Valuing Patient Safety

Responsible Workforce Design

Dr. Maura MacPhee, RN, PhD

CFNU

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Project manager: Linda Silas

CFNU advisory committee: Vicki McKenna (ONA), Paul Curry (NSNU), Beverly Balaski (SUN), Judith Grossman (UNA), Carol Reichert (CFNU)

Project team: Oxana Genina, Arlene Wortsman

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Table of Contents

The Canadian Federation of Nurses Unions (CFNU)

The Canadian Federation of Nurses Unions (CFNU) 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.

Valuing Patient Safety

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Message from the CFNU

Linda Silas

In recent years, it has become commonplace for governments and health administrations to talk about patient-centred collaborative care. However, it does not exist in isolation. One of the most important factors that fundamentally impacts patient safety, and collaborative teamwork, is how the workforce is structured, particularly how nurses – the largest group of health care professionals – deliver care to their patients. Recently, in Canada and globally, workforce redesign – driven by budgetary constraints – is underway. In many jurisdictions such redesign fails to consider patient impacts. Meanwhile, employers and governments continue to praise the concept of patient-centred care without providing any meaningful impetus to propel institutional action.

As nurses, the onus is on us to act. We are bound by our own *Code of Ethics* to be advocates for our patients if we believe their health is being compromised "by factors beyond their control, including the decision making of others." We are asked to "question and intervene" if

unsafe practices or conditions interfere with our ability to provide “safe, compassionate, competent and ethical care” to our patients. And we are encouraged to speak out about situations that concern us (*Code of Ethics for Registered Nurses*, CNA, 2008).

The Canadian Nurses Association (CNA) and the CFNU are actively working with Accreditation Canada and the Canadian Patient Safety Institute on the quality and safety agenda. Together, we have produced a document based on roundtable discussions with patients and their families, nursing leaders, direct care nurses, nurse union representatives and researchers. We conclude that nursing workforce design at all levels needs to be evidence-based, based on four key priorities: 1) empower patients and the public through education and supports that are key enablers of quality and safety; 2) support nursing students and nurses; 3) promote evidence-based staffing practices; and 4) promote strong nursing leadership.

As nurses, we can no longer stand by as witnesses to irresponsible workforce design. We must act now to protect our patients. If we, as nurses, don’t defend our turf, who will? And let’s be clear: “our turf” is about patient care – it is about safe, quality care! Collectively, we must act to reverse the dangerous trends in patient care delivery. It is up to us to make our voices heard so that the public, governments, health care administrations and our colleagues understand what is at stake.

How do we recognize workforce redesign when it happens? Staff mix and staffing level changes are the first signs. For nurses, this often translates into heavy workloads, excessive overtime, and an increase in injuries and illness. In 2012, public sector nurses worked over 21 million hours of both paid and unpaid overtime, and almost 19,000 publicly employed nurses were absent from work due to illness or injury on a weekly basis. 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. Meanwhile, more than 10,000 new nurses graduate each year but many are unemployed. In 2011-2012, a little more than 1,000 RNs joined the workforce. There are no published nursing workforce projections in most of the country.

As we go blindly into the future, we may inadvertently recreate the health care crisis that we experienced in the 1990s. That is why, until there are clear, evidence-based projections, Canada's nurses unions call on governments to place a moratorium on all workforce redesign that reduces full-time equivalent nursing positions. We also need to provide new graduates with permanent employment to ensure the retention of last year's graduates with the same strategy for this year's graduates.

For patients, irresponsible workforce redesign means a deterioration in the quality of patient care. According to a recent study undertaken in European hospitals, an increase in a nurse's workload by one patient increases the likelihood of an inpatient dying. The same study found that the level of education of nurses has a direct impact on patient safety.

The evidence is clear. Sick patients need educated and qualified nurses. As nurses, we can no longer afford to be complacent if we are to protect patient safety and our health care system's integrity. When we speak about ensuring that the appropriate care provider is in place, we are collectively defending patient safety and quality of care. As this report points out, health care is a high reliability industry similar to the aviation industry. No one would suggest that a pilot be replaced with a flight attendant or other members of the aviation team. Similarly, nurses should only be replaced by those possessing the same competencies.

A series of inquiries into increased mortality rates in the UK's National Health Service provides lessons for Canada about the perils of workforce redesign that does not put patients first. In the UK, workforce redesign meant reduced nurse staffing levels and nurses' replacement with unregulated care providers. The result: substandard care and high patient mortality rates. The *Francis Report's* recommendations are detailed in this paper. Internationally, nurses are now standing up and raising their collective voices for patient safety.

We owe it to all Canadians – to patients and their families – to implement the recommendations in *Valuing Patient Safety: Responsible Workforce Design*. The key argument in this paper is that "patient-centred care" means that the patient must be front and centre in all decision making and especially in workforce redesign.

I would like to thank Dr. Maura MacPhee, a professor in the UBC School of Nursing, for authoring this report, and the CFNU advisory committee – Beverly Balaski (SUN), Judith Grossman (UNA), Paul Curry (NSNU), Vicki McKenna (ONA) and Carol Reichert (CFNU) – for their significant contributions to this publication. While this report contributes to the available research and evidence regarding responsible (and irresponsible) workforce design and its effects on patient safety and quality of care, we must remember that as nurses, and nurses' unions, we must do more. We cannot walk blindly into the future, allowing the health care crisis of the 1990s to be replayed because of our failure to act.

Let's face it – a failure to act means a failure to respect our own *Code of Ethics*. Health care employees, nurse supervisors, managers, and direct care nurses: maybe it is time to revisit why we became nurses and why for us, patients' quality of care is our number one priority, regardless of the health care sector we work in.

In solidarity always,

Linda

Preface

Dr. Maura MacPhee, RN, PhD

This paper is about valuing patient safety during a time when budgetary restraints, in particular, are challenging how health care systems deliver safe, quality care. There is a lot of workforce redesign going on in Canada and other parts of the world. Workforce redesign describes how nurses deliver care, and staff mix and staffing level changes are the two most common, outward examples of nursing care delivery redesign. We know there are problems when nurses begin to speak of excessive workloads; when nurses cannot complete their work; when new nurses cannot get regular positions to consolidate and hone their skills; when nurse injuries and sick leave increase; when patient satisfaction decreases, and patients experience poor quality, unsafe care.

We have to look around and see if this is happening – and we/nurses have to speak up and take action to reverse dangerous trends in how we provide care to our patients. We have to let the public, the government, health care administrations and our colleagues know that we value patient safety.

The recent, highly publicized Francis Report from the National Health Service (NHS) England highlighted the harm done to patients through thoughtless workforce redesign – in this instance, nurse staffing cuts for financial reasons led to patient injury, neglect and unnecessary death.

I was horrified by what happened in England, but I am anxious, fearful and concerned that in Canada, our complacency towards ongoing workforce redesign may lead us down the same path as NHS England. I do not believe that nurses can wait for others, such as the government or health care administrators, to speak up about thoughtless or dangerous workforce redesign.

We have to respond as a unified voice to others who want to control our practice. I see this most clearly in scope/role blurring that is going on within provinces/territories. Our scope of practice is what defines what we can do legally, and each nurse classification (registered nurses, licensed or registered practical nurses, registered psychiatric nurses, nurse practitioners) should have clearly defined legal boundaries so that we can better appreciate how each classification can optimally contribute to care delivery.

In the literature, a common term associated with care delivery redesign is "collaborative" practice and teamwork. This is hard to do when team members do not know or understand each other's scope of practice. Mistrust, tension and communications failures stem from lack of understanding and confusion.

I am passionate about nursing, and I take great pride in being a member of the nursing discipline. In the dictionary, a simple definition of a discipline is "region of activity, knowledge or influence."

As you read this paper and review the policy recommendations, please consider how the evidence and the policy actions detailed in this paper will assist us in recognizing the important *activity* of nursing, our *knowledge* and *influence*: we need to start asserting ourselves as a discipline if we value patient safety.

Executive Summary

Myra, RN (SUN)

Over a decade ago, a government task force in Ontario commissioned nurse researchers to analyze the public needs for nursing care and make evidence-based policy recommendations related to safe, quality patient care delivery. The researchers' report focused on the impending shortage of nurses to care for our Canadian population – a population with growing complex care needs. Their policy recommendations included several strategies to address the critical nurse shortage. In particular, they highlighted the importance of thoughtful workplace and workforce design.

This paper is a re-evaluation of where we are now. Are working conditions better for nurses? Is the nursing workforce being supported? Are nurses being appropriately utilized to meet patient needs?

There is no doubt that nurses' workplaces make a difference. A great deal of nursing research has documented those components necessary for healthy work environments: excellent nurse leadership, adequate staffing, effective communications, collaborative work relationships, organizational supports (such as professional development opportunities and continuing education), and nursing control over their own practice.

Workforce design refers to nursing care delivery. Many care delivery changes or workforce redesign initiatives have been, and are, underway in Canada. Redesign needs to be done thoughtfully within complex health care systems because one small change can have a domino effect. This paper includes workforce redesign examples from Canada, other Commonwealth countries, the U.S. and Europe.

One of the most publicized examples of dangerous workforce redesign occurred in the National Health Service (NHS) England, the public health care system of the UK. Nurse staffing levels were dramatically reduced and nurses were replaced with unregulated care providers. Despite ongoing documentation of substandard care and high patient mortality rates, NHS administrators in one Trust, the Mid-Staffordshire Trust, refused to listen. It took a very public inquiry to finally force change.

This paper also discusses responsible workforce redesign that values patient safety. Some key ingredients include systems-level planning (to avoid negative domino effects), stakeholder engagement (including nurses, patients and their families), and data usage (to responsibly track outcomes).

Redesign goes on at many levels, and is often driven by executive-level, administrative decisions. Higher level decisions, however, impact what happens at the bedside. What do direct care nurses need to do to provide quality, safe patient care?

The patient must be front and center – that is what we mean by patient-centered care. To properly assess patients' needs, based on factors such as acuity, stability and complexity, real-time tools need to be used to determine patients' priority care needs. Once patient needs have been determined,

nurses and their managers should make staffing assignments based on the best fit between patient needs and nurse competencies. This paper includes examples of tools that have been successfully used to guide real-time staffing decisions, such as the Synergy Model patient characteristics tool which was successfully piloted in BC and Saskatchewan.

Nurse competencies are synonymous with the knowledge, skills, attitudes and professional judgments nurses possess. These competencies are acquired through accredited or approved educational programs. The depth of educational preparation should be reflected in nurses' scopes of practice and provide clear legal boundaries for nurses of different classifications. Scopes of practice should also act as a guide for the creation of job descriptions and nurses' roles and responsibilities in different health care settings. Scope/role clarity enhances collaborative teamwork.

Another nursing workforce issue is replacement strategies. In Australia the language "like for like" was adopted through the nurses' collective bargaining agreement in one state, New South Wales, to prevent the replacement of RNs with non-RNs during RN unplanned absence, such as unexpected sick leave. In these instances, an RN must replace an RN. If an RN replacement is not possible, and another classification of nurse must be used, the nurse manager is expected to consider if a non-RN replacement will influence workload and patient safety: Staffing accountability is a requirement. "Like for like" replacement language is appearing in Canadian nurse collective bargaining language, such as in BC. It is similar to pilot replacement policies and legislation in the aviation industry.

Aviation and health care are both considered high reliability industries. High reliability implies that health care organizations, for instance, must provide highly reliable, consistent and effective service to prevent serious public harm. High reliability organizations are known for having quality/safety checks and balances to reduce the possibility of human error. In aviation, strict regulatory replacement policies for pilots ensure that the right pilot is flying the right aircraft at the right time. "Like for like" language will hopefully provide similar quality/safety controls for nursing.

Collective bargaining agreements, nursing policies and related legislation in many parts of the world demonstrate how we, as nurses, value patient safety. The most notable workforce redesign safety changes have come from the NHS England – following the Mid-Staffordshire public inquiry. The NHS England recently began to reinvest in RNs after cutting their positions over several years. English NHS hospitals are required to maintain evidence-based nurse staffing levels and publicly report staffing levels.

This paper may seem like a broken record. In 2012 Berry and Curry produced a CFNU document on evidence (and policy recommendations) related to nursing workload and patient care. Safe staffing, nurses' workloads, healthy practice environments and workforce design/redesign are closely connected. Taken together, the Berry and Curry document, this paper and many other nurse reports should be a wake-up call to use evidence in ways that truly value patient safety.

Samantha, RN (UNA)

Recommendations

Lori, Registered Psychiatric Nurse (MNU)

1. **Patient needs assessment tools (e.g., Synergy Model patient needs assessment tool) must be used to make evidence-based determinations of patient needs, and to support collaborative staffing decisions between nurses and nurse managers on a real-time, shift-by-shift basis.**

2. **Health care organizations and their leadership must strive to ensure Magnet-like work environments for best possible quality, safe care delivery. Magnet-like environments are known for effective nursing leadership at all levels of the organization (i.e., front-line, mid-level, executive), collaborative teamwork, staffing adequacy, effective communications, and nurse control over practice (e.g., clinical autonomy, shared governance).**

3. **Once patient needs are known, care needs should be determined based on nurses' formal educational qualifications and competencies. Nurses' scopes of practice should clearly distinguish between the three regulated groups' educational attainment, foundational knowledge and skills.**

4. **After nurse qualifications and competencies have been matched to specific patient needs, nurses should only be replaced with nurses with similar formal educational qualifications and competencies. "Like for like" replacement policy should ensure that RNs are replaced with RNs, LPNs/RPNs are replaced with LPNs/RPNs, and registered psychiatric nurses are replaced with registered psychiatric nurses.**

5. **The delivery of education associated with regulated nurses' scopes of practice must take place within formal, accredited or approved educational programs.**

6. **Inability to replace "like for like" should be a rare event (e.g., unusual amount of sick calls). Replacing care providers with a different classification (LPN/RPN replacing an RN) should not be a typical staffing solution. If this does occur, the in-charge RN should be required to document evidence to support the decision, and provide evidence that patient safety is not being compromised.**

7. **Scope of practice clarity avoids role confusion, fragmentation of care, and inappropriate use of nurses. Regulatory bodies, unions and nurse education program coordinators must work collaboratively to ensure scope of practice clarity.**

8. **Scope and role clarity should be enhanced through employer policies and job descriptions that make explicit the regulatory and educational distinctions between RNs, LPNs/RPNs and registered psychiatric nurses, and the distinctions between regulated and unregulated health care providers.**

9. **Patients and their families must be present, powerful and involved with quality/safety initiatives at all levels of the health care system.**

10. **Standardized patient adverse events data (e.g., nurse-sensitive structure-process-outcomes indicators) need to be collected, reported and acted upon in a timely manner. These data should be transparent and publicly accessible.**

11. **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.**

12. **There must be regular, formal reviews of administrative data (e.g., overtime, absenteeism, vacancies, staffing levels) and patient adverse events data at all levels of the organization. Nurse leaders at all levels must be engaged in these reviews and have the power to adjust nursing care delivery to ensure patient-centred, quality, safe care.**

13. **The review process for professional responsibility forms (PRFs) and critical incident reports needs to be carried out within a mandatory time period, and similarly, recommendations need to be enacted within a mandatory period of time.**

Introduction

Charity, RN (ONA)

Growing health care workforce shortages, cost-conscious health care budgets, and quality and safety concerns have spurred many workforce redesign initiatives within health care. Nurses comprise the largest proportion of the health care workforce, and many initiatives focus on nursing care delivery redesign or new ways to deliver nursing care (Kimball et al., 2007).

The purpose of this paper is to provide examples of health care workforce redesign with a particular emphasis on nursing care delivery. Redesign examples will be provided from Canada, other Commonwealth countries, Europe, and the United States. Evidence-based policy recommendations at the end of this paper are provided for stakeholders' serious consideration.

These recommendations offer strategies for optimizing the use of the current and future Canadian nursing workforce. These recommendations also include strategies associated with patient-centred, quality, safe care delivery.

This paper is a focused review of peer-reviewed and grey literature on health care workforce redesign. Purposively selected nurse union representatives and nurse regulators from Canada, Australia and the United Kingdom were consulted to obtain updates on current redesign initiatives underway in their respective countries.

Health care workforce redesign is closely associated with a large body of published research literature and practice/policy documents on safe nurse staffing, effective nurse workload management, healthy practice environments, and nurse education and competencies. Some important related documents include: *A Nursing Call to Action: the Health of our Nation, the Future of our Health System* (Canadian Nurses Association [CNA], 2013); *Nursing Workload and Patient Care* (Berry & Curry, 2012); *Evidence to Inform Staff Mix Decision-Making: A Focused Literature Review* (Harris & McGillis Hall, 2012); *Nurse Fatigue and Patient Safety* (CNA and RNAO, 2010); *Within Our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System* (Quality Worklife Quality Healthcare Collaborative, 2007); *Staffing for Safety: A Synthesis of the Evidence on Safe Staffing and Patient Safety* (Ellis et al., 2006); *Nursing Education in Canada: Historical Review and Current Capacity* (Pringle et al., 2004); *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses* (Canadian Nursing Advisory Committee on Health Human Resources, 2002); and *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System* (Canadian Health Services Research Foundation, 2001). *Safe staffing: statement of principles* (International Council of Nurses, 2013); *Global Nurses United of Nurse, Healthcare Worker Unions, Born* (Global Nurses United Press Release, 2013).

Search Strategies

A health service librarian from the University of British Columbia assisted with the literature search. Searching began with the Database of Abstracts of Reviews of Effects (DARE) provided by the Centre for Reviews and Dissemination at the University of York (NHS NIHR) to identify systematic reviews (including Cochrane reviews).This was followed by searching in three streams: a) health literature (CINAHL, PubMed/Medline); b) business literature (Business Source Complete; ABI/Inform (Abstracted Business Information)); and c) sociology literature (Sociological Abstracts). The business and sociology literature databases were searched broadly for studies on nurses. Other searches included the Canadian Health Research Collection and Google Advanced. Reference mining and Web of Science citation techniques were also used. The search was focused on recent studies (2006 to 2013)

in English from North America, Australia, New Zealand and the United Kingdom. The project database using RefWorks contains 354 citations: these were reviewed by the librarian with about 130 citations sent to the researcher.

Permutations of the following subject headings and keywords were used to search the health literature: “care delivery,” “RN mix,” “skill mix,” “staff mix,” “nurse-patient ratio,” ”nursing staff,” “hospital, personnel staffing and scheduling,” ’team nursing,” “staffing models,” “outcomes,” “outcomes assessment,” “patient safety.” The following subheadings in CINAHL were used to filter as needed: “evaluation,” “standards,” “statistics and numerical data,” and “legislation.” Google Advanced used limitations for domain name: a) keywords from the health literature and b) the phrase “workforce redesign.” A similar process was used to review RN and LPN/RPN scope of practice in Canada by province and territory. Australian nurse regulators and union reps were also interviewed, and their quotes are included in the text.

Note: The majority of research evidence comes from acute care settings, although there is increased attention on workforce redesign in long-term care settings and primary care delivery. Most examples refer to RNs and LPNs/RPNs, with fewer articles related to registered psychiatric nurses.

Health Care Workforce Redesign and Nursing

Ricardo, RN (NSNU)

Changes to nursing care delivery need to be considered from a broader, systems perspective (Dubois & Singh, 2009). Given the complexity of today's health care systems, workforce redesign requires systems-level thinking, diverse stakeholder engagement, and appropriate data use to optimize workforce planning and create sustainable, cost-effective change (Tomblin Murphy & MacKenzie, 2013). In Canada, as in many other countries, workforce redesign typically has been based on historical levels of service provision and/or political factors (Tomblin Murphy & MacKenzie). If redesign is not thoughtfully planned, implemented and evaluated with population/patient needs front and center, workforce inequities and inefficiencies often persist (Birch et al., 2007; Evans, 2009).

In Canada, workforce redesign is not new. Over a decade ago, the Ontario Minister of Health and Long-Term Care Nursing Task Force commissioned nurse researchers to analyze the public needs for nursing care and make evidence-based workforce redesign policy recommendations (O'Brien-Pallas & Baumann, 2000). Their analysis included a comprehensive examination of nurse supply and demand. At that time, there was a significant projected shortage of nurses to meet the needs of an aging population with increased acuity and complexity. There were also media reports of unsafe work environments due to heavy workloads and an insufficient number of nurses. Workforce redesign recommendations were focused on mechanisms to recruit and retain more nurses. The task force included recommendations for financial investments in more full-time nursing positions, healthy work environments, nursing education, and data management systems to better track population needs and nurse supply (O'Brien-Pallas & Baumann). Research on Canadian nurse workloads and recent union representatives' reports indicate that these evidence-based policy recommendations have not been heeded (Berry & Curry, 2012).

Where are we now with respect to health care workforce redesign?
This question will be explored in more depth throughout the remainder of this paper.

The Canadian Nursing Profession


Lisa, RN (NLNU)

Within the Canadian nursing profession there are four types of regulated nurses: registered nurses (RNs), licensed or registered practical nurses (LPNs/RPNs), registered psychiatric nurses, and nurse practitioners (NPs) – advanced practice nurses who are also registered nurses. This paper will focus on the first three classifications of regulated nurses.

Provincial/territorial regulatory bodies for RNs, LPNs/RPNs and registered psychiatric nurses provide public protection by ensuring that their licensed members are competent to practice. All nursing groups must meet the basic professional standards and competency requirements of their respective regulatory bodies. Competencies differ by education and knowledge base. Nurse competence/competency refers to the knowledge, skills, attitudes and professional judgments associated with quality, safe patient care delivery (Black et al., 2008; CNA, 2007).

Regulated nursing groups receive their education from approved nursing programs that meet educational standards established by their provincial/territorial regulatory bodies. Educational standards for regulated nurses help ensure that graduates will successfully pass their licensure exams and enter the nursing profession as competent, ethical and safe practitioners (Pringle et al., 2004).

Given the complexity of today's health care system, the majority of provinces and territories require a bachelor's degree for RN and registered psychiatric nurse entry-to-practice (CNA, 2014). Licensed practical nurses (or RPNs in Ontario) receive their theoretical and clinical education in one to two-year community college programs (Health Canada, 2006).

Within their respective educational programs, RNs, LPNs/RPNs and registered psychiatric nurses learn from the same body of nursing knowledge. For example, all nurses understand nursing process: patient assessment, planning, implementation and evaluation. They vary, however, by the depth and breadth of their foundational knowledge. For instance, there are differences in how nurses with different formal educational preparation make independent decisions about patient status changes and actions to take. Decision-making is a complex process that is integral to quality, safe care delivery. Research indicates that decision-making is influenced by education. Greater formal educational preparation is associated with those critical thinking skills necessary to make independent decisions related to patient care, particularly in demanding patient care situations (e.g., acutely ill patients) (Boblin et al., 2008; Tanner, 2006).

Each nursing regulatory body establishes its own scope of practice that legally defines what its licensed members are competent to perform at an entry level to practice (Oelke et al., 2008). Scopes of practice and competencies are linked to approved educational programs within each province/territory. To safely practice, nurses from each regulated group must know their scope of practice and the scopes of practice of other regulated groups with whom they work (Besner et al., 2005; Oelke et al., 2008; White et al., 2008). Formal education differentiates among the three regulated groups: the variability in provincial/territorial education (See box of definitions with educational examples) no doubt contributes to scope confusion.

One Canadian study found a significant lack of collaboration and communication across educational programs for the three regulated groups. The authors emphasized the importance of creating councils with representatives from the three nursing groups to enhance intraprofessional education, training opportunities and collaborative practice across Canada (Pringle et al., 2004). As stated in one Canadian nursing textbook (Gaudine & Lamb, 2014, p. 235): "As a registered nurse, you might move from one regulatory jurisdiction to another and encounter regulated groups that are new to you. For example, if you are new to working in a western province, you might work with registered psychiatric nurses for the first time in your nursing career."

The box below includes definitions and examples of educational preparation for RNs, LPNs/RPNs, registered psychiatric nurses and NPs.

Registered nurses (RNs) represent the largest regulated nursing group in Canada. One RN definition is: "RNs are self-regulated health care professionals who work autonomously and in collaboration with others. RNs enable individuals, families, groups, communities and populations to achieve their optimal level of health. RNs coordinate health care, deliver direct services and support clients in their self-care decisions and actions in situations of health, illness, injury and disability in all stages of life. RNs contribute to the health care system through their work in direct practice, education, administration, research and policy in a wide array of settings" (CNA, 2007).

RN educational preparation: Since the late 1990s, provinces/territories have moved from diploma-level education to a baccalaureate degree in nursing (BSN). The Atlantic provinces (Prince Edward Island, Newfoundland and Labrador, New Brunswick and Nova Scotia) were the first provinces to adopt the BSN as entry level for RN practice in 1998. The Northwest Territories and Nunavut completed the transition to BSN entry level in 2010. Quebec continues to offer diploma programs while supporting the development of baccalaureate partnerships between CEGEP (collèges d'enseignement général et professionnel) and universities. The Yukon has no entry-level educational programs (CNA, 2014).

Definition: Licensed Practical Nurses (LPNs) or Registered Practical Nurses (RPNs in Ontario). LPNs/RPNs "work independently or in collaboration with other members of a health care team. LPNs assess clients and work in health promotion and illness prevention. They assess, plan, implement and evaluate care for clients" (CIHI, 2013).

LPN/RPN educational preparation: LPNs/RPNs receive their education through 1-2 year diploma programs offered in post-secondary institutions (Health Canada, 2006). Alberta requires 2 years of post-secondary education and training. "This education allows LPNs to participate in all phases of care from prevention to acute care, long-term and palliative care, to management in certain settings, usually continuing care. LPNs may work independently or interdependently, and have a contributing role within health care teams" (Alberta Canada, 2014). In Manitoba, there are three approved 2-year degree programs (College of Licensed Practical Nurses of Manitoba, 2011). Ontario has 24 approved RPN programs: the program of study can typically be completed in 4 semesters (Practical Nursing Online, 2014).

Definition: Registered Psychiatric Nurses. Registered psychiatric nurses are the largest single group of mental health professionals found in Alberta, BC, Manitoba, Saskatchewan and the Yukon. These nurses "provide services to clients whose primary care needs relate to mental and developmental health. RPN duties include planning, implementing and evaluating therapies and programs on the basis of psychiatric nursing assessments" (CIHI, 2013).

Registered Psychiatric Nurse educational preparation: "The context of psychiatric nursing practice responds to demands and trends related to the delivery of health care services and the implementation of new service delivery models from in-patient to community-based care in Canada, including primary health care models. The increasing complex health challenges and increasing levels of acuity require RPNs to have an enhanced theoretical base and additional clinical learning experiences than can be delivered within the context of a diploma program" (RPNC, 2008).

Definition: Nurse Practitioners (NPs). NPs are RNs with advanced educational preparation and practice experience. Some competencies include autonomously diagnosing, ordering and interpreting diagnostic tests and prescribing pharmaceuticals (CNA, 2009). To offer better primary health services access to the Canadian public, the government created the Primary Health Care Transition Fund in 2004 that funded the Canadian NP initiative. This initiative involved representatives from provincial/territorial governments, regulators, educators, employers and health care professionals (CNA, 2009).

NP educational preparation: Primary health care NPs care for families/all ages. These NPs are educated in post-baccalaureate and masters-level programs in Canada. There are three types of acute care NPs (adult, pediatric, neonatal), and acute care NPs are educated at the masters level. Matters related to NP education are discussed annually at the Canadian Association of Schools of Nursing Graduate Program Coordinators' Forum (Martin-Misener et al., 2010).

Health care organizations must comply with regulatory scopes of practice and plan nursing care delivery based on their patient population – matching nurse competencies to patient needs. Health care organizations may not legally expand nurses' scope of practice but they can create organizational policies that limit or restrict what nurses are allowed to do within their organizations (College of Registered Nurses of British Columbia, 2013; Oelke et al., 2008).

Considerable confusion exists around regulated nurses' scopes of practice and 'who can legally do what.' Although there are differences in the foundational knowledge and competencies of the three regulated nurses' groups, nurses and others often describe what nurses do in terms of their functional roles and responsibilities (Besner et al., 2005; Oelke et al., 2008). Substantial overlap exists with respect to nurses' functional tasks or roles (e.g., giving oral medications). In fact, when they think of their roles and responsibilities in terms of functional tasks, Canadian RNs and LPNs/RPNs often have a hard time describing what is unique and different between their scopes of practice. An inability to clearly differentiate between legal scopes of practice creates anxiety among nurses and often leads to under- or over-utilization of different classifications of nurses (Besner et al., 2005; Oelke et al., 2008).

Adding to nurses' confusion is the presence of unregulated health care providers (e.g., care aides, personal support workers). Health care organizations, not regulatory bodies, determine what tasks may be performed by unregulated providers (Harris & McGillis Hall, 2012). Within health care organizations, therefore, role confusion is exacerbated by reliance on tasks to distinguish between regulated and unregulated health care staff.

Scope/role confusion is associated with unsafe, compromised care delivery (Baker et al., 2008). Optimal use of the nursing workforce depends on recognizing that "nursing care is not merely a collection of tasks…" (White et al., 2008, p. 53). Rather, scope differentiation between regulated nursing groups must focus on foundational knowledge and nurse competencies.

Foundational knowledge = formal educational preparation within approved provincial/territorial programs of nursing.

Nurse competencies = knowledge, attitudes, skills and professional judgments associated with quality, safe patient care delivery.

Scope = what a nurse is formally educated to do and can legally do upon entry to practice.

Role = what a nurse is allowed to do within a specific health care setting. Organizational policy, for instance, may limit a nurse's scope by restricting a nurse's roles and responsibilities.

Scope/role confusion is particularly worrisome when nurse managers are making staffing assignments, and when RNs and LPNs/RPNs are working together in teams. Fortunately, there are an increasing number of evidence-based staff decision-making tools and resources available to enhance scope/role clarity. In this paper, under the section entitled "Examples of Workforce Redesign" (Canada), there are examples of some successful decision-making tools (e.g., the Synergy Model patient needs assessment tool).

Besner et al. (2005) conducted an extensive study on nursing scopes of practice in Alberta and Saskatchewan. They identified the challenges associated with nurses' scope/role confusion and made the following recommendations: a) regulatory bodies and unions of the three nursing groups should work together to better educate their respective members about their unique and shared responsibilities; b) employers should engage health care providers in discussions about distinct and shared responsibilities to improve role clarity, especially among teams; and c) educators need to teach their students about scopes of practice, and the roles and responsibilities of nurses and other providers.

Summary: To optimize nurses' delivery of care, staffing assignments must match patient needs to nurse competencies. Nurses' scopes of practice should clearly distinguish between the three regulated groups based on their foundational knowledge and competencies – not functional tasks. A report on nursing education in Canada (Pringle et al., 2004) recommended that representatives from the three nursing groups should work together to enhance intraprofessional education, training opportunities and collaborative practice. There needs to be scope clarity within provinces/territories and across Canada. Currently there is provincial/territorial variability in educational qualifications and scopes of practice that causes confusion for nurses, other health care providers and employers. Scope/role confusion can be reduced by using evidence-based decision-making tools and resources.

Marcia, RN (ONA)

Nursing Care Delivery Models and Collaborative Practice


Amy, RN (NBNU)

A specific aspect of health care workforce redesign is nursing care delivery design. Many new care delivery models are based on collaborative practice and collaborative teamwork. Nursing collaborative practice means that members of the nursing profession work together to deliver patient-centred, quality safe care. A similar concept, interprofessional collaborative practice, refers to health care providers from different disciplines working together. Whether collaborative practice is intra- or interprofessional, care is typically delivered by teams. Given the increase in patient care complexity, a solo provider is considered less effective and efficient than a team approach (Kalisch & Lee, 2013). Collaborative nursing teamwork is associated with nurse self-reports of better work environments and higher job satisfaction (Kalisch et al., 2010; Rafferty et al., 2007). One Canadian survey study found that nurses associate healthy nursing

work environments with a culture of teamwork, a sense of community, respectful communications and social support among colleagues (Lavoie-Tremblay et al., 2006).

Certain factors are paramount to collaborative nursing teamwork (Kalisch et al., 2009; Kalisch et al., 2010). In one U.S. study, Kalisch et al. (2009) conducted separate focus groups for RNs, LPNs/RPNs and unregulated care aides. Based on participants' comments, they found that an effective team leader is necessary to support and role model team values. "Our manager really values us working well together and expects it" (p. 300). Effective leaders also ensure staffing adequacy and access to necessary resources and information. A related theme, communications, highlights the importance of timely sharing of critical patient information among team members (e.g., shift handovers and safety huddles). Another key priority is team orientation and the importance of putting the needs of the patient (i.e., patient-centred care) above individual self-interests. A culture of safety is aligned with collaborative nursing teamwork. In a safety culture, team members have a heightened awareness of quality and safety factors within their work environment, and they mutually monitor each other's performance and provide constructive feedback. "We are aware of each other. It isn't negative but if we see someone forget to wash their hands, we remind them. We do it for each other" (Kalisch & Lee, 2010, pp. 238-239).

Missed nursing care refers to errors of omission (e.g., not giving a medication, not teaching a patient). Kalisch and Lee (2010) examined those factors associated with missed nursing care. Nurse reports of missed nursing care were significantly diminished in the presence of collaborative teamwork and adequate staffing. "When teamwork is present, it is much more likely that the care will not be missed, because team members believe that the team is more important than the individual staff member and that work is 'ours.' This leads to being aware of other team members' workload and then backing one another up by moving in to assist" (Kalisch & Lee, 2010, pp. 238-239).

Based on the work of Kalisch and her colleagues (2009, 2010), nursing collaborative practice is evident when: a) RNs and LPNs/RPNs

communicate critical information with one another; b) RNs and LPNs/RPNs make shared patient care decisions; c) RNs and LPNs/RPNs understand each other's roles and responsibilities; d) RNs and LPNs/RPNs respect each other's team contributions; and e) RNs and LPNs/RPNs support and enable teamwork.

Magnet hospitals are known for a number of core qualities that enable collaborative practice among nurses: effective nursing leadership, collaborative teamwork, staffing adequacy, effective communications and control over practice (e.g., clinical autonomy, shared governance). Magnet hospitals go through a rigorous accreditation process to attain their Magnet recognition and are known to attract and retain nurses (Kramer & Schmalenberg, 2006), and have greater nurse job satisfaction, lower nurse burnout and better patient outcomes when compared to hospitals without these core qualities (Friese et al., 2008; Kelly et al., 2011). Hospitals with these Magnet-like qualities are predictive of nurses' reports of positive work environments and strong patient safety work climates (Armstrong et al., 2009; Laschinger, 2008), according to Canadian research.

Clinical autonomy, a component of nurses' professional control over their practice, is a Magnet hospital quality that is often misunderstood. Clinical autonomy refers to nurses' capacity to make patient care decisions based on regulatory rules, organizational policies, and one's own level of competence. It involves independent and interdependent actions. Independent actions include the capacity to know when to seek consultation or support from others (Weston, 2008). Within collaborative practice models, the interdependent nature of clinical autonomy is emphasized.

A document from Prince Edward Island illustrates the interdependent roles of RNs and LPNs/RPNs within collaborative practice models. *Exemplary Care: Registered Nurses and Licensed Practical Nurses Working Together* arose through a joint initiative by the Association for Registered Nurses of Prince Edward Island (ARNPEI), the Licensed Practical Nurses Association of PEI (LPNA) and the PEI Health Sector Council (PEIHSC). The document examines RNs and LPNs working together individually and collaboratively (2009). The guiding principles are summarized in Table 1.

The interdependent/collaborative roles of RNs and LPNs are described with respect to the nursing process. For example, under "Planning" the RN takes

the lead in developing a comprehensive care plan and coordinating care for a client that includes “medium and long-range plans for care;” the LPN “collaborates and contributes” to the planning process and “reviews and interprets the plan of care focusing on current and day-to-day needs” (p. 9).

Many provincial and organizational-level documents exist that provide similar language and guidance for RNs and LPNs/RPNs working together. “Collaboration is ongoing communication and decision-making with the goal of working towards identified client care outcomes. It respects the unique contributions and abilities of each member” (ARNPEI, 2009, p. 12).

Table 1. Exemplary Care: RNs and LPNs Working Together

1. RNs and LPNs have a duty to provide safe, appropriate client care.
2. RNs and LPNs act in accordance with their provincial legislation, standards of practice, code of ethics and “other relevant legislation” (p. 3).
3. RNs and LPNs require access to the following supports and resources: effective nursing leadership; appropriate, adequate staffing; time to discuss client needs.
4. The care delivery model must support collaborative care.
5. As clients’ health needs increase, the breadth and depth of nurse competencies also increase; “clients require more of the competencies that fall within the RN scope of practice and fewer of the competencies within the LPN scope of practice” (p. 3).
6. If clients’ health needs increase (e.g., increased acuity, complexity, variability), LPNs need additional support from RNs. Additional support may include RN consultation, sharing the assignment with an RN, or having the RN take full responsibility for the client.
7. Effective communications must be in place among nurses and within the organization.
8. Nursing responsibilities and accountabilities must be understood by nurses and clear at every level within the organization.

Although there are clear-cut advantages to collaborative teamwork, and enablers for this type of teamwork have been well documented in the nursing literature, there are barriers to collaborative teamwork that must be recognized and seriously addressed. Canadian researchers Lemieux-Charles and McGuire (2006) suggest that teamwork often falls short of its promise because we take for granted that care providers will know how to communicate and collaborate within teams. This rarely happens without the right team structures, processes and supports in place. As mentioned previously, the three regulated groups of nurses are typically educated in different programs and rarely learn how to practice together prior to graduation. Therefore, traditional nursing education is one significant barrier to collaborative teamwork (Pringle et al., 2004). Another serious barrier is the hierarchical nature of health care organizations that fosters cultures of greater and lower status within the workforce. These invisible cultural divisions of labour can impede team efforts to recognize and respect the contributions of all its members. Research indicates that more egalitarian approaches to problem solving and decision-making lead to better nurse and patient outcomes, but organizational cultures are hard to change (Weinberg et al., 2011). This is not to say that different types of nurses are interchangeable, but rather that patient care and healthy working conditions are promoted when each provider's contribution is respected.

Amanda, RN, Cedric, LPN (NSNU)

Summary: In today's complex health care settings no provider can deliver safe, quality care without team support. Effective teamwork requires collaboration. The trademarks of collaborative teamwork are RNs and LPNs/RPNs working together to provide safe, quality patient care, sharing critical information with each other, and demonstrating mutual respect for each other. Collaborative teamwork is foundational to safe, quality care delivery, but other factors must not be overlooked, such as staffing adequacy and access to necessary resources and supports. Enablers of collaborative teamwork are found in Magnet-like environments. One critical quality of Magnet-like environments is clinical autonomy, or the capacity for nurses to work independently and interdependently within their respective scopes of practice. There are tools, such as the ARNPEI document, to help guide collaborative teamwork. And finally, collaborative teamwork should not be taken for granted – especially within health care organizations that are typically hierarchical in nature.

"What is needed now are innovative care delivery models with intentional outcomes that address patient needs and wants, span sites of care, result in more efficient use of resources, and demonstrate measurable improvement in patient satisfaction and quality outcomes over time."

(Kimball et al., 2007, p. 393).

Valuing Patient Safety
Responsible Workforce Design

The Quality and Safety Phenomenon
High Reliability Organizations

Allyson, RN (SUN)

Before moving on to specific redesign examples, the importance of quality and safety must be emphasized. The literature cites economic and workforce shortages as two key drivers of redesign, but quality and safety considerations must be the foremost determinants of workforce design (Jacob et al., 2013). The Francis report (2013), described in more detail under "Examples of Workforce Redesign" (UK), is symbolic of patient safety failures resulting from other priorities taking precedence, such as finances.

In Canada, there are national and provincial-level organizations associated with the quality and safety agenda. At the national level is the non-profit

organization, the Canadian Patient Safety Institute (CPSI) (See: http://www.patientsafetyinstitute.ca/English/Pages/default.aspx). At the provincial level, there are health quality councils (e.g., the Health Quality Council of Alberta at: http://qualityalberta.ca/) to assist with the implementation and evaluation of quality, safe health care practices.

Within Canada, there is a nursing movement to build a national database of nursing quality indicators that will demonstrate nurses' important contributions to patient and organizational outcomes: the National Nursing Quality Report (the Academy of Canadian Executive Nurses, 2011). Canadian nurse researchers and leaders have been developing and piloting "nurse-sensitive" indicators that show direct relationships between the presence of these indicators and safe, quality nursing care provision (Doran, 2003; Doran et al., 2006; Sidani et al., 2004).

The National Nursing Quality Report in Canada (NNQR-C) project includes structure-process-outcomes indicators and shows the important linkages between them. When the appropriate nursing structures are in place, necessary activities or processes can be carried out leading to positive outcomes. Some nurse structure indicators include staffing measures, such as the percentage of total nursing hours spent on direct inpatient care per day. Nurse process indicators include the percentage of completed patient fall risk assessments and pressure ulcer risk assessments. Some outcomes reflect nurses' management of patients' pain and self-care upon discharge. Publicly available nurse-sensitive data will enable nurses to make a stronger case for how they contribute to safe, quality care delivery.

Many health care best quality/safety practices have been borrowed from high reliability organizations, such as the aviation, oil and nuclear power industries, which must provide highly reliable, consistent and effective service in order to prevent serious public harm. Health care is considered a high reliability organization (Hudson, 2003; Pronovost et al., 2006; Sutcliffe, 2011). These organizations are known for their effective communications and clear roles and accountability. Team structures and processes are designed to promote collaborative teamwork and the seamless, safe delivery of services. High reliability organizations are regulated to ensure public safety.

Some additional lessons can be learned from high reliability organizations. For example, in the aviation industry there are clear distinctions between the roles and responsibilities of different team members (e.g., pilots, co-pilots, airline crew). Strict regulatory replacement policies are in place for pilots of every type of aircraft, based on the variable operational and service needs of the type of aircraft (e.g., helicopter, commercial carrier). Pilot certifications are also closely monitored. Pilots must meet specific health requirements (i.e., must be mentally and physically fit to operate an aircraft), and pilots are recognized for their years of experience in flight, whether they are at "expert," "operational," or "below-operational" levels. Some regulatory documents can be found at Transport Canada website (See: http://www.tc.gc.ca/eng/civilaviation/regserv/cars/menu.htm).

Canadian health care organizations are beginning to borrow many of the communication tools and resources from other high reliability organizations, but nursing regulatory practices need reinforcement to better protect the public. Unlike the clear regulatory distinctions and policies that exist for aviation team members, scope/role confusion often exists among nursing team members (Oelke et al., 2008; Besner et al., 2005). In aviation, the first consideration is the type of aircraft. Regulations and policies dictate what type of pilots and crew best match the operational and service needs of specific types of aircraft. Parallels may be drawn to nursing, where the first consideration must be the patient. Once patient needs have been determined, staffing assignments should reflect a match between patient needs and nurse competencies. Nurses' scopes of practice and organizational policies should distinguish the provider most suited for patient-centred, safe, quality care delivery. Once evidence-based patient-nurse staffing decisions have been made, substitutions or replacements should be questioned. Registered nurses should only replace RNs, LPNs/RPNs should only replace LPNs/RPNs, and registered psychiatric nurses should only replace registered psychiatric nurses.

"Like for Like"

Sabrina, RN (ONA)

The "like for like" term is relatively new in the health care sector. It is beginning to appear in nurse collective bargaining agreements in Victoria (Australia), California (U.S.), and British Columbia (Canada) as confirmed through personal communications with union representatives. To date, this replacement policy has been aimed at RN replacement but it has similar implications for LPN/RPN and registered psychiatric nurse replacement.

The "like for like" term originated in New South Wales (Australia) where it was part of a 2010 collective bargaining agreement between the registered nurses' union (NSW Nurses and Midwives' Association) and the New South Wales (NSW) government. The term came about to prevent the replacement

of RNs with non-RN providers during unplanned RN absences, such as an unexpected sick leave. Union members reported several instances of RN replacement with non-RN staff, leading to documented instances of unsafe working conditions for staff and patient safety concerns. To prevent violations of “like for like” replacement policy, the 2010 contract stipulates that when there is an unplanned RN absence, the absence may be filled with a nurse of another classification (i.e., LPN/RPN) only if another RN is not available. In these circumstances, managers must consider how replacement with a non-RN will influence workload and safety for staff and patients. Safe staffing accountability is a requirement.

“Like for like” language has been used to ensure safe staffing during short, unplanned absences, and it has implications for nursing care delivery redesign. When considering new nursing care delivery approaches, the first consideration must be patient/population needs. Patient-centred care considers the patient first, and then determines how to best organize care to maximize positive patient outcomes (Curley, 2007). Once patient care needs have been identified, nurse staffing should be based on nurse formal educational qualifications and competencies: what classification of nurse is best suited to care for specific types of patients? Policies, such as “like for like” replacement, ensure safe patient care by preventing employers from diluting the nursing workforce by always turning to the least expensive worker. Safe, quality care delivery requires us to recognize nurses’ different qualifications and competencies.

Summary: Health care organizations are high reliability organizations – care delivery needs to be highly reliable to ensure the safety of patients. Health care has borrowed many tools and resources from other high reliability organizations, such as aviation. One regulatory policy, “like for like” replacement policy, is beginning to appear in nurse collective bargaining language and organizational policies. It is similar to replacement policies in aviation. Patient-centred care begins with a determination of patient care needs. Once those needs have been established, staffing should be based on a match between patient needs and nurse competencies. Nurse distinctions, based on foundational knowledge, should be evident in regulatory scopes of practice.

Examples of Workforce Redesign

Examples of Nursing Care Delivery Redesign

Katherine, LPN (NSNU)

This section will present examples from Canada, Australia, the UK, the U.S. and New Zealand. Workforce redesign is happening around the world. What lessons are being learned? Examples vary from national- level changes (e.g., England) to unit/facility-level pilots (e.g., Canada).

Canada

In British Columbia, a joint initiative between nurses' unions and the BC Ministry of Health Nursing Directorate supported a pilot of collaborative teamwork and staffing decision-making (MacPhee et al., 2010a). Pilot projects were conducted at eight sites across the province, two sites per health sector (i.e., acute care, long-term care, community and mental health). Project teams

at each site reflected the typical staff mix for that site. A project team in long-term care, for example, included RNs, LPNs/RPNs and care aides. Each project team leader was a frontline nurse leader for the site, and there were regular team communications with the nurse directors of the sites. Project teams used the Synergy Model patient needs assessment tool to determine patient/resident/client needs for their unit or facility.

The Synergy Model patient needs assessment tool uses a holistic, systems approach to establish patient needs. There are eight patient needs dimensions: predictability, stability, resilience, complexity, vulnerability, capacity to care for self, capacity to make independent care decisions, access to resources and supports (Curley, 2007). For each dimension, there is a Likert-type 5-point rating scale that is similar to the Canadian Triage and Acuity Scale for emergency departments. With respect to complexity, for example, a 1-2 indicates a patient with multiple co-morbidities or involvement of many systems; a 3 indicates moderate complexity, and a 4-5 indicates minimal complexity. The Synergy tool can pinpoint dimensions of greatest need per patient, and averaged Synergy scores (i.e., the average of each patient's eight scores) can be used to organize and distribute care more equitably among care teams.

For the BC pilot project, teams were taught how to use the tool, and practice sessions were conducted until team members had high scoring agreement (> 90% agreement). Project teams typically became comfortable and confident with the tool use after two or three practice sessions. A collaborative approach was used by the project team to establish safe staffing guidelines for their patient population based on Synergy scores (MacPhee et al., 2010b). For example, one acute care unit's staffing guidelines stipulated that for patients with averaged Synergy scores of 1-2, experienced RNs (i.e., not new graduates) should be the primary care providers. Given the one-year length of the pilot, it was not possible to evaluate sustainability or long-term outcomes. However, short-term outcomes included evidence of enhanced team communications and collaborative decision-making.

In Saskatchewan, the BC pilot served as a template for a similar pilot project in one acute care medical unit (Rozdilsky & Alecxe, 2012). A project work group with RNs, LPNs/RPNs and management representation worked together to assess patients on each shift using the Synergy tool. "Patient assignment became based on the holistic assessment of patient needs according to the PST (Patient Synergy Tool) results rather than geography (for example, one nurse assigned

to a multi-bed unit regardless of the acuity/capability of patients in the unit)" (p. 103). Data collection during the project's one-year timeframe showed positive impacts on patient outcomes, such as decreased nosocomial infection rates and decreased falls per patient day. "Greater diligence in reporting medication incidents was also noted as a positive step in facilitating systems improvement" (p. 110). Based on project team and staff feedback, the researchers concluded that this approach brought patient needs to the forefront of team communications and decision-making.

Another collaborative teamwork approach was introduced to Vancouver General Hospital, BC (Harvey & Priddy, 2012). This project began with scope/role clarification for members of the collaborative nursing team: RNs, LPNs/RPNs and care aides. The collaborative teamwork process included nine steps that are outlined in Table 2.

Table 2. The Collaborative Teamwork Process

1. Define the patient population/unit.
2. Determine patient acuity/unit.
3. Determine routine care needs of patients.
4. Identify the unit's current staffing profile.
5. Involve the unit staff, manager and union representatives in developing a new care delivery model based on patient care needs.
6. Present the new model to provincial union representatives and develop labour adjustment plans as needed.
7. Determine what positions are needed (including vacation relief), hire needed new staff and develop new rotations.
8. Educate staff on the collaborative practice model and hold regular staff meetings during/post-implementation to clarify scope/role confusion.
9. Create a responsive staffing algorithm to assist in-charge nurses and patient care coordinators with decision-making.

To facilitate this process, a real-time patient needs assessment tool was used that rates patient acuity and dependency. Educational supports for staff and leadership were critical to scope/role clarity and collaborative teamwork. Project evaluators documented a reduction in vacancies and overtime during project implementation. This approach has since been adapted and tested in two long-term care facilities within this one health region (Harvey & Priddy, 2012).

In Ontario, a toolkit was developed and evaluated for RN and LPN/RPN decision-making based on the College of Nurses of Ontario's (CNO) practice standards for RNs and LPNs/RPNs (Blastorah et al., 2010). This toolkit project began in acute care medical-surgical hospital units. The CNO standards assert that care delivery decisions must consider the patient (complexity of care needs, predictability of outcomes, risk of negative outcomes), the nurse (knowledge, skills, judgment) and the environment (support tools, consultation, stability of the environment). The toolkit was created to operationalize key evidence-based patient, nurse and environment factors that are associated with patient-centred, quality, safe care delivery. It includes a Patient Care Needs Assessment (PCNA) tool that was validated through a consensus-based process for reviewing and determining patient needs. Staff involvement was a critical component of toolkit use and evaluation. The use of tools and a consensus-based review process helped to "improve decision-making in matching patient needs to nursing human resources, focusing on the patient's needs, the nurse caring for the patient and the unit environment" (p. 48).

Summary: The above redesign efforts based on collaborative teamwork are not exhaustive. They are meant to illustrate unit/facility-level approaches to patient-centred, quality, safe care delivery. In these instances, patient needs assessment tools were used to determine patient needs first, followed by other considerations, such as nurse educational qualifications and competencies, and the environmental context. Collaborative practice models require collaborative teamwork, and collaborative teamwork is not a given – specific factors enable intraprofessional (and interprofessional) teamwork. The process of building consensus, comfort, and trust among team members includes shared communications and decision-making. Educational supports and frequent check-ins are integral to maintaining scope/role clarity.

Australia

Australia provides examples of redesign efforts at the national level. The Health Workforce Australia website (See: http://www.hwa.gov.au/) describes redesign initiatives underway to build partnerships between government, the health and higher education sectors, and "address critical priorities in the planning, training and reform of Australia's health workforce." The impetus for these initiatives has been workforce mal-distribution and workforce shortages. Some initiatives have included: a) the development of a national framework to guide workforce reform; b) the establishment of clinical training networks; c) international marketing campaigns to boost nursing and allied health recruitment; and d) pilot projects to clarify scopes of practice for nursing and other professional groups.

Australian scholars (Jacob et al., 2013) provide an excellent overview of workforce redesign efforts related to enrolled nurse (EN) use. Enrolled nurses are comparable to Canadian LPNs/RPNs. The original role of ENs (1980s) was to assist with patient care under the supervision of an RN. Enrolled nurses were expected to assist with activities of daily living, health status monitoring and basic procedures. By the 1990s, ENs were part of team care delivery with more generalist nursing functions. This role expansion was promoted by an RN shortage and rising patient acuity: RNs were expected

to care for sicker patients, and many RNs were shifted into specialist roles. Concomitantly, EN education became more formalized (i.e., shift from an apprenticeship model to formal vocational education). Soon after, a review of the EN role in aged care and rural settings resulted in legislation to permit EN medication administration. This legislation was accompanied by adjustments to EN educational curriculum.

Prior to 2010, each Australian state had their own legislation board that caused confusion due to variance in EN scope of practice legislation and education from state to state. By 2010, an Australian Qualifications Framework was developed with a standardized career/education pathway for ENs. There are national standards for ENs to proceed into specialty areas: 12-month certificates, 18-month diplomas and two-year advanced diplomas. Higher levels of education include medication administration and advanced skills. This pathway is linked to entry to university and eventual RN qualification (Jacob et al., 2013).

Similar to other countries, including Canada, Australia has been challenged with developing scopes of practice that clearly distinguish between RNs and ENs, and are broad enough to accommodate diverse geographic and patient care settings. The Australian Nursing and Midwifery Council developed national competency standards for RNs and ENs, and a decision-making framework to guide RN and EN practice. Resources accompanying the framework are intended to guide day-to-day care delivery decisions (Bellchambers & McMillan, 2007; Chaboyer et al., 2008; Jacob et al., 2013, 2013; Nankervis et al., 2008).

Interviews with Australian NSW nurse union representatives and regulators indicated that there have been some strong gains in scope of practice clarity due to close collaboration between the union, regulatory bodies and educators. “There is a culture in Oz around complementarity. People know what the RN can do and the EN – ENs are there to support RNs, but not replace them. Complementarity has to be supported through our regulatory frameworks and education – we complement – we don’t replace.”

“Our national registration body has a lot of literature to help people differentiate between nurse types. I think there is clear differentiation between the two – and resources to support role clarity. On the other hand, our AINs (care aides) are not regulated at all. We would love to see them regulated.

There is an AIN implementation package in NSW that explicitly describes their employment requirements and roles. There have been situations where AINs take on expanded duties in the public health system – so we helped create an implementation package to give a clear position description and roles. We are concerned that organizations might provide education on their own to expand what they do."

"We have decision-making tools. There is a pathway for education and there are boundaries that clearly define what RNs can do, ENs. Each health authority or region also provides job descriptions that give clarity to what people do. And it is the culture. When you have worked with ENs, you know what they can and cannot do."

Summary: Due to variations in nurses' scope of practice across Australian states, the major regulatory body, the Australian Nursing and Midwifery Council, developed a framework for legally differentiating between ENs and RNs. Regulatory differentiation is complemented by distinctions between EN and RN curricula (now at a national level), and health care organizations are expected to provide clear job descriptions and staffing decision-making supports to enhance scope/role clarity. Interviewees in Australia felt that scope/role clarity is part of their health care culture, contributing to more effective, collaborative teamwork among RNs and ENs.

New Zealand

This example illustrates the complexity of systems-level decisions. Changes were made to nursing care delivery that negatively impacted nurses and patients. McCloskey & Diers (2005) describe negative outcomes related to re-engineering efforts in New Zealand during the 1990s-2000s. Prior to reengineering, there was a staff mix of approximately 85% RNs to 15% ENs. After reengineering, ENs were eliminated and RN direct care hours were decreased by 36% to control costs. During this time, there were significant increases in patient adverse events, such as sepsis rates and the presence of pressure ulcers. In addition, there were government mandates to decrease hospital length of stay, and a 20% reduction in patient length of stay compressed nurses' workloads (See Berry & Curry, 2012).

Fortunately, the New Zealand government and nurses' union were monitoring outcomes from workforce redesign. As patient and nurse safety concerns

began to surface, a national multi-employer collective agreement established a safe staffing commission to assess data related to nursing care delivery. Policies were also created to promote healthy work environments (See: http://www.nzno.org.nz/support/workplace_rights/safe_staffing).

Summary: In New Zealand, redesign involved a number of changes, including: a) elimination of ENs; b) reduction in overall RN hours; and c) mandated reductions in hospital patient length of stay. This redesign resulted in a 'perfect storm' that increased nurses' workloads. Safety concerns resulted in the creation of a collaborative agreement between the nurses' union and the health authorities to address those factors associated with quality, safe care delivery.

The U.S.

In the U.S., nursing workforce redesign includes increased utilization of LPNs/RPNs and safe nurse staffing legislation at national and state levels.

In the U.S., nursing care delivery models have primarily focused on the independent contributions of RNs. Redesign efforts are underway to examine how LPNs/RPNs and collaborative practice models can be better utilized within different health care sectors (Livornese, 2012; Seago et al., 2006).

DeWitt (2009) describes a pilot project in one perianesthesia care unit (PACU) where LPNs/RPNs were gradually integrated into the nursing care delivery team. The nursing staff and management were involved in an environmental scan of the PACU, to assess whether or not LPNs/RPNs would have the requisite education, skills and knowledge to meet established professional standards for PACU care delivery. A state board of nursing (regulatory body) was consulted, and their decision-making algorithm was used to clarify LPN/RPN scope of practice. In addition, staffing guidelines were developed based on the PACU patient population, and educational sessions were conducted to discuss the shift to a new, collaborative teamwork process. This pilot began with the gradual introduction of one LPN working with an RN to care for three patients. Over time, optimized use of LPNs and collaborative teamwork resulted in improved delivery of patient care for a mixed patient acuity workload. This gradual shift in care delivery (from RN to an RN and LPN/RPN mix) was time-intensive, and it required

real resource commitments from leadership. The PACU shift took a long time due to nurse reservations about the process, but eventually, true collaborative teamwork led to positive measurable results, including better patient flow in and out of the operating room.

In contrast to the redesign example above, care delivery designs in U.S. skilled nursing facilities (SNFs) are currently being questioned. These facilities provide post-acute care to improve patients' health and functioning after hospitalization. Although the Office of the Inspector General in the U.S. has paid considerable attention to acute care patient outcomes, little research (until now) has looked at the safety and quality of care delivery in SNFs. A recent report from the Department of Health and Human Services (DHHS) (2014) found that changes to nursing care delivery models need to be carefully reconsidered. Audits of SNFs receiving government support found that 22% of Medicare beneficiaries experienced adverse events during their SNF stays, and physician reviewers determined that over half of these incidents could have been prevented with closer nurse monitoring and more efficacious care delivery. Agency surveyors who review SNF and long-term care facilities are being charged with reviewing nursing care structures and processes, and identifying ways to reduce adverse events (DHHS, 2014).

Safe nurse staffing is a critical component of care delivery design. The American Nurses Association website (2013) summarizes different approaches to U.S. federal and state staffing laws. At the federal level, the Registered Nurse Safe Staffing Act requires each state to "ensure that staffing is appropriate to meet patients' needs safely." The states are using three types of legislation to meet the federal law: a) mandate specific nurse-patient ratios (e.g., California); b) mandate health care organizations to have a "nurse driven staffing committee" to establish safe staffing plan processes for their specific patient population needs (e.g., Washington, Oregon); and c) require health care organizations to disclose their staffing levels to the public and/or regulatory bodies (e.g., New York, Illinois).

In Massachusetts, a joint venture between the Massachusetts Hospital Association, the Organization of Nurse Leaders of MA-RI, and the Home Care Alliance of Massachusetts recently established PatientCareLink, an online, publicly accessible site that links staffing levels of member

organizations with patient safety outcomes (See http://patientcarelink.org/). PatientCareLink makes staffing plans available from every hospital clinical unit and emergency department by shift. The key staffing decision roles of nurse leaders and nurses are highlighted throughout this site.

Summary: Redesign examples from the U.S. highlight efforts to better utilize RNs and LPNs/RPNs within their current scopes of practice. The example of PACU redesign illustrates the intensive, sustained investment of organizational resources and supports that are associated with positive outcomes. In contrast, redesigns in SNFs are producing worrisome patient outcomes that are currently being audited and questioned. The U.S. also exemplifies different state and federal legislation related to safe staffing (e.g., mandated nurse-patient ratios, mandated staffing plan processes). Legislative trends highlight the importance of public transparency – making clear links between nursing care delivery and patient outcomes.

The UK: National Health Service England

The redesign of nursing care delivery in the National Health Service (NHS) England is now known worldwide as an example of a preventable tragedy. The NHS workforce redesign began over a decade ago with the elimination of LPNs/RPNs and replacement of RNs with unregulated care aides (Bach et al., 2008; Kessler et al., 2006). Since the 1990s, the NHS workforce has expanded by 40%, while the RN workforce was diluted from 29.3 % of the total health care workforce in 2002 to 27.7% in 2012 (Royal College of Nursing [RCN], 2013a). A review of NHS Trust Foundation three-year plans found an additional 4% planned reduction in RN numbers for 2014-2016 (Monitor, 2013).

Some sectors have suffered more significant losses of RNs, namely the mental health, community and learning disabilities sectors (RCN, 2013a). The loss of RN positions in the community sector is particularly concerning since the UK redesign includes a shift to primary care delivery in community settings. Griffiths et al. (2010) examined the relationship between patient quality indicators and nurse staffing in NHS community care settings. Better performance on clinical domains (e.g., blood pressure control, seizure control) was found in practices with higher RN staffing. The highest levels of RN staffing were associated with significantly better clinical outcomes

for a range of conditions, such as COPD, congestive heart failure, diabetes and hypothyroidism.

Changes to nursing care delivery have resulted in alarming safe staffing reports from the RCN (2013a) and a number of high profile inquiries on the quality and safety of NHS care (Berwick, 2013; Francis, 2010, 2013; Keogh, 2013). As stated in one commissioned report of 14 NHS trusts (Keogh, 2013), review teams "found frequent examples of inadequate numbers of nursing staff in some ward areas… this was compounded by an over-reliance on unregistered staff and temporary staff…" "There were particular issues with poor staffing levels on night shifts and at weekends" (p. 22). The Keogh Mortality Review was commissioned by the Prime Minister to examine sites with consistently high mortality rates. The review, led by Professor Sir Bruce Keogh, the NHS Medical Director for England, makes the following recommendations: "Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards." "Directors of Nursing in NHS organizations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and the patient experience" (p. 11).

Another high profile case, the Mid Staffordshire General Hospital NHS Trust Inquiries (Francis, 2010, 2013), began with a report published by the Healthcare Commission in 2009. High mortality rates and poor standards of care were documented in this report. Concerns by the public led to an independent, commissioned inquiry in 2010 (Francis) and a public inquiry in 2013 (Francis). In Canada and the UK, public inquiries differ from commissioned studies. As the name implies, this type of inquiry occurs in a more transparent, public forum.

The 2010 inquiry revealed appalling care conditions that were allowed to persist despite a number of quality/safety reporting mechanisms in existence that were used by patients, their families and staff. Patients were left in excrement for prolonged periods of time; patients who could not feed themselves were not assisted; water was left out of reach; privacy and dignity were denied; and specialty areas, such as emergency department triage,

were staffed by untrained personnel. Despite formal complaint processes, the trust did not listen. The inquiry found that staffing cuts and RN staff mix dilution were ongoing, as a way to control finances. The inquiry also showed how the Trust Board used a very traditional, centralist approach to make financial decisions that severely influenced nurse staffing levels. There was no evidence of clinical engagement or consultation. According to Francis (2010, p. 227), "It is by no means clear that the only way of finding the necessary savings was to implement a workforce reduction programme."

The 2010 commissioned inquiry was not enough to meet public satisfaction, particularly among family members who had lost loved ones. Two individuals were recently honoured for the role they played in instigating the public inquiry of the Mid-Staffordshire Trust. One individual, Julie Bailey, created a family-led organization, CURE, to represent relatives of patients who died as a result of substandard care. Her own mother died from the lack of a sufficient oxygen supply. The collective public voice was necessary to force action partly because of the NHS' elimination of the Commission for Patient and Public Involvement in Health. Each trust was forced to work out its own form of patient and public involvement (Francis, 2013).

The Francis public inquiry report (2013) cites a number of conditions that resulted in quality and safety breeches. These conditions include: a business culture versus a patient-centred culture; tolerance for poor standards and risks to patients; communications failures among different regulatory agencies; and assumptions about monitoring and responsibility for follow-up.

In particular, the Francis report emphasizes the importance of striving for a patient-centred culture (putting the patient first) and ensuring "openness, transparency and candour throughout the system" (p. 4). The report describes a "culture of fear," a "culture of secrecy," and a "culture of bullying" that severely compromised patient safety and quality of care (p. 10). The report contains 290 concrete recommendations for improvement. In addition to a culture change that puts patients at the center of decision-making, the report urges proper risk assessment of RN reductions. The recommendations also explicitly detail (from macro-government levels to local community levels) how to solicit and engage patients, their families and staff.

Of note is that, prior to the Francis public inquiry, the evidence of quality, safety transgressions throughout the NHS was abundant. All the evidence warned of “unhealthy cultures, poor leadership, and an acceptance of poor standards…” (Francis, 2013, p. 25). Some other published examples are: Patients Not Numbers, People Not Statistics (Patients Association, 2009) and a report by the National Confidential Enquiry for Patient Deaths (2009) that reviewed care of patients who died within four days of admission.

The RCN produced and published numerous surveys and reports warning of dire redesign consequences. Its 2009 survey (Ball & Pike) found that 55% of NHS nurses (N=4,845) across the entire UK were too busy to provide adequate care. Workload was a key factor underlying their concerns with inadequate care provision. This document also describes concerning quality/safety breaches such as hospitals in two trusts with C. Difficile outbreaks. The RCN investigation found a number of similarities between these trusts. “Both had undergone difficult organizational mergers (which impinged on systems for clinical governance and risk assessment), were pre-occupied with finances, had poor environments, and had very high bed occupancy levels… Financial pressures led to the Trusts reducing further already low numbers of nurses…apparent from patient and staff comments, was that too frequently basic nursing care was not provided putting patients’ safety and lives at risk” (p. 16). Based on 2009 survey findings, the RCN safe staffing document (2010) includes recommendations for safe staffing, minimum safe staffing levels, and a review of staff planning tools.

In its most recent member survey (RCN, 2013b), nursing work conditions were not improved. This survey found that 73% of participants reported increased stress and 80% reported increased workloads. Stress was also reported as a major reason for workplace sick leave. Approximately 60% of nurses said they were considering leaving their job. “Unless urgent action is taken to reverse this trend, there is a high risk that many nurses will decide to take early retirement or leave the profession, further damaging the ability of the NHS workforce to meet current and future health care demands” (RCN, 2013a, p. 15).

To display a collaborative voice, the RCN recently joined forces with senior nurse leaders, other professional organizations (e.g., Florence Nightingale Association, UNISON – the UK’s largest public service union), patient

organizations (e.g., Patients Association) and nurse academics to create the Safe Staffing Alliance (http://www.kcl.ac.uk/nursing/research/nnru/news/Alliance-Statement-May-2013.aspx). This site provides evidence that links nurse staffing levels to quality of care delivery, and the Alliance has its own staffing level recommendations. For instance, the Alliance states that a staffing ratio of one registered nurse to eight patients (excluding the nurse in charge) is the level below which there is a significant risk of harm. The Alliance recently issued "*Safe and Sound: Five New Year Wishes for Nursing*" (Snell, 2013) that are summarized as: minimum RN staffing levels; patient access to information on RN staffing; annual Board reviews of RN staffing with direct input from Chief Nursing Officers; more power for clinical nurse leaders to control ward staffing levels and resources; and investment in nursing research and the development of tools and data collection methods to link nursing to safe, quality care delivery.

Dr. Donald Berwick, the former President and Chief Executive Officer for the U.S.-based Institute for Healthcare Improvement, headed a National Advisory Group on the Safety of Patients in England to study the accounts from the Mid Staffordshire reports, and to recommend key changes to the English government and senior officials of the NHS (Berwick, 2013). Berwick's key recommendations are summarized in Table 3.

Table 3. Improving the Safety of Patients in England (Recommendations)

1. The NHS should commit to an ethic of continuous learning.

2. All leaders concerned with NHS health care (political, regulatory, governance, executive, clinical and advocacy) should consider patient safety and quality of care their top priorities with respect to "investment, inquiry, improvement, regular reporting, encouragement and support" (p. 5).

3. Patients and family members should be "present, powerful and involved at all levels of health care organizations from wards to boards of Trusts" (p. 5).

4. The government, health educators of England and the NHS should ensure that staff are available in sufficient numbers, well-trained and supported.

5. Quality and safety knowledge should be incorporated into education (preparatory, ongoing) for health care staff and administrators.

6. The NHS should use "learning organization" principles. These principles emphasize stakeholder participatory problem-solving and decision-making.

7. "Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organizations or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public" (p. 5).

8. All organizations should include patients and families as an important component of their quality and safety monitoring.

9. Supervisory and regulatory systems should be clear and non-overlapping to avoid diffusion of responsibility.

10. Organizations should have responsive regulations in place to ensure a culture of safety – versus a culture of blame.

Given the level of outcry over NHS workforce redesign outcomes, the NHS has begun to reinvest in its nursing workforce (Lintern, 2013). Workforce reversal (and RN reinstatement) will take a long time to correct. The RCN's (2013a) roadmap for safe nurse staffing calls for an "end to boom and bust nursing workforce planning" (p. 23). Most recently, BBC news publicly announced that UK hospitals will be expected to publish monthly details about their staffing levels. Tingle (2014) provides an overview of government quality and safety actions.

Summary: The NHS England workforce redesign (starting in the 1990s) involved elimination of LPNs/RPNs, the reduction of RNs and greater use of unregulated staff – even in community care, where some evidence links positive patient outcomes to RN care delivery. Despite many warning signs, such as high patient mortality rates, public action was necessary to force government accountability. The high-profile public inquiry, the 2013 Francis report, recommends culture change from a culture of fear, blame and bullying to a patient-centred safety culture. Other recommendations involve closer surveillance and monitoring of quality, safety indicators and greater empowerment of frontline staff and leaders to address staffing levels and resource concerns that impede the delivery of safe, quality care. The Safe Staffing Alliance, a collaboration of professional organizations, nurse leaders and academics, has also come forward with safety recommendations, including use of evidence-based staffing tools for shift-to-shift staffing, and minimum RN staffing levels to guarantee "a floor – not a ceiling" for safe staffing. Berwick's national advisory group produced similar recommendations that support an NHS transformation to a culture of safety. In England, the convergence of evidence has resulted in many new NHS patient safety initiatives, including transparent, public reporting of staffing levels in all NHS hospitals.

Europe

The NHS Mid-Staffordshire Trust tragedy has highlighted the importance of actively monitoring and responding to available evidence, and for that reason, it is important to include the most recent piece of research evidence from nine European countries. This study was funded by the European Commission to provide scientific evidence for "decision makers in Europe about how to get

the best value for nursing workforce investments, and to guide workforce planning to produce a nurse workforce for the future that will meet population health needs" (Aiken et al., 2014, p.2). The study was conducted in 300 hospitals in nine European countries (Belgium, England, Finland, Ireland, the Netherlands, Norway, Spain, Sweden, Switzerland). This study found that an increase in nurses' workloads increased the likelihood of inpatient deaths, and an increase in nurses with Bachelor's degrees was associated with a decrease in hospital deaths (Aiken et al.). These findings are very similar to workload/staffing studies conducted in the U.S. and Canada (See Berry & Curry, 2012).

Shortly after the publication of this study, the Ontario Nurses' Association (ONA) released a statement in the *Toronto Star* newspaper urging hospital decision-makers to reconsider ongoing cuts to nurse positions. As noted in the newspaper article, the Canadian Institute of Health Information indicates that Ontario has the second worst RN-to-population ratio of all provinces after BC. Ironically, 12.9% of new RN graduates were unemployed in Ontario in 2012 (Boyle, 2014).

Summary: The latest study from Europe, following soon after media attention on NHS England, must be a wake-up call to Canadian decision-makers.

A Collaborative Look at Patient-Centred, Quality, Safe Care


Vanessa, RN (NLNU)

The initiatives discussed have much to teach us about workforce redesign as it relates to nursing and quality, safe patient care. If done properly, redesign can enhance communication and collaborative decision making, bringing patient needs to the forefront. This requires adequate education and recognition of the different scopes of practice of different care providers, ensuring that we match nursing resources to patient care needs. On the other hand, redesign efforts that seek to balance budgets by reducing the nursing workface have led to severely negative results including a demoralized nursing workforce, dramatic increases in adverse patient results and health system disarray.

A recent patient safety initiative between the Canadian Nurses Association (CNA), the Canadian Federation of Nurses Unions (CFNU), Accreditation Canada and the Canadian Patient Safety Institute (CPSI) has produced a document based on roundtable discussions with patient/family representatives, nurse leaders, direct care nurses, nurse union representatives, and nurse health services researchers (CNA-CFNU, 2014). This collaboration emphasizes a true joining of forces for quality and safe patient care. Conclusions from roundtable discussions echo what has been presented throughout this paper: Nursing workforce design at all levels needs to be evidence-based. Key stakeholders need to participate in redesign efforts. Data, such as nurse-sensitive adverse events indicators and human resources data (e.g., sick leave, vacancies, overtime, turnover), should be closely monitored and consulted during any/all redesign activities. One roundtable participant commented that uninformed nursing care delivery redesign is a “dangerous experiment.” Patients expect to be ethically informed when changes are made to their treatment protocols and medications. Patients should also know when changes are being made to nursing care delivery, and they need to know how these changes may or may not influence their outcomes – to ensure accountability.

Legal Considerations

Unsafe workforce redesign can be addressed through a number of routes. Every province and territory has workplace processes in place to report and to collaboratively address safety concerns. Some of these nurse-driven processes have been negotiated through collective bargaining agreements, and stewards are typically available to discuss nurse concerns and provide counsel. Some issues can be resolved through nurse-manager discussions, but there are other avenues, such as formal documentation (e.g., professional responsibility forms), that require administrative investigation and resolution (See Ontario Nurses' Association example at: http://www.ona.org/professional_practice/professional_responsibility_workload_report_forms.html).

What can be done beyond the individual nurse level to address unsafe workforce redesign? Every province and territory has Occupational Health and Safety legislation, such as the *Workers Compensation Act* of BC that protects health care providers from hazardous work conditions and enables providers to refuse unsafe work. See: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96492_01.

The following sections represent legal actions nurses can take within three specific provinces: Ontario, Nova Scotia and Saskatchewan. They were researched by a legal consultant for the CFNU Gavin Gardener. Please note that these examples are provided with the caveat that legislation will differ from province to province.

Ontario

Occupational Health and Safety legislation in Ontario restricts the right of nurses to refuse unsafe work. However, there are other legislative means that Ontario nurses can utilize to influence staffing practices and workforce redesign. Additionally, professional practice provisions of most collective bargaining agreements in the province allow for nurses to address concerns through workload report forms.

Legislation

The Ontario *Occupational Health and Safety Act*, RSO 1990, c. O.1 Section 43.2(d), restricts the right of nurses in Ontario to refuse work that is unsafe if it is in the normal course of their work (43.1(a)) or if it endangers the health or safety of another person, such as a patient (43.1(b)). Unfortunately, due to the first restriction in particular, it would be difficult for nurses in Ontario to raise workload concerns as a matter of workplace safety under the protection of this *Act*. However, there are OHS regulations in the *Health Care and Residential Facilities, Ontario Reg 67/93* Section 8 and 9, which require employers, in consultation with the joint health and safety committee, to develop procedures around safe work practices (9.1.1) and safe working conditions (9.1.2). There is nothing to suggest that these provisions should not include regulations around safe staffing levels and workforce redesign.

Ontario comes the closest to legislatively regulating a staffing mix of the nursing workforce. The *Excellent Care for All Act, SO 2010 c14*, is the first of its kind in Canada to statutorily require research and evidence to inform health care planning: Section 12c is intended to promote health care that is supported by the best available scientific evidence. Specifically, committees are empowered under Section 12.1.c of the *Excellent Care for All Act* to make recommendations to health care organizations and other entities on standards of care in the health system, based on or respecting clinical practice guidelines and protocols.

In accordance with Section 3 of the *Act*, every Ontario health care organization will establish a quality committee to monitor and report on quality issues, including the overall quality of services provided in the health care organization (Section 4.1). These committees are required to reference appropriately collected data and to prepare annual quality improvement plans (Section 4.4).

Both of these functions are advisory only and neither speak directly to the regulation of nurse staffing mix, but they do introduce the guidance by research and best practice to the legislative regime, and they result in publicly accessible reports which can be used to influence decision-makers.

In Ontario, the profession of nursing is regulated by the *Nursing Act, SO 1991* c32, as well as the *Regulated Health Professions Act, SO 1991 c18*, which delegates the power to set practice standards to the College of Nurses of Ontario (CNO). The CNO as per this authority requires Registered Nurses in Ontario to promote the best possible care for clients, advocate on their behalf, ensure practice standards are met and act when client safety is compromised (CNO, 2002, p. 4). Each of these practice requirements may be affected in a workplace which is improperly staffed.

Nurse supervisors, in particular, are in a position to ensure adequate staffing under CNO practice guidelines. These nurses are required to make staffing decisions which are in the best interest of professional practice and the clients – not the employer – and are responsible to advocate for a quality practice setting that supports nurses' ability to provide safe, effective and ethical care (CNO, 2002, p. 4).

Collective Agreements

The majority of registered nurses in Ontario are covered by the collective bargaining agreements negotiated by the Ontario Nurses' Association (ONA). The collective agreement provides legal mechanisms for nurses to address staffing issues in addition to the legislative framework of the province. Specifically related to the ability to contribute to workforce redesign and shift replacement, Article 8 of the Hospital Central Agreement, Article 24 of the Community Care Access Centre Template Agreement, and Article 19 of the Nursing Homes Central Agreement Template outline a process to raise concerns related to workload and professional practice. ONA has developed a Professional Responsibility Workload Report Form to report concerns based upon these provisions in the collective agreement.

Article 8.01 of the Hospital Central Agreement creates the jurisdiction for Independent Assessment Committees (IAC) to review RN concerns about issues relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing in order to proactively address matters. This provision is mirrored in different articles of other Ontario Nurses' Association collective agreements. ONA provides publically accessible reports from these Independent Assessment Committees on its website.

Nova Scotia

Legislatively, Nova Scotia nurses have relatively limited options to assert control over workforce changes and replacement with "like" qualified care providers. However, new language in the recently approved Collective Bargaining Agreement between the Nova Scotia Nurses' Union (NSNU) and Nova Scotia Health Authorities around workload concerns and acuity measurement is a model for many other agreements across the country.

Legislation

The Nova Scotia *Occupational Health and Safety Act, SNS 1996*, C 7 Section 43, allows for employees to refuse work deemed unsafe.

Their professional responsibilities are outlined by the College of Registered Nurses of Nova Scotia which regulates nursing practice in the province in

accordance with section 4.d.iii of *the Registered Nurses Act, SNS 2006*, c.21. The College Council has adopted the Canadian Nurses Association 2008 Code of Ethics for Registered Nurses for members in Nova Scotia. Of particular note are ethical responsibilities to "question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same" (CNA, 2008, p. 41).

Collective Agreements

The Collective Bargaining Agreement between the Nurses Union of Nova Scotia and the Nova Scotia Health Authorities signed on January 14, 2014 and expiring on October 31, 2014 contains new language around workplace capacity in article 17 (NSNU, 2014). Under the new terms, a Clinical Capacity Report can be filled out by any Registered Nurse or Licensed Practical Nurse covered under the agreement who believes that patient safety is affected by staffing levels, including the failure to replace scheduled staff with similarly qualified staff. This new approach, which replaces Work Situation Reports present in many other agreements across the country, includes patient acuity measures, clearer timelines and a mandate to go higher up the institutional ladder.

Saskatchewan

As in Ontario and Nova Scotia, Saskatchewan occupational health and safety legislation and nursing legislation provide some limited opportunities for nurses to address unsafe working conditions. Saskatchewan RNs also have powerful language within their collective agreements, which can be used to promote safe staffing levels and to limit wrong-headed redesign initiatives.

Legislation

No legislation in Saskatchewan speaks directly to optimal staffing mix of the nursing workforce. However, there are several statutes which outline the role and scope of nursing practice in the province. Saskatchewan registered nurses may rely upon this robust legislative regime which regulates many

aspects of their practice to support claims for replacement with other RNs and raise objections to unsafe workforce redesign.

First, *The Registered Nurses Act, 1988*, provides licensing requirements and competency thresholds which RNs are required to meet in order to be licensed practitioners in Saskatchewan. Many of the powers in the Act are delegated to the Saskatchewan Registered Nurses Association (SRNA).

As outlined in the SRNA 2013 standards of practice document (*Standards and Foundation Competencies for the Practice of Registered Nurses*), under Standard I, it is expected that a registered nurse "Advocates and intervenes, as needed, to ensure client safety" as well as, "Identifies, reports, and takes action on actual and potential unsafe practices or situations that have risk to clients, health care team members and/or others" (SRNA, 2013, p. 9). Nurses who do not follow these standards of practice, including registered nurses in supervision positions, responsible for staffing levels and workforce redesign, could be reported to the licensing body for non-compliance.

Like other jurisdictions, Saskatchewan registered nurses are covered by *Occupational Health and Safety Act, 1993, c O-1.1*. In addition to any collective bargaining agreement nurses may have, provisions of the *Occupational Health and Safety Act* provide a potential legal mechanism which nurses may utilize in order to halt unsafe workforce redesign.

Section 23 of the *Occupational Health and Safety Act*, in particular, could provide nurses with power to halt unsafe workforce redesign. This section states that any employee has the right to refuse work deemed unsafe. It is possible that unsafe staffing levels or redesign decisions which endanger nurses or patients could be protested under this provision. While the provision is broadly stated, recent court decisions such as *Canada Post Corp. v. Pollard, 2007, FC 1362 and Verville v. Canada (Correctional Services), 2004, FC 762,* set out the test for what is considered sufficiently dangerous to constitute an unsafe workplace (at least in accordance with the federal labour code).

Collective Agreements

The vast majority of Registered Nurses in Saskatchewan are covered by the SUN/SAHO Collective Bargaining Agreement. The Collective Agreement provides legal mechanisms for nurses to address staffing issues in addition to the legislative framework of the province.

Employers are required to adhere to professional standards set for nurses in Article 58 of the most recent SUN/SAHO Agreement which was ratified on April 1, 2012. Article 58.05, in particular, empowers Saskatchewan RNs to address short staffing and other workforce redesign issues which may affect the professional standards nurses hold themselves to.

Article 56 of the SUN/SAHO Agreement establishes Nurse Advisory Committees which provide a mechanism for nurses to document their issues and have them forwarded to be addressed by the employer. Of particular note in Article 56 is the ability to document events through Workplace Situation Reports that registered nurses believe prevent them from carrying out the highest-quality, expert care for patients. As in Ontario and Nova Scotia, workload issues can also end up before an Independent Assessment Committee (IAC). In Saskatchewan's case, the IAC's decisions are binding insofar as they relate to nurse workload concerns.

One of the more unique clauses in the Saskatchewan Agreement, which could be used to explore staffing levels on a more macro level, is Article 37.16 which relates to full-time and other than full-time relief for existing shift lines. Under this article, the employer is required to analyze leave usage by existing employees on an annual basis. Positions are then created to proactively account for vacancies based on past data. This provision is an innovative preemptive tool to ensure safe staffing levels at all times.

Summary: There are individual actions nurses can take to report unsafe conditions. Nurses' right to refuse to work under unsafe conditions varies by province. Legislation and protections gained through collective bargaining also vary by province. Nurses must be proactive, using available legal protections to advocate for patient-centred, quality safe care.

Concluding Remarks and Recommendations

Margo, RN (NBNU)

Where are we <u>not</u> with respect to health care workforce redesign?

There is no doubt that health care is expensive and budgets are tight. Resources must be carefully allocated, based on the best available evidence. We have evidence from around the world and within Canada to determine patient-centred, quality, safe strategies for health workforce redesign. Will decision makers learn from best practices and heed the mistakes of others?

These recommendations follow from the evidence discussed in this paper.

1. Patient needs assessment tools (e.g., Synergy Model patient needs assessment tool) must be used to make evidence-based determinations of patient needs, and to support collaborative staffing decisions between nurses and nurse managers on a real-time, shift-by-shift basis.

2. Health care organizations and their leadership must strive to ensure Magnet-like work environments for best possible quality, safe care delivery. Magnet-like environments are known for effective nursing leadership at all levels of the organization (i.e., front-line, mid-level, executive), collaborative teamwork, staffing adequacy, effective communications, and nurse control over practice (e.g., clinical autonomy, shared governance).

3. Once patient needs are known, care needs should be determined based on nurses' formal educational qualifications and competencies. Nurses' scopes of practice should clearly distinguish between the three regulated groups' educational attainment, foundational knowledge and skills.

4. After nurse qualifications and competencies have been matched to specific patient needs, nurses should only be replaced with nurses with similar formal educational qualifications and competencies. "Like for like" replacement policy should ensure that RNs are replaced with RNs, LPNs/RPNs are replaced with LPNs/RPNs, and registered psychiatric nurses are replaced with registered psychiatric nurses.

5. The delivery of education associated with regulated nurses' scopes of practice must take place within formal, accredited or approved educational programs.

6. Inability to replace "like for like" should be a rare event (e.g., unusual amount of sick calls). Replacing care providers with a different classification (LPN/RPN replacing an RN) should not be a typical staffing solution. If this does occur, the in-charge RN should be required to document evidence to support the decision, and provide evidence that patient safety is not being compromised.

7. Scope of practice clarity avoids role confusion, fragmentation of care, and inappropriate use of nurses. Regulatory bodies, unions and nurse education program coordinators must work collaboratively to ensure scope of practice clarity.

8. Scope and role clarity should be enhanced through employer policies and job descriptions that make explicit the regulatory and educational distinctions between RNs, LPNs/RPNs and registered psychiatric nurses, and the distinctions between regulated and unregulated health care providers.

9. Patients and their families must be present, powerful and involved with quality/safety initiatives at all levels of the health care system.

10. Standardized patient adverse events data (e.g., nurse-sensitive structure-process-outcomes indicators) need to be collected, reported and acted upon in a timely manner. These data should be transparent and publicly accessible.

11. 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.

12. There must be regular, formal reviews of administrative data (e.g., overtime, absenteeism, vacancies, staffing levels) and patient adverse events data at all levels of the organization. Nurse leaders at all levels must be engaged in these reviews and have the power to adjust nursing care delivery to ensure patient-centred, quality, safe care.

13. The review process for professional responsibility forms (PRFs) and critical incident reports needs to be carried out within a mandatory time period, and similarly, recommendations need to be enacted within a mandatory period of time.

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Appendix A

Message from the CFNU: Linda Silas (French)

Au cours des dernières années, il est devenu courant, au sein des gouvernements et des régies de la santé, de parler de soins axés sur le patient et dispensés en collaboration. Toutefois, cela ne peut pas se faire de façon isolée. Un des plus importants facteurs ayant un impact fondamental sur la sécurité des patients et le travail d'équipe en collaboration est la structure de la main-d'œuvre, plus particulièrement comment les infirmières – le plus grand groupe de professionnels de la santé – dispensent les soins à leurs patients. Récemment, au Canada et dans le monde entier, une restructuration de la main-d'œuvre – motivée par les resserrements budgétaires – s'est amorcée. Dans plusieurs cas, cette restructuration ne tient pas compte des répercussions sur les patients. Entre-temps, les employeurs et les gouvernements continuent de vanter les mérites du concept des soins axés sur le patient, sans pour autant donner une impulsion vigoureuse pour inciter les établissements à agir.

C'est donc à nous, infirmières, de porter le fardeau d'agir. Conformément à notre *Code de déontologie*, nous devons nous porter à la défense des patients lorsque nous jugeons que leur santé est compromise « par des facteurs hors de leur contrôle, y compris par des décisions prises par les autres.» Les infirmières doivent « remettre en question et contrer les pratiques ou les conditions qui, n'étant pas favorables à la sécurité, à la compassion, à l'éthique ou à la compétence, nuisent à leur capacité de dispenser des soins sécuritaires, compatissants, compétents et conformes à l'éthique. » On encourage aussi les infirmières à signaler les situations préoccupantes. (*Code de déontologie des infirmières et infirmiers*, AIIC, 2008).

L'Association des infirmières et infirmiers du Canada (AIIC) et la Fédération canadienne des syndicats d'infirmières et infirmiers (FCSII) collaborent activement avec Agrément Canada et l'Institut canadien pour la sécurité des patients pour promouvoir la qualité et la sécurité des soins. Ensemble, nous avons élaboré un document fondé sur des tables rondes réunissant des patients et leur famille, des dirigeants du secteur infirmier, des infirmières dispensant des soins directs, des représentants syndicaux, et des chercheurs. Nous avons conclu que la structure de la main-d'œuvre infirmière, à tous les paliers, doit se fonder sur les données probantes et sur quatre priorités : 1) autonomisation des patients et du public grâce à l'éducation et à des soutiens qui favorisent la qualité et la sécurité; 2) soutien aux infirmières et aux étudiants en sciences infirmières; 3) pratiques de dotation fondées sur les données probantes; et 4) leadership infirmier solide.

En qualité d'infirmières, nous ne pouvons plus rester sans rien faire devant une structure irresponsable de la main-d'œuvre. Nous devons agir dès maintenant pour protéger nos patients. Si nous, les infirmières, ne défendons pas notre territoire, qui le fera? Soyons clair, « notre territoire » ce sont les soins aux patients, et il s'agit de la qualité et de la sécurité des soins! Nous devons agir collectivement pour renverser cette tendance dangereuse. C'est à nous de nous faire entendre afin que le public, les gouvernements, les régies de la santé, et nos collègues comprennent ce qui est en jeu.

Comment savoir qu'une restructuration de la main-d'œuvre est en cours? Les changements à l'éventail des compétences et à la composition du personnel sont les premiers signes. Pour les infirmières, cela se traduit souvent en lourdes charges de travail, en nombre excessif d'heures

supplémentaires, et en augmentation des blessures et des maladies. En 2012, les infirmières du secteur public ont fait plus de 21 millions d'heures supplémentaires, rémunérées et non rémunérées. Près de 19 000 infirmières étaient absentes du travail à chaque semaine en raison de maladie ou blessure. Cette situation est insoutenable à long terme, particulièrement si l'on tient compte de l'augmentation du nombre d'infirmières approchant l'âge de la retraite. Les infirmières autorisées (IA) représentent la majorité de la main-d'œuvre infirmière, et plus de 25 % d'entre elles ont 55 ans et plus. Entre-temps, plus de 10 000 étudiantes en sciences infirmières obtiennent leur diplôme à chaque année, mais plusieurs sont sans emploi. En 2011-2012, un peu plus de 1 000 IA se sont jointes à la main-d'œuvre. Il n'y a aucune projection publiée sur la main-d'œuvre pour la plupart des régions du pays.

Nous nous dirigeons à l'aveuglette vers l'avenir et nous pourrions, par mégarde, recréer la crise des années 1990 dans le secteur de la santé. C'est pourquoi, avant d'avoir des projections claires et fondées sur les données probantes, les syndicats infirmiers du Canada demandent aux gouvernements d'imposer un moratoire sur toute restructuration de la main-d'œuvre qui réduit les postes infirmiers équivalents temps plein. Il faut aussi offrir des emplois permanents aux nouvelles diplômées afin de maintenir en poste les diplômées de l'an dernier, et il faut adopter la même stratégie pour celles de cette année.

Pour les patients, une restructuration irresponsable de la main-d'œuvre signifie la détérioration de la qualité des soins. Selon une étude récente menée dans des hôpitaux européens, un seul patient ajouté à la charge de travail de l'infirmière fait augmenter la probabilité de décès chez les patients hospitalisés. La même étude indique que le niveau d'études des infirmières a un impact direct sur la sécurité des patients.

Les données sont claires. Les patients malades ont besoin d'infirmières éduquées et qualifiées. En qualité d'infirmières, nous ne pouvons plus nous permettre d'être complaisantes si nous voulons assurer la sécurité des patients et l'intégrité du système de soins de santé. Lorsque nous parlons

d'affecter le fournisseur de soins approprié, nous défendons collectivement la qualité et la sécurité des soins dispensés. Comme le souligne ce rapport, les soins de santé sont une industrie à haute fiabilité, similaire à l'industrie aéronautique. Personne n'oserait suggérer de remplacer un pilote par un agent de bord ou autre membre de l'équipage. De façon similaire, les infirmières devraient seulement être remplacées par des infirmières ayant les mêmes compétences.

À partir d'une série d'enquêtes sur l'augmentation des taux de mortalité au sein du National Health Service du Royaume-Uni, le Canada peut tirer des leçons sur les dangers d'une restructuration de la main-d'œuvre qui ne met pas le patient à l'avant-plan. Au R.-U., la restructuration de la main-d'œuvre s'est faite en réduisant les niveaux de dotation infirmière et en remplaçant les infirmières par des fournisseurs de soins non règlementés. Résultat : soins inférieurs aux normes et taux élevé de mortalité chez les patients. Ce document énumère les recommandations des rapports Francis. À l'échelle internationale, les infirmières ont maintenant haussé leur voix collective pour revendiquer la sécurité des soins aux patients.

Nous devons, pour tous les Canadiens, les patients et leur famille, mettre en œuvre les recommandations de *Valoriser la sécurité des patients : structure responsable de la main-d'œuvre*. Ce document stresse le fait que les « soins axés sur le patient » signifient que le patient doit être au cœur de toute prise de décision, particulièrement les décisions relatives à la restructuration de la main-d'œuvre.

Je tiens à remercier Maura MacPhee, Ph. D., professeur à l'École des sciences infirmières de l'Université de la Colombie-Britannique (UBC), pour avoir rédigé ce rapport, ainsi que le comité de révision de la FCSII composé de Beverly Balaski (SIIS), Judith Grossman (IIUA), Paul Curry (SIINÉ), Vicki McKenna (AIIO) et Carol Reichert (FCSII), pour leur importante contribution. Ce rapport ajoute aux études et données disponibles sur la structure responsable (et irresponsable) de la main-d'œuvre, et les répercussions sur la qualité et la sécurité des soins. Toutefois, en qualité d'infirmières et de

syndicats infirmiers, ne perdons pas de vue qu'il faut faire davantage. Nous ne pouvons pas nous diriger à l'aveuglette vers l'avenir et répéter la crise des années 1990 dans le secteur de la santé en raison de notre défaut d'agir.

Il faut se l'avouer, ne pas agir signifie de pas respecter notre propre *Code de déontologie*. Employés du secteur de la santé, infirmières gestionnaires et surveillantes, et infirmières dispensant des soins directs : le temps est peut-être venu de repenser aux raisons pour lesquelles nous sommes devenues infirmières et pourquoi la qualité des soins est notre principale priorité, qu'importe le secteur dans lequel nous travaillons.

Toujours solidaire,

Linda

Appendix B
Executive Summary (French)

Melanie, NP (PEINU)

Il y a plus d'une décennie, à la suite d'une commande de la part d'un groupe de travail du gouvernement de l'Ontario, des chercheurs en soins infirmiers ont analysé les besoins de la population en matière de soins de santé, et fait des recommandations, fondées sur les données probantes, pour assurer la qualité et la sécurité des soins dispensés. Le rapport de recherche met l'accent sur les pénuries imminentes de personnel infirmier pouvant prendre soin de la population canadienne, une population qui a de plus en plus besoin de soins complexes. Les orientations recommandées comprennent plusieurs stratégies pour remédier à la pénurie criante de personnel infirmier. Ils soulignent, plus particulièrement, l'importance d'une structure réfléchie du milieu de travail et de la main-d'œuvre.

Ce document est une réévaluation de la situation actuelle. Les conditions de travail des infirmières, se sont-elles améliorées? La main-d'œuvre infirmière, reçoit-elle du soutien? L'affectation des infirmières, se fait-elle adéquatement pour répondre aux besoins des patients?

Il ne fait aucun doute que les milieux de travail font une différence. De nombreuses études sur les soins infirmiers précisent les composantes nécessaires à un milieu de travail sain : excellent leadership infirmier, dotation adéquate, communications efficaces, relations de travail axées sur la collaboration, soutiens organisationnels (par exemple, développement professionnel et formation continue), et contrôle de l'infirmière sur l'exercice de sa profession.

La structure de la main-d'œuvre fait référence à la prestation des soins infirmiers. Plusieurs changements à la prestation des soins, ainsi que des initiatives de restructuration de la main-d'œuvre, ont été mis en œuvre ou sont en cours au Canada. La restructuration au sein de systèmes de soins de santé complexes doit se faire après mûre réflexion car un seul petit changement peut provoquer une réaction en chaîne et un effet de cascade. Ce document fournit des exemples de restructuration de la main-d'œuvre venant du Canada, d'autres pays du Commonwealth, des États-Unis et de l'Europe.

Un des exemples les plus médiatisés de restructuration dangereuse de la main-d'œuvre est celui du National Health Service (NHS) Angleterre, le système public de soins de santé du Royaume-Uni. Les niveaux de dotation infirmière ont été drastiquement réduits, et les infirmières ont été remplacées par des fournisseurs de soins non règlementés. Malgré les rapports continus de soins de normes inférieures et de taux élevés de mortalité, les administrateurs d'un Trust du NHS, le Mid-Staffordshire Trust, ont fait la sourde oreille. Il a fallu une enquête publique pour obtenir des changements.

Ce document met aussi en relief la restructuration responsable de la main-d'œuvre qui valorise la sécurité des patients. Cela comprend principalement la planification à l'échelle des systèmes (pour éviter les réactions en chaîne), l'engagement des principaux intervenants (y compris les infirmières, les patients et leur famille), et l'utilisation des données (afin de suivre de près les résultats).

La restructuration se fait à plusieurs paliers, souvent sous l'impulsion de décisions administratives des cadres dirigeants. Or, les décisions prises à un haut niveau hiérarchique ont un impact sur ce qui se passe au chevet du patient. Que doivent faire les infirmières qui dispensent des soins directs pour assurer la qualité et la sécurité de ces soins?

Le patient doit être à l'avant-plan. C'est cela que nous voulons dire lorsque nous parlons de soins axés sur le patient. Si nous voulons déterminer les besoins des patients en fonction de facteurs tels que l'acuité, la stabilité et la complexité, il faut utiliser des outils en temps réel pour déterminer les besoins prioritaires des patients en matière de soins. Une fois les besoins des patients déterminés, les infirmières et leurs gestionnaires doivent affecter le personnel infirmier en s'assurant de jumeler les besoins du patient aux compétences de l'infirmière. Ce document fournit des exemples d'outils, qui ont connu du succès, et qui ont été utilisés pour faciliter la prise de décisions relatives à la dotation en temps réel, dont le modèle Synergy servant à déterminer les caractéristiques des patients, et mis à l'essai dans le cadre de projets pilotes menés en Colombie-Britannique et en Saskatchewan.

Compétences infirmières signifient connaissances, habiletés, attitudes et jugement professionnel. Pour acquérir ces compétences, la future infirmière doit suivre un programme de formation accrédité et approuvé. Le niveau d'études devrait être reflété dans le champ de pratique des infirmières, et des distinctions claires devraient être établies pour chaque catégorie d'infirmières. Les différents établissements de soins de santé devraient aussi s'appuyer sur les champs de pratique pour élaborer les descriptions d'emploi ainsi que les rôles et les responsabilités du personnel infirmier. La clarté du champ de pratique, et des rôles, favorise la collaboration au sein des équipes.

Un autre problème lié à la main-d'œuvre infirmière est celui des stratégies de remplacement. En Australie, l'expression *like for like* a été adoptée dans le cadre de la convention collective des infirmières de l'État de New South Wales, dans le but d'éviter de remplacer des IA par des non IA lors d'absences non prévues, par exemple lorsqu'une personne se porte malade de façon imprévue. Lorsque cela survient, l'IA doit être remplacée par une IA. Si c'est impossible, et que le remplacement doit se faire par une infirmière d'une autre classification, l'infirmière gestionnaire doit alors considérer comment ce remplacement, par une non IA, va influencer la charge de

travail et la sécurité des patients : l'obligation de rendre compte par rapport à la sécurité de la dotation est une exigence. Au Canada, le remplacement par une personne de même compétence (*like for like*) commence à faire partie du libellé de conventions collectives, notamment celle de la Colombie-Britannique. Cette politique de remplacement est similaire à la politique et à la législation régissant le remplacement des pilotes dans l'industrie aéronautique. Le secteur de l'aéronautique et des soins de santé sont des secteurs à haute fiabilité. Ainsi, les organisations de santé à haute fiabilité doivent offrir des services très fiables, stables et efficaces afin de prévenir tout effet nuisible. Les organisations à haute fiabilité ont des mécanismes de vérification de la qualité et de la sécurité leur permettant de réduire les erreurs humaines. Dans l'industrie aéronautique, grâce aux politiques rigoureuses de remplacement des pilotes, le bon pilote se retrouve dans le bon aéronef au bon moment. Le libellé de remplacement par une personne ayant les mêmes compétences *(like for like)* permettra de mettre en place des mécanismes similaires de contrôle de la qualité et de la sécurité dans le secteur des soins infirmiers.

Dans plusieurs pays du monde, les conventions collectives, les politiques relatives aux soins infirmiers et la législation connexe illustrent bien comment les infirmières accordent de l'importance à la sécurité des patients. Les changements les plus marqués par rapport à la sécurité nous viennent du NHS Angleterre, et de la restructuration de la main-d'œuvre qui s'est amorcée à la suite de l'enquête publique Mid-Staffordshire. Le NHS Angleterre a récemment commencé à réinvestir dans les IA après avoir éliminé leurs postes pendant plusieurs années. Les hôpitaux du NHS doivent maintenant maintenir des niveaux de dotation fondés sur les données probantes, et soumettre des rapports, destinés au public, sur les niveaux de dotation.

Ce document peut vous sembler une répétition de la même rengaine. En 2012, Berry et Curry ont rédigé un document pour la FCSII sur les données (et les orientations recommandées) liées à la charge de travail du personnel infirmier et aux soins aux patients. Il y a un lien très étroit entre les niveaux sécuritaires de dotation infirmière, les charges de travail du personnel infirmier, les milieux de travail saine et la structure ou restructuration de la main-d'œuvre. Ensemble, le document de Berry et Curry, ce document-ci et plusieurs autres rapports sur les soins infirmiers devraient être un signal d'alarme pour inciter à utiliser les données de façon à réellement favoriser la sécurité des patients.

Appendix C
Recommendations (French)

1. Les outils d'évaluation des besoins des patients (par exemple, le modèle Synergy) doivent être utilisés pour déterminer les besoins des patients en se basant sur les données probantes, et pour favoriser la collaboration entre les infirmières et les infirmières gestionnaires lors de la prise de décisions relatives à la dotation, en temps réel, et d'un quart de travail à l'autre.

2. Les organisations de santé et leurs cadres dirigeants doivent déployer des efforts pour créer des milieux de travail de type *Magnet* et, ainsi, favoriser la meilleure prestation possible de soins sûrs et de qualité. Les milieux de type *Magnet* sont reconnus pour leur leadership infirmier efficace à tous les paliers de l'organisation (premières lignes, cadres intermédiaires, cadres supérieurs), le travail d'équipe axé sur la collaboration, la pertinence de la dotation, l'efficacité de la communication, et le contrôle pouvant être exercé par l'infirmière sur sa pratique (autonomie clinique, gouvernance partagée).

3. Lorsque les besoins des patients ont été déterminés, les besoins en matière de soins doivent être déterminés en se basant sur le niveau de scolarité, les qualifications et les compétences des infirmières. Les champs de pratique des infirmières devraient faire une distinction claire entre le niveau de scolarité, les connaissances de base et les compétences des trois groupes d'infirmières réglementées.

4. Une fois les qualifications et les compétences de l'infirmière jumelées aux besoins particuliers des patients, les infirmières devraient seulement être remplacées par des infirmières ayant le même niveau d'études, les mêmes qualifications et compétences. La politique de remplacement par une personne d'égale compétence et qualifications (like for like) assure le remplacement des IA par des IA, le remplacement des IAA par des IAA, et le remplacement des infirmières psychiatriques autorisées par des infirmières psychiatriques autorisées.

5. La formation sous-jacente au champ de pratique des infirmières doit se faire dans le cadre de programmes approuvés, offerts dans des établissements accrédités.

6. Le remplacement d'une infirmière par une infirmière qui n'a pas les mêmes compétences devrait rarement se faire (par exemple, lors d'un nombre inhabituel d'infirmières téléphonant pour dire qu'elles sont malades). Remplacer les fournisseurs de soins par des fournisseurs d'une classification différente (une IAA remplaçant une IA) ne devrait pas être la solution typique pour assurer la dotation adéquate. Si cela survient, l'infirmière responsable devrait alors documenter les faits à l'appui de cette décision et fournir des preuves selon lesquelles la sécurité des patients n'est pas compromise.

7. La clarté du champ de pratique permet d'éviter la confusion des rôles, la fragmentation des soins et une mauvaise utilisation du personnel infirmier. Les organismes de réglementation, les syndicats et les personnes chargées des programmes de formation en sciences infirmières devraient collaborer pour assurer la clarté des champs de pratique.

8. La clarté du champ de pratique et des rôles doit être reflétée dans les politiques de l'employeur et les descriptions d'emploi. Ces documents doivent préciser les distinctions, en matière de règlementation et de formation, entre les IA, les IAA et les infirmières psychiatriques autorisées, ainsi que les distinctions entres les fournisseurs de soins réglementés et non réglementés.

9. Les patients et leur famille doivent être présents, avoir du pouvoir, et participer aux initiatives visant l'amélioration de la qualité et de la sécurité, à tous les paliers du système de soins de santé.

10. Les données normalisées sur les événements indésirables liés aux soins infirmiers (par exemple, indicateurs des facteurs liés aux soins infirmiers, notamment structure des soins, processus de soins, résultats des soins) doivent être recueillies et signalées, et il faut agir en temps opportun s'il y a lieu. Ces données devraient être transparentes et d'accès public.

11. Les données sur la prestation des soins, notamment les niveaux de dotation et la composition du personnel, doivent être d'accès public afin d'assurer la transparence et la responsabilisation de l'organisation. Les données sur les événements indésirables liés aux soins infirmiers au sein des unités doivent être comparées aux données sur la prestation des soins.

12. Il faut avoir, à tous les paliers de l'organisation, des examens officiels réguliers des données administratives (par exemple, heures supplémentaires, absentéisme, postes vacants, niveaux de dotation), et des données sur les événements indésirables liés aux soins infirmiers. Les gestionnaires infirmiers de tous les paliers doivent participer à ces examens et avoir l'autorité d'adapter la prestation des soins afin d'assurer des soins sûrs et de qualité, axés sur le patient.

13. Le processus d'examen des formulaires de responsabilité professionnelle et des rapports d'incidents doit être amorcé dans un délai fixé, et les recommandations doivent aussi être mises en œuvre dans un délai fixé.

"You can have the best educated and most experienced nurses in the world in place in a care setting, but spread them too thinly, put them in the wrong environments with poor relationships with health care workers from other disciplines and without support from their managers and supervisors, and not only will you see problems with quality of care, but you will also watch the work take an unnecessary toll on those nurses' physical and mental health."

Dr. Sean Clarke
Director, McGill Nursing Collaborative
McGill University

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