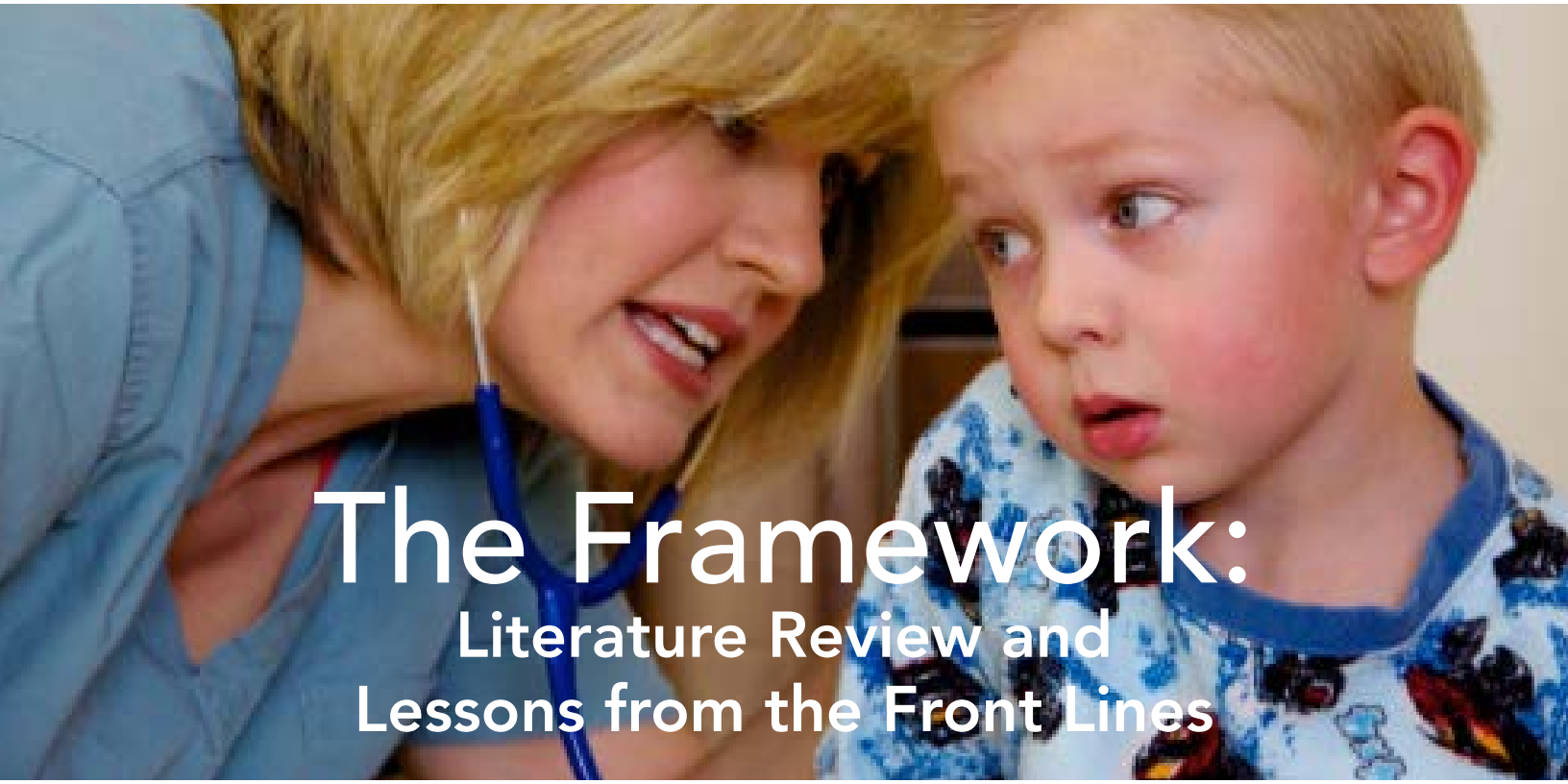
EXAMPLE

- Creation of the Health Accord brought the federal and provincial/territorial governments together with health care stakeholders in a unique collaboration to tackle major challenges within the health care system. In the spirit of this Accord, drawing on the knowledge and experience of frontline health care workers, the provinces need to engage with nurses as partners in health system reform to reduce the cost of staffing inefficiencies (turnover, excessive overtime, absenteeism due to own illness or disability, etc.), to close gaps in the continuum of care, as well as to introduce measures that would save billions per year, while improving patient health outcomes (promoting health, national pharmacare, etc.).

The Council of the Federation has directed that decisions about transforming the health system be guided by the concept of appropriateness. The CFNU believes that the following are the key elements of appropriateness:

- **Patients**: evidence related to patient health outcomes.
- **Policy**: coherent and coordinated policy, processes and practices across the system.
- **Practice**: engage provider knowledge from hands-on practice.
- **Public accountability**: publicly available data, information, and evaluation.
- **Provincial/territorial engagement**: as the health care front line, nurses must be with provincial/territorial leaders guiding, informing, and reinforcing decision making.

The CFNU strongly recommends that to accomplish a key objective of Canada's Premiers – a safe, accessible and sustainable health care system for all Canadians – all decision makers must include the front line of health care with the meaningful representation and engagement of nurses unions and employers' representatives as an integral part of the Council of Federation health care innovation consultation process. We all must adopt these elements as a framework for assessing the appropriateness of transformation initiatives.



The Framework:
Literature Review and Lessons from the Front Lines

1. PATIENTS: focus on patient and population health outcomes

The literature offers evidence that focusing on positive patient health outcomes drives change which, in turn, reduces costs, improving the value of the health system. For example, one of the foundations of the various re-engineering methodologies is that all activities be gauged against their value to the client or patient. For the front line, purging waste means, among other things, re-assigning non-clinical duties to non-clinical staff and making work areas more efficient. This would allow nurses and other clinicians more time with patients. While industrial methodologies may not be perfect, insofar as they can respect the patient-centred care model, they enhance the value of health services, both community-based and institutional. This cannot be done safely without the input, assessment, and evaluation by frontline staff, and should focus on enhancing the quality of the work environment, excluding the delivery of care process.

The patient-centred approach is fundamental to safe, quality care. The literature also demonstrates a link between patient-centred care and cost effectiveness. Evidence shows, for example, that in long-term care facilities that provide higher nursing hours per resident, residents have better outcomes, including better physical and cognitive functioning, fewer hospital admissions, and lower mortality rates.[9] Each of those outcomes translates into reduced health system expenditures.

According to a recent study undertaken in 300 European hospitals in nine countries and published in *The Lancet*, an increase in nurses' workload increases the likelihood of inpatient deaths. The same study found that the level of education of nurses has a direct impact on patient safety,

leading to a decrease in hospital deaths.[10] These findings are very similar to workload/staffing studies conducted in the U.S. and Canada.[11]

A 2013 report from the World Health Organization (WHO) observes that strong health systems are "people-centred".[12] WHO offers that delivery methods that facilitate access to health services – using electronic technology, for example – enhance population health outcomes. People-centred thinking is the basis of the 290 recommendations contained in the Francis Report, the result of a public inquiry which addressed the "appalling patient suffering" in the UK's Mid Staffordshire National Health Service (NHS) Foundation Trust. The Report recommends corrective action, including the adoption of a people-centred approach which includes the identification of standards to measure the effects of service delivery methods on patients.[13]

In Canada, a decade ago, concern for patient safety led to the creation of the Canadian Patient Safety Institute (CPSI). The CPSI safety competency framework recognizes that a number of factors affect safety: work-life imbalance; sleep deprivation/sleep debt; surge conditions; work interruptions; ergonomics, including system design; and work flow.[14] In Australia, the framework for safe and quality health care is built around the following principles: care is consumer centred, driven by information, and organized for safety.[15]

In the literature, one finds insights and best practices related to patient safety. For example, the Francis Report, and two subsequent reports[16] in response to its findings, identify the need for clear staffing requirements and professional standards, proposing tools to assess the needs of patients and to match needs to staffing decisions. The Report also proposes that data on outcomes, care delivery, and staff mix be collected and reviewed to inform future decisions about patient care.[17]

> *Ward Manager, responsible for a 36 bed ward, around 50 staff and around 45 patients…looking after a bay of nine patients… Balancing budgets, staff issues and training, complaints and so on…all the stuff that a manager, in other industries, normally does every day. We imagined the equivalent in manufacturing – a manager who was responsible for 50 staff…but was actually working 'full time' on the line and on shifts….* [18]

To augment the ability of the system to respond to patient needs, safe staffing tools are being implemented.

The U.S. has also codified patient care to support the Medicare program: hospitals must have adequate numbers of frontline providers to assure immediate bedside care to meet patient needs. New patients cannot be accommodated unless the standard is met.[19] There has been no assessment of the impacts of mandated ratios in a jurisdiction with a publicly funded health system but in Australia and the State of California mandated nurse-to-patient ratios are in use. If the ratios cannot be met, then new patients are turned away. There is no unique or consistent perspective on the merits of mandating nurse-to-patient ratios; researchers do agree that staffing decisions that take into account patients' needs increase the efficiency of service delivery.[20]

The CFNU commends the use of six metrics to assess the progress of a facility and/or a system toward patient-centred health delivery.[21] The metrics were developed by the Commission on a High Performance Health System of the Commonwealth Fund:

1. Patients' clinically relevant information is available to all providers at the point-of-care and to patients through electronic health record systems.
2. Patient care is coordinated among multiple providers, and care transitions across settings are actively managed.
3. Providers (including nurses and the rest of the care team) both within and across settings have accountability to each other, review each other's work, and work together to reliably deliver high-quality, high-value care.
4. Patients have easy access to appropriate care and information, including off-hours. There are multiple points of entry to the system, and the providers are culturally competent and responsive to the needs of the patient.
5. There is clear accountability for the total care of the patient.
6. The system is continuously innovating and learning in order to improve the quality, value, and patient experience of health care delivery.

Health outcomes are measured through mortality and morbidity rates; nutritional status; physical and cognitive functioning; infection rates; incidents of falls; and hospital admissions. The literature establishes a direct correlation between direct nursing care and each of those measurements.[22] Better care will result from facilities and units redesigning work processes and reconfiguring work spaces so that frontline providers can spend more time with patients. In a study conducted in Alberta, lower 30-day mortality rates correlated with a lower proportion of casual and temporary nurses in relation to permanent full-time nursing staff. In the same study, hospitals with higher scores on collaborative nurse-physician relationship scales were associated with lower rates of 30-day patient mortality.[23]

The CFNU recognizes that there are long-term financial benefits from improved patient outcomes. It believes that innovations can only be deemed appropriate if, and when, they are people-centred and engage frontline nurses in the decision making process.

2. POLICY: coherence and adoption of a system-wide perspective

No single change in policy or practice will, on its own, transform the health system. Instead, a range of concurrent, sequential, and mutually reinforcing changes are needed. Improvements to the operational processes of the health system are needed at various levels of the system. Changes are needed at the unit and facility levels to the current ways of working, as well as to administrative and safe staffing procedures such as location of services, governance, and IT systems and infrastructure. At the national or multi-jurisdictional level, changes in supports for professional development, performance measures, and governance are all at play.

In their work on transformation lessons for the Canadian health care system, Denis and colleagues point to models of insured health services being relocated from hospitals and other institutional settings. They reference compelling evidence that safe and effective care can be provided in the public system, with positive patient outcomes, in ambulatory settings closer to the places Canadians live and work.

"Health care in Canada is a work continuously in progress. We need to embrace comprehensive policy solutions that tackle root causes instead of surface symptoms; that bring about systemic changes instead of quick fixes; that promote long-term benefits instead of short-lived gains." [24]

Roy Romanow, February 2012

They argue that moving services – such as diagnostic tests, palliative care, dialysis, IV antibiotics treatment, and post-surgical follow-up – away from institutional walls enhances timeliness and convenience. However, attention to the consequences of changing models of care is needed. Changing one element in a system affects some or all other elements.[25] This idea is captured in the following statement from the UK's Royal College of Nursing: "To effectively shift care out of hospitals and re-provide these services in the community, a whole-system approach is needed. Hospital restructuring cannot happen in isolation but must go hand-in-hand with reinvestment strategies."[26]

Average Cost of Care – for one week, for 424 seniors:[27]

Hospital Bed	$2 500 000
Long-term care bed	$374 000
Care at home	$125 000

In Canada, much of the health care workforce is unionized: over 80% of public sector nurses are unionized. In some areas of the country, we do not have wage and benefit parity across all health care sectors which will impact retention and recruitment measures. Taking this into consideration, we need to bring all the players to the table before we plan health care transformation to ensure that our acute care sector remains strong, while simultaneously enhancing the capacity of community and ambulatory care.

Nurses have identified system integration and coordination as a major vector for improving productivity and effectiveness in the health system. They spoke about the efficiency of seamless care, for patients and families, for providers, and in terms of costs. Nurses spoke of gaps in the

current approaches to system reform. At a system level, nurses believe that the connectedness of the system will be enhanced by:

- Building and strengthening communications between settings;
- Assuring compatible information technologies, including electronic records;
- Clarifying appropriate roles and scopes of practice of various providers;
- Articulating distinct responsibilities for each member of a health team;
- Linking safe staff mix decisions to patient needs;
- Following policy changes affecting the consequential realignment of legislation, professional practice standards, collective agreements language, or administrative processes;
- Assessing issues related to professional liability insurance;
- Increasing access to all health care professionals – doctors, nurses, nurse practitioners and other health care professionals.

Based on the experience of various organizations, the Institute for Healthcare Improvement (IHI) advocates a systems approach to change. The IHI approach includes: identification of target populations; definition of system aims and measures; development of a portfolio of project work that is sufficiently strong to move system-level results, and rapid testing and scale-up that is adapted to local needs and conditions. The IHI approach also includes a requirement to look at contextual factors, including the range of social services.[28] Through the experiences of the front line, the CFNU has insights on barriers and enablers to coherence between the health system and other sectors. When designing care plans, frontline nurses deal with officials and policy makers in sectors like criminal justice, housing, education, and social welfare. This knowledge could inform system transformation decisions.

The front line believes that to be effective and sustainable, health policy decisions must assess and address the system-wide impacts, both direct and indirect.

3. PRACTICE: build on the knowledge of those who provide care

There are over 375,000 nurses in the workforce in Canada.[29] They are well-educated, highly skilled, and positively regarded by patients and families. Nurses assess, treat, educate, advise and support. They work in hospitals, primary care, clinics, long-term care facilities, rehabilitation services, respite care, public, mental and community health programs, as well as home care. Nurses have direct knowledge of the health system. Nurses play a central role in ensuring the quality and safety of care. Their vigilance is an important defence against medical errors.

Eroding this vital defence are the many challenges nurses face on a daily basis in their workplaces – excessive workloads, high rates of overtime, illness, injury and burnout are common. In 2012, public sector nurses worked well over 21.5 million hours of overtime, and almost 19,000 publicly employed nurses were absent from work due to their illness or disability on a weekly basis.[30] This situation is untenable in the long term, especially since the number of nurses approaching retirement is increasing. Among RNs, who make up the majority of the nursing workforce, more than 25% of nurses are 55 or older.[31] Meanwhile, more than 10,000 new nurses graduate each year but many do not have permanent full-time employment or are not employed in nursing.[32]

Research confirms that in an environment where nurses are engaged to think creatively about making changes, have ideas, and be part of the process, patient safety and satisfaction improve. Moreover, there is growing evidence that involving frontline workers in quality improvement is essential for large, sustainable transformations in health care. Programs like *Transforming Care at the Bedside* are built on the belief that frontline providers are a strong source of ideas and innovations. Nurses have identified gaps and barriers as well as enablers; their ideas have resulted in dramatic improvements in the quality of patient care as well as improving the work environment for frontline staff.[33]

As the CFNU's new publication, *Valuing Patient Safety: Responsible Workforce Design*, emphasizes, patients must be at the forefront of any redesign decisions. This means patient priority care needs must be properly assessed using real-time tools, based on factors such as acuity, stability and complexity. Once patient needs are determined, nurses and their managers should base staffing assignments on the best fit between patient needs and nurse competencies.[34]

Innovative programs managed by frontline providers offer benefits to system performance. For example, the evaluation of the UK NHS program, *Releasing Time to Care*, identified improved patient experiences, cost savings, and greater staff satisfaction and retention.[35]

In addition to guiding system reform, the knowledge of nurses with experience in clinical practice is important to optimizing the delivery of care. With the increasing complexity of patients, frontline providers in Canada, as elsewhere, want advice from experienced clinicians. A 2009 study found strong interest among younger nurses in mentoring programs.[36] There is evidence showing that strengthening leadership can reduce turnover rates.[37] Other research concludes that opportunities for professional development and skills upgrading are a key retention tool.[38]

If one accepts the perspective of Henry Ford that "There are no big problems, there are just a lot of little problems," one must recognize the potential of ideas that staff generate, encourage their creativity, and share their learning. Two examples[39] of small-scale improvements demonstrate this:

- In response to patients' confusion about their care path, nursing staff proposed that a whiteboard be set up for each patient. The board is used to identify the procedures scheduled on a given day, as well as the physician and nurse responsible for the patient that day. The patient is encouraged to write down questions and concerns on the whiteboard as well.
- Nursing staff recommended redesigning the physical space to co-locate supplies and patient information. This has reduced time to prepare a room for chemotherapy from 14 minutes to six minutes. Evaluations show improvements in both patient and provider satisfaction. Providers have also identified increases in work efficiency.

The CFNU has an inventory of best and promising practices identified and managed by the front line. These have been shown to improve the efficiency of the operation of the health system.

4. PUBLIC ACCOUNTABILITY: accountability and evidence-based decision making

Accountability is a key element of system reform. According to the literature, accountability offers two benefits:[40]

1. It identifies connections among individual interventions, and thus, supports a system-wide perspective on health sector reform.
2. It supports improved service delivery and management through feedback and learning.

Value is the key deliverable of accountability. There are three types of accountability: financial, performance, and political/democratic.[41] To assess quality, outcomes, and costs (the components of value), one must be able to measure and interpret data and information.

> *Value establishes a road map to accountability and effective medical system reform.*[42]

Evidence-based decision making is the process of considering the results of research as well as data collected in observational studies, pilots, randomized controlled trials, and program and policy evaluations that include qualitative and quantitative research. In addition, expert opinion from consensus documents and commission reports as well as policy and program evaluations can and should inform decisions. Frontline providers point to gaps in data and research that impede effective decisions.

Between 2000 and 2006, there were ten major national reports addressing human resource planning issues in the health sector; each outlined issues related to the nursing workforce in Canada.[43] The reports identified the following challenges in the work environments of the front line: frequent interruptions; role confusion; limited technical and human support; lack of integration and coordination and ever-increasing patient acuity. They also pointed to overwork. An analysis of two decades of research shows that nursing workload, as well as the quality of nursing work environments, affect patient outcomes. It identifies gaps in workforce data to support workforce planning. A 2014 review of human resource planning found an absence of pertinent, quantified data on the nurse workforce.[44] This limits the analysis and planning necessary to ensure appropriate and quality care. The review concludes that actions are needed to address the data gap.[45]

Assessing appropriateness requires the collection of evidence to assess the impacts of actions on the achievement of better health, better care and better value. The appropriateness of innovations to transform the health system should be judged based on an analysis of patient data. Policy makers, administrators and frontline providers alike, need data that links patient acuity, health outcomes, and system-wide experience with staff mix across a range of health care settings.

The UK's National Institute for Health and Care Excellence (NICE) audits the performance of the health system; it is also responsible for defining quality standards and identifying best practices. NICE supports health system transformation decision making. Its independence from political and bureaucratic structures mean that NICE "stands out as an example of a context where high-quality economic evaluation plays a major role in decision making".[46] An institution with similar functions to NICE in Canada would support appropriate decision making.

The 2013 Francis Report suggests that the data on outcomes, care delivery, and staff mix be collected, reviewed, and publicly reported.[47] This recommendation speaks to the accountability issues identified as a result of the Mid Staffordshire Foundation Trust tragedy. In the UK and the U.S., legislative measures have been put in place to support health system transformation. UK law specifies that health facilities publicly report their staffing plans.[48] As of April 2014, NHS hospitals are required to publish staffing levels on a ward-by-ward basis together with the percentage of shifts meeting safe staffing guidelines. This is mandatory and is done on a monthly basis.[49] There is a bill before the U.S. Congress which mirrors legislation adopted in at least seven states, and requires accountability reporting of staffing, including confirmation that only frontline providers with appropriate education and experience are staffed in a unit.[50]

Nurse staffing is one of the few areas in health care in Canada where evidence is ignored in decision making.[51]

The literature recommends the development of quality standards against which to measure the performance of programs and policies as well as the system.[52] Standardized information systems that allow evaluation of the impacts of decisions against goals are needed. In the case of the work of the Council of the Federation, the goal of transformation has been defined as the Triple Aim.

Conclusion

Provincial/Territorial Engagement

Nurses' regular, close proximity to patients and scientific understanding of care processes across the continuum of care give them a unique ability to act as partners ... and to lead in the improvement and redesign of the health care system and its many practice environments.[53]

The health system in Canada is not functionally optimal. The Canadian Federation of Nurses Unions recognizes that changes are needed to improve the health status of Canadians and to strengthen the efficiency of the health system.

Based on consultations with its members and analysis of research, the CFNU believes that the successful and sustainable transformation of the health system depends on the appropriate actions and interventions. Appropriateness can be gauged against a framework that includes:

- **Patients**: patients as the focus of all decisions and activities in the health sector.
- **Practice**: the knowledge and experience of those who deliver care engaged.
- **Policy**: recognition of the inter-connectedness of the health system.
- **Public accountability**: data and evidence being collected and analyzed to support decision making; data and evidence also being available to the public in order to ensure that patients and their families are present, powerful and involved with quality/safety initiatives at all levels of the health care system.
- **Provincial/territorial engagement**: Nurses are on the front lines of health care. Nurses must be with provincial/territorial leaders to guide, inform and reinforce decision making. To do this, frontline nurses and other health care professionals must be part of all health care transformations (this provision should be incorporated into new legislation). Finally, provincial/territorial governments must continue to encourage the federal government to assume its role in health care, by providing appropriate funding and national leadership.

In the spirit of the past Canada Health Accord, premiers should make a commitment to implement these five points and report back to the public and health care stakeholders on an annual basis.

As a representative of the front line of health care, the CFNU has a message for provincial/territorial leaders:

1. **First, we must unite in opposition to the federal government's continued erosion of health care funding to the provinces. The decline in funding has resulted (and will continue to result) in negative health outcomes for all Canadians, leading to a dramatic loss of nurses for our treasured health care system.**

2. **We must stand together to develop and implement a national pharmacare program in this country, a measure which could save up to $11.4 billion annually, money which could be reinvested in our health care system.**

3. **Health care leaders must support and improve frontline patient care in all sectors of our health system. Direct staffing decisions must be made based on patient needs, best practices and evidence-based research, rather than resulting from ill-conceived budget cuts.**

4. **A long-term National Health Human Resources Plan needs to be developed that includes a more equitable and efficient distribution of nurses, support for the current workforce through safe staffing and safer workplace measures to safeguard patient safety, and initiatives that ensure permanent stable employment for new graduates.**

5. **Finally, frontline nurses have proven to be key partners with premiers in the past, and they have demonstrated the effectiveness of nurse-led innovations within the public system. We are prepared to plan, innovate, and implement initiatives, but to do so, frontline nurses must be included as partners in future discussions on system design and innovation if leaders want to implement successful long-term, effective solutions.**

References

1. Conference Board of Canada. How Canada Performs. Retrieved from http://www.conferenceboard.ca/hcp/details/health.aspx

2. Health Council of Canada. (2013). *Progress report 2013: Health care renewal in Canada*. Ottawa: Author.

3. OECD. (2013). *Health at a Glance 2013*. Retrieved from http://www.oecd.org/els/health-systems/health-at-a-glance.htm

4. Canadian Foundation for Healthcare Improvement (CFHI). (2013). *Reassessing existing funded health services and products to support appropriate care.* Retrieved from http://www.cfhi-fcass.ca/OurImpact/ImpactStories/ImpactStory/2013/11/29/reassessing-existing-funded-health-services-and-products-to-support-appropriate-care

5. Canadian Public Health Association. Making the Economic Case for Investing in Public Health and the SDH. Retrieved from http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/economics.aspx

6. Gagnon, Marc-André. (2014). *A Roadmap to a Rational Pharmacare Plan*. Ottawa: CFNU.

7. Informetrica Limited (2013). *Trends in Own Illness or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses — Quick Facts*. Report prepared by Informetrica Limited for CFNU. Retrieved from https://nursesunions.ca/report-study/absenteeism-and-overtime-quick-facts-2013

8. CFNU. (2011). *Research to Action. CFNU Backgrounder.* Retrieved from http://nursesunions.ca/sites/default/files/2011.backgrounder.rta_.e.pdf

9. Harrington, C., O'Meara, J., Collier, E., Schnelle, J. (2003). Nursing indicators of quality in nursing homes. *Journal of Geronotological Nursing*, 5-11, October 2003.

10. Aiken, L., et al. (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *The Lancet*. DOI: org/10.1016/S0140-6736 (13)62631-8.

11. Berry, L., & Curry, P. (2012). *Nursing Workload and Patient Care*. Ottawa: CFNU.

12. World Health Organization. (2013). *Towards people-centred health systems: An innovative approach for better health outcomes*. Geneva: Author.

13. Francis, R. (2013). *Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report*. Retrieved from http://www.midstaffspublicinquiry.com/

14.Frank, J.R., Brien, S., (Editors) on behalf of The Safety Competencies Steering Committee. (2008). *The Safety Competencies: Enhancing Patient Safety Across the Health Professions*. Ottawa: Canadian Patient Safety Institute.

15. Australian Commission on Safety and Quality in Health Care. (2011). *Australian Safety and Quality Framework for Health Care. Putting the framework into action: getting started*. Retrieved from http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/ASQFHC-Guide-Healthcare-team.pdf

16. Berwick, D. (2013). *A promise to learn—a commitment to act. Improving the safety of patients in England*. National Advisory Group on the Safety of Patients in England. Retrieved from Government of UK https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Keogh, B. (2013). *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. Retrieved from National Health Service England http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

17. Francis, R. (2013). *Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report*. Retrieved from http://www.midstaffspublicinquiry.com/

18. Taylor, Ian; Baker, Marc. (2010). Lean Healthcare: Who's (or Where's) the Boss. *Lean Health Blogspot*. Retrieved from http://lean-health.blogspot.ca/2010/02/whos-or-wheres-boss.html

19. American Nurses Association. (2009, March 20). *ANA's Safe Staffing Saves Lives: Campaign Secures Victory for Patient Safety* (press release). Retrieved from http://nursingworld.org/HomepageCategory/NursingInsider/Archive_1/2009-NI/Mar-09-NI/Safe-Staffing-Campaign-Victory-for-Patient-Safety.html

20. Rozdilsky, J., Alecxe, A. (2012). Saskatchewan: Improving Patient, Nursing and Organizational Outcomes Utilizing Formal Nurse-Patient Ratios. *Nursing Leadership*, 25(Sp) March 2012: 103-113. DOI:10.12927/cjnl.2012.22802.

21. Stephen C. Schoenbaum, et al. (2008). *Organizing the U.S. Health Care Delivery System for High Performance: Executive Summary*. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx

22. Needleman J, Buerhaus PI, Mattke S, Stewart M, Zelevinsky K. (2001). *Nurse staffing and patient outcomes in hospitals*. Boston: Harvard School of Public Health.

Aiken L., et al. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *J Am Med Assoc* 2002; 288: 1987–1993.

Aiken, L., et al. (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *The Lancet*. Doi: org/10.1016/S0140-6736 (13)62631-8.

23. Estabrooks, C., et al. (2011). The impact of hospital nursing characteristics on 30-day mortality. *Journal of Nursing Administration*, 41 (7/8), S58 — S68.

24. Romanow, R. (2012). *The Future of Health Care: Medicare must be preserved and made truly comprehensive*. Ottawa: Canadian Centre for Policy Alternatives.

25. Denis, J.L., et al. (2011). *Assessing initiatives to transform healthcare systems: Lessons for the Canadian healthcare system*. CHSRF series on healthcare transformation: Paper 1. Retrieved from http://www.cfhi-fcass.ca/SearchResultsNews/11-07-21/c70d5dc2-98b6-43cb-b735-e03144d0cf7a.aspx

26. Royal College of Nurses. (2013). *Moving Care to the Community: An International Perspective*. Retrieved from http://www.rcn.org.uk/__data/assets/pdf_file/0006/523068/12.13_Moving_care_to_the_community_an_international_perspective.pdf

27. North East LHIN. (2011). HOME First Shifts care of Seniors to HOME. *LHINfo Minute*. Retrieved from http://www.nelhin.on.ca/WorkArea/showcontent.aspx?id=11258

28. Institute for Healthcare Improvement. IHI Triple Aim Initiative. Retrieved from http://www.ihi.org/offerings/Initiatives/TripleAIM/Pages/default.aspx

29. Canadian Institute for Health Information. (2014). *Regulated Nurses, 2013*. Ottawa: Author.

30. Informetrica Limited (2013). *Trends in Own Illness or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses — Quick Facts*. Report prepared by Informetrica Limited for CFNU. Retrieved from https://nursesunions.ca/report-study/absenteeism-and-overtime-quick-facts-2013

31. Canadian Institute for Health Information. (2014). *Regulated Nurses, 2013*. Ottawa: Author.

32. Canadian Nurses Association (CNA). (2013, October 8). *Problematic trends for registered nurse workforce, report reveals*. (press release) Retrieved from http://www.cna-aiic.ca/en/news-room/news-releases/2013/problematic-trends-for-registered-nurse-workforce-report--reveals

33. Garrett, K. (2012). *Transforming Care at the Bedside (Phase 2)*. Robert Wood Johnson Foundation. Retrieved from http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf403009

34. MacPhee, Maura. (2014). *Valuing Patient Safety: Responsible Workforce Design*. CFNU. Retrieved from http://nursesunions.ca/news/valuing-patient-safety-responsible-workforce-design

35. National Health Service Institute for Innovation and Improvement. (2010). *Improving healthcare quality at scale and pace – Lessons from The Productive Ward. Releasing Time to Care Programme*. Retrieved from http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

36. Wortsman, A.; Crupi, A. (2009). *From Textbooks to Texting: Addressing issues of intergenerational diversity in the nursing workforce*. CFNU. Retrieved from https://nursesunions.ca/report-study/textbooks-texting-addressing-issues-intergenerational-diversity-in-the-nursing-workplac

37. Sabine, S., William, D. (2007). Organizational configuration of hospitals succeeding in attracting and retaining nurses. *Journal of Advanced Nursing*, 57(l):45-58.

38. Ontario Nurses' Association. (2006). *Patients Matter: the roots of a health care problem and how to alleviate it.* Ottawa: Author.

39. Taming of the Queue 2011. (2011, March 24). *Presentation by Dr. Patricia O'Connor & Brenda MacGibbon*. Retrieved from http://www.cfhi-fcass.ca/NewsAndEvents/Events/Taming_of_the_Queue/TamingOfTheQueue2011/TamingOfTheQueue2011FinalReport/Introduction/Day1ThursdayMarch24.aspx

40. Brinkerhoff, D. (2003). *Accountability and Health Systems: Overview, Framework, and Strategies*. The Partners for Health Reformplus Project. Retrieved from http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf

41. Ibid.

42. Cutter, B. (2011, March 23). Accountability in Health Care: Definition and Implementation. *Lyceum Newsletter Perspectives*. Retrieved from http://www.talkingtransitions.com/2011/03/how-to-define-and-implement.html

43. Berry, L., Curry, P. (2012). *Nursing Workload and Patient Care*. Ottawa: CFNU.

44. Janowitz, S. (2014). *Nursing Workforce: Retirement and New Graduate Employment Trends*. Ottawa: CFNU. Unpublished Research.

45. Ibid.

46. Buxton, M.J. (2006). Economic evaluation and decision making in the UK. *Pharmacoeconomics*. 2006;24 (11):1133-42.

47. Francis, R. (2013). *Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report*. Retrieved from http://www.midstaffspublicinquiry.com/

48. Ibid.

49. NHS Employers. Safe Staffing Guidance. Retrieved from http://www.nhsemployers.org/your-workforce/plan/nursing-workforce/safe-staffing-guidance

50. American Nurses Association. (2013, May 8). *Registered nurse staffing bill introduced into Congress*. (press release). Retrieved from http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NurseStaffing/Registered-Nurse-Safe-Staffing-Bill-Introduced-in-Congress.pdf

51. McGillis Hall, L., et al. (2006). Decision Making for Nurse Staffing: Canadian Perspectives. *Policy, Politics & Nursing Practice*, 2006 Nov; 7 (4): 261-9.

52. Mando, J., Saleh, G. (2014, January 28). Overcoming the Challenges of Lean in Public Health. *The Lean Post*. Retrieved from http://www.lean.org/leanpost/Posting.cfm?LeanPostId=136#.UvTaufvxlkJ

53. IOM and Robert Woods Johnson Foundation. (2010). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press.

Appendix A:
Letter to the Premiers (French)

Honorables premiers ministres,

Au nom de près de 200 000 infirmières et infirmiers représentés par la Fédération canadienne des syndicats d'infirmières et infirmiers (FCSII), nous sommes ravies de vous soumettre notre dernier document d'information *À la croisée de la politique et des soins infirmiers de première ligne. Cadre de travail pour déterminer la pertinence d'un système de soins de santé viable et axé sur la sécurité*.

Premiers ministres, nous applaudissons le travail positif amorcé par le Conseil de la fédération par l'intermédiaire du Groupe de travail sur l'innovation en matière de santé et de l'Alliance pancanadienne d'achat de médicaments. Depuis sa formation en 2003, et la signature de l'Accord 2004 sur la santé, le Conseil de la fédération a déployé des efforts, au nom de tous les Canadiens et les Canadiennes, pour améliorer le système de soins de santé.

Avec l'Accord sur la santé qui prend fin, le Conseil de la fédération n'a jamais été aussi important pour assurer l'avenir de notre système de soins de santé. Les infirmières et les infirmiers reconnaissent l'importance de vos efforts et veulent vous offrir leur énergie et leur expertise.

En qualité de représentante des premières lignes des soins de santé, la FCSII a un message pour les leaders provinciaux et territoriaux :

1. Premièrement, nous devons nous unir et nous opposer à l'érosion continue, par le gouvernement fédéral, du financement alloué aux provinces pour la santé. La réduction du financement se traduit (et continuera de se traduire) en résultats de santé négatifs pour tous les Canadiens, et entraînera une perte majeure d'infirmières et d'infirmiers au sein du système de soins de santé.
2. Nous devons nous unir pour élaborer et mettre en œuvre un programme national d'assurance-médicaments dans le pays. Cela permettrait d'économiser jusqu'à 11,4

milliards par année et cet argent pourrait être réinvesti dans le système de soins de santé.

3. Les leaders du secteur de la santé doivent offrir un soutien aux soins de première ligne et les améliorer dans tous les secteurs du système de soins de santé. Les décisions relatives à la dotation doivent être fondées sur les besoins des patients, les pratiques exemplaires, et les données probantes, plutôt qu'être motivées par des compressions budgétaires irréfléchies.
4. Il faut élaborer une stratégie nationale à long terme sur les ressources humaines en santé qui prévoit une distribution plus équitable et efficiente du personnel infirmier, un soutien à la main-d'œuvre actuelle grâce à la dotation axée sur la sécurité, de meilleures mesures de sécurité au travail afin d'assurer la sécurité des patients, ainsi que des initiatives pour assurer des emplois stables et permanents aux nouveaux diplômés en sciences infirmières.
5. Finalement, les infirmières et les infirmiers ont prouvé, par le passé, qu'ils pouvaient être des partenaires-clés pour les premiers ministres, et ils ont démontré l'efficacité des innovations qu'ils pilotaient au sein du système. Nous sommes prêts à planifier, innover et à mettre en œuvre des initiatives mais, pour le faire, les infirmières et les infirmiers doivent être des partenaires lors des discussions futures au sujet des innovations et de la structuration du système. Ainsi, les leaders pourront mettre en place des solutions efficaces à long terme.

Cordialement.

Appendix B:

Executive Summary (French)

La Fédération canadienne des syndicats d'infirmières et infirmiers, qui représente le personnel infirmier de première ligne du Canada, offre ce qui suit afin d'encourager les discussions productives entre tous les principaux intervenants et les décideurs.

À l'avis du Conseil de la fédération, toute décision relative à la réforme du système de soins de santé doit être fondée sur le concept de pertinence.

À la suite d'une revue de la littérature internationale, et d'entretiens avec le personnel infirmier de première ligne, la Fédération canadienne des syndicats d'infirmières et infirmiers (FCSII) conclut que la pertinence comprend les éléments suivants :

1. PATIENTS : leur mieux-être, leurs soins, leur dignité en tant que personnes

- Accent mis sur les changements motivés par les patients.
- Systèmes solides de soins de santé axés sur les personnes.
- Modèles de prestation des soins qui facilitent l'accès aux services de santé.
- Soins efficaces et sécuritaires pouvant être offerts au sein du système public, avec des résultats positifs pour les patients, dans le cadre de soins communautaires et ambulatoires.
- Accent sur la promotion de la santé : de nombreuses études nous indiquent que la plus grande partie des dépenses de santé sont attribuables à des maladies évitables. Investir dans la promotion de la santé pourrait signifier des économies annuelles de plusieurs milliards. Un meilleur accès aux médicaments sur ordonnance, grâce à un régime universel d'assurance-médicaments, pourrait se traduire en économies de 3 milliards à un peu plus de 11 milliards par année.

- Accent sur le vieillissement en adoptant une approche différente relativement aux soins destinés aux aînés : gestion intégrée des maladies chroniques, y compris éducation complète sur la santé et soutien aux personnes soignantes.
- Accès aux soins en fonction des besoins des patients et soins dispensés par des équipes axées sur la collaboration et regroupant des infirmières praticiennes, des infirmières autorisées, des médecins et autres professionnels de la santé.

EXEMPLES

- Technologie électronique pour améliorer les résultats de santé de la population.
- Consolider le rôle du personnel infirmier en tant que défenseurs des patients.
- Augmenter le nombre de cliniques de soins dirigées par des infirmières dans la collectivité, par exemple dans les centres commerciaux et à proximité des endroits où les gens vivent et travaillent, et dans le cadre d'un système de soins financé, administré et délivré par l'État.
- Se rendre dans les collectivités et faire un dépistage préliminaire des populations à risque (par exemple, les Premières nations).

2. POLITIQUE : un système de soins de santé qui s'appuie sur des politiques stratégiques à long terme fondées sur les données probantes

- Interdépendance des structures, des politiques et des processus entourant le système de soins de santé : modifier un élément affecte un ou plusieurs autres éléments.
- Un seul changement à une politique ou à la pratique ne peut transformer le système de soins de santé.
- Nécessité d'une approche systémique prévoyant une gamme de changements concurrents, séquentiels et se renforçant mutuellement.
- La planification à long terme des ressources humaines en santé doit tenir compte de l'inefficacité de la dotation (roulement de personnel, heures supplémentaires excessives, absentéisme en raison de maladie ou blessure, etc.), du nombre de départs à la retraite, du nombre de personnes approchant la retraite, et du nombre de nouveaux diplômés.
- Parité salariale dans tous les secteurs des soins de santé.
- La coordination améliore la production et l'efficacité du système de soins de santé.
- Les travailleurs de première ligne connaissent l'impact, sur les patients, des changements apportés au système. Il faut en tenir compte lors du processus décisionnel.
- Tous les principaux intervenants, y compris le personnel infirmier, les patients et leur famille, doivent participer à la prise de décisions relatives aux soins de santé.

EXEMPLE

- Les compressions au sein du National Health Service (NHS) Angleterre, système public de soins de santé, motivées uniquement par les contraintes budgétaires, ont mené à une réduction des niveaux de dotation infirmière et au remplacement des infirmières par des

fournisseurs de soins non réglementés. Résultat : soins sous les normes, négligence des patients, taux élevés de mortalité, et enquête très médiatisée dont le rapport (Rapport Francis) est un signal d'alarme pour les Canadiens et les Canadiennes.

3. PRATIQUE : tirer profit des connaissances des travailleurs de la santé de tous les secteurs

- Mettre en place des politiques en matière de dotation axée sur la sécurité afin d'obtenir des résultats positifs pour les patients.
- Créer un milieu de travail qui encourage le personnel infirmier et les autres professionnels de la santé à penser de façon créative, à avoir des idées, et à faire partie du processus pour améliorer la sécurité et la satisfaction des patients.
- Faire participer les fournisseurs de première ligne favorise le maintien en poste et se traduit en économies et en une plus grande satisfaction chez le personnel.
- Les différents outils de restructuration doivent tenir compte de la valeur des travailleurs de première ligne et exiger qu'ils participent de façon active. Ces outils devraient servir à améliorer la qualité du milieu de travail, et non pas cibler la prestation des soins.
- Toute initiative d'innovation doit s'inspirer des connaissances collectives et de l'expérience des professionnels de la santé de première ligne.

EXEMPLE

- En 2008-2009, Santé Canada a financé le projet de la FCSII De la recherche à l'action. Il s'agissait de 10 projets pilotes dans le cadre desquels les infirmières et les infirmiers mettaient en œuvre des activités particulières (par exemple, mentorat, leadership et orientation). L'évaluation des projets révèle une réduction de 10 % des heures supplémentaires, de l'absentéisme et des coûts liés au roulement du personnel, ainsi qu'une augmentation de 147 % du nombre d'infirmières et d'infirmiers mentionnant un niveau élevé de leadership et de soutien.

4. PUBLIC – REDDITION DE COMPTE

- Le rôle et les responsabilités du gouvernement fédéral doivent être clairs, et sa présence doit être manifeste.
- Une évaluation des répercussions des changements, ainsi que rapports destinés au public, contribuent à augmenter la confiance du public dans le système.
- Les nouveaux modèles de prestation exigent de revoir les mesures du rendement fondées sur les données probantes, ainsi que les structures de gouvernance.
- Les patients et leur famille doivent être une voix forte au sein du système de soins de santé.

EXEMPLES

- À l'échelle provinciale, il faut recueillir, analyser et communiquer les données sur les emplois permanents des nouveaux diplômés, les départs à la retraite, les ressources infirmières, et les projections en matière de demande, afin de toujours avoir en main des données actuelles et exactes sur les ressources humaines en santé.
- Des données normalisées sur les événements indésirables chez les patients doivent être recueillies, communiquées, et il faut agir en conséquence et en temps opportun. Ces données doivent être transparentes et rendues publiques.
- Les données liées à la prestation des soins, notamment les niveaux de dotation et la composition du personnel, doivent être rendues publiques afin d'assurer la transparence de l'organisation et la reddition de compte. Les données sur les effets indésirables au sein de chaque unité doivent être mises en relation avec les données sur la prestation des soins.

5. PROVINCES ET TERRITOIRES – ENGAGEMENT

- La majeure partie de la main-d'œuvre du secteur de la santé, y compris le personnel infirmier, est syndiquée. C'est pourquoi, pour assurer le succès de toute transformation, les employeurs et les employés doivent participer au dialogue et travailler directement avec les syndicats infirmiers provinciaux et les organisations d'employeurs.
- Les infirmières et les infirmiers sont aux premières lignes des soins de santé. Ils doivent être aux côtés des leaders provinciaux et territoriaux afin d'orienter, éclairer et renforcer la prise de décisions.
- Les gouvernements provinciaux et territoriaux doivent continuer à encourager le gouvernement fédéral à remplir son rôle dans le secteur de la santé, à fournir le financement adéquat et à exercer un leadership à l'échelle nationale.

EXEMPLE

- L'élaboration de l'Accord sur la santé a permis au gouvernement fédéral, aux gouvernements provinciaux et territoriaux, et aux principaux intervenants du secteur de la santé de collaborer de façon unique pour surmonter les défis majeurs au sein du système de soins de santé. Dans l'esprit de cet Accord, et en tirant profit des connaissances et de l'expérience des travailleurs de première ligne, les provinces doivent considérer les infirmières et les infirmiers comme des partenaires lors de la réforme du système afin de réduire les coûts de la dotation inadéquate (roulement, heures supplémentaires excessives, absentéisme en raison de maladie ou blessure, etc.), réduire les écarts dans le continuum de soins, et adopter des mesures qui permettraient d'économiser des milliards annuellement tout en améliorant les résultats des patients (promotion de la santé, régime national d'assurance-médicaments, etc.)

À l'avis du Conseil de la fédération, toute décision relative à la réforme du système de soins de santé doit être fondée sur le concept de pertinence. Selon la FCSII, la pertinence comprend les éléments-clés suivants :

- **Patients** : données probantes relatives aux résultats de santé des patients.
- **Politique** : politiques, processus et pratiques cohérents et coordonnés dans l'ensemble du système.
- **Pratique** : tirer profit des connaissances des fournisseurs acquises par expérience directe.
- **Public – reddition de compte** : données, informations et évaluations rendues publiques.
- **Provinces et territoires – engagement** : constituant la première ligne des soins de santé, les infirmières et les infirmiers doivent être aux côtés des leaders provinciaux et territoriaux pour les guider, les informer et éclairer les prises de décisions.

Si nous voulons atteindre l'objectif-clé des premiers ministres du Canada, notamment un système de soins de santé universel, viable et axé sur la sécurité, la FCSII recommande de faire participer tous les travailleurs de la santé de première ligne à la prise de décisions. Cela signifie une représentation adéquate et l'engagement des syndicats infirmiers et des représentants des employés, qui seront alors partie intégrante du processus de consultation et d'innovation en matière de santé du Conseil de la fédération. Nous devons tous adopter ces éléments et en faire le cadre de travail pour déterminer la pertinence des initiatives de transformation.

“Le défi futur du Canada sera d’adapter adéquatement les priorités et s’assurer que le financement réponde aux besoins des personnes ayant besoin de soins à domicile et au sein de la collectivité.” [Traduction]

John Abbott
Chef de la direction
Conseil canadien de la santé