

Experts & Evidence *Opportunities in Nursing*

Canadian Federation
of Nurses Unions



Jane Coutts

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The Nursing Workforce: A Snapshot

Nurses are the largest group of regulated health professionals in Canada. As of 2008, there were 261,889 registered nurses (RNs), 74,380 licensed practical nurses (LPNs), and 5,162 registered psychiatric nurses (RPNs) working as nurses in Canada.

- 11.1% of RNs, 18.6% of LPNs and 16% of RPNs worked in rural or remote settings or in the North.
- Nurses comprise one third of the Canadian health care workforce and their numbers are growing: the nursing workforce has increased by about 5% since 2005.

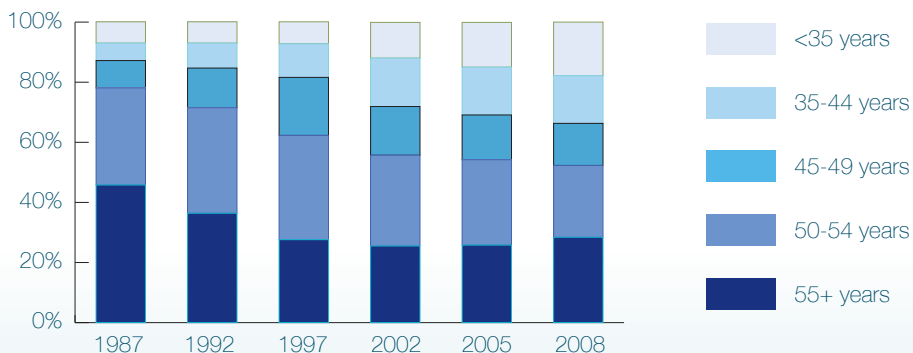
The Canadian Institute for Health Information (CIHI) study, *Regulated Nurses: Canadian Trends, 2004-2008*, reported that in 2008:

- There were 341,431 regulated nurses working as nurses in Canada.
- 63% of RNs worked in the hospital sector and 14% worked in the community health sector. 89.1% worked in direct patient care (as opposed to administration 6.6%, education 3.6%, and research 0.8%).
- 46% of all LPNs were employed in hospitals and 39% were employed in nursing homes and long-term care. 98.5% worked in direct patient care (as opposed to administration 0.8%, education 0.7%, and research less than 0.1%).
- RPNs worked mostly in the hospital sector (41%), while 26.5% were employed in the community health sector and 19.6% in nursing homes. 90.7% worked in direct patient care (as opposed to administration 6.4%, education 2.8%, and research 0.1%).

Sources: Canadian Institute for Health Information. (2008). *An up-close look at seven major health professions*, http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_01dec2008_e

Statistics Canada. *Labour Force Survey*. Ottawa: Statistics Canada, 2009.

Public Sector Nurses by Age, 1987-2008



Source: Lasota, M. (2009). *Trends in own illness or disability-related absenteeism and overtime among publicly-employed registered nurses: Summary of key findings*. Prepared for Canadian Federation of Nurses Unions by Informetrica Ltd.



Message from Linda Silas, president of the Canadian Federation of Nurses Unions

On behalf of Canada's nurses, I would like to applaud governments and all health care stakeholders for the extensive amount of work that has been accomplished over the past decade to benefit nursing practice. During this time, millions of dollars have been directed towards initiatives that promote education, innovation and research in order to improve the delivery of health care. Nursing as a profession has benefited tremendously from this, and by extension, so has the health of Canadians.

In the last ten years we have seen high-quality nursing research produced thanks to the Canadian Nursing Advisory Committee, the Nursing Sector Study, health research foundations across the country, and academic institutions among others. Research is an ongoing requirement for quality care and must be sustained over time. Now is not the time to stop! Thanks to the great deal of nursing research and innovation within Canada alone, we now have evidence that increasing nursing care is making a difference both to the cost effectiveness of health systems and to patient safety. You will read examples of such research in this publication, as a selection of Canada's leading nursing researchers talk frankly about the state of nursing in Canada and, from their perspective, what their research tells us the prescriptions for the future should entail.

Unfortunately, research also tells us that many nursing workplaces are in crisis: they are understaffed and overstretched; nurses face higher rates of violence than prison guards; rates of overtime and absenteeism are rampant and significantly higher than the Canadian average... and so the list continues.

Today, many nursing work environments are confronted by the impact of restructuring imposed by external consultancies that have the bottom line as their mandate. It is at times reminiscent of the approach to restructuring in the 1990s – where administrative priorities focused on restructuring through cost reduction at a grave cost to patients.

For years, provincial, national, even international nursing organizations have been urging government and health administrators to heed existing evidence that links nursing care to better patient outcomes as well as balanced budgets. We as nurses unions have to speak up. Simply put, it is dangerous and costly to attempt to balance budgets on the backs of nursing and, ultimately, patient care. We as nurses have to speak up when nursing hours are reduced in spite of evidence that says it is dangerous to do so. We have to speak up when we see the workers with no patient care training, taking care of patients.

Do not read this as a means of discounting innovation. We applaud nursing researchers who create, test, and evaluate innovations in the field. When we do find innovations with promise we must implement them with caution. The workplace is where innovations take shape and have the greatest impact. The workplace is where broad and meaningful consultation (from CEOs to the frontline) must take place prior to any practice changes.

A Culture of Safety

A healthy workforce is a prerequisite to effective care. Practice environments with a strong culture of safety help keep nurses safe and on the job, which in turn improves patient care.

A culture of safety is about:

- Shared commitment of administration, management and employees to ensure a safe work environment where the safety of patients and health care workers is paramount.
- Attitudes and customs of a workplace that determine the impact of programs, policies and safe work procedures.
- A frame of mind where safety is at the forefront of everything that is planned, prepared and actioned.

Source: CFNU & Ontario Nurses Association. *A Culture of Safety: A must for pandemic preparedness*. Presentation to the 24th Quadrennial Congress of the International Council of Nurses, June 30, 2009.

CFNU values collaboration to strengthen the nursing profession and ultimately patient care. By working with academia, government, employers and organizations, we are doing everything we can to ensure that nursing workplaces are innovative, safe and supportive environments. As health care professionals, we have an immense responsibility to protect our patients and their families by providing safe and high-quality care. Therefore, we must be vigilant to ensure that policies which impact patient care are informed by research evidence, ongoing dialogue with frontline health care providers of all disciplines, and, of course, common sense.

Over the past several years, in conjunction with Health Canada, provincial governments, nurses organizations and health care employers, CFNU has been leading applied research initiatives across the country through the project Research to Action. By analyzing research and putting findings into practice, we are implementing and testing a number of positive practices designed to improve practice environments for nurses and patients. We must continue to apply the evidence we have already gained and direct research towards practical applications that can make permanent and positive differences to practice environments today.

I would like to thank Jane Coutts, the author of this document, for her hard work, and the nursing experts profiled within for their dedication to nursing and input into this paper. My appreciation also goes to the National Executive Board of the CFNU and our advisory committee – Vicki McKenna (ONA), Amber Alecxe (SUN), and Deb Stewart (MNU) – for their guidance and vision on this project.

Nurse-Patient Ratios: Report from Victoria, Australia

A 2004 report by the Australian Centre for Industrial Relations found that more than 50% of nurses will resign, retire early or reduce their hours if nurse-patient ratios are abandoned. The report concludes that:

Ratios have contributed to a major improvement in patient care and working life. The ratios have helped stabilise a difficult situation in the Victorian public health system. Any removal of the ratios is likely to result in the system slipping from a 'stable, but critical' condition, to one of chronic crisis.

Source: Buchanan, J., Bretherton, T., Bearfield, S., & Jackson, S. (2004). *Stable, but critical: the working conditions of Victorian public sector nurses in 2003*, Report by the Australian Centre for Industrial Relations for The Australian Nursing Federation (Victorian Branch). Accessed at: <http://www.anvic.asn.au/about/infopages/3004.html>

Any change to practice environments must be subject to a comprehensive and ongoing framework of consultation – including nursing leaders of all backgrounds: employers, government, academia and nurses unions. This would ensure that new ideas receive the consideration they deserve within an evaluative context that would consider both evidence and stakeholders. Only with all of us working together can we reinvigorate the workplace, bringing those ideas of today into the nursing practice environments of tomorrow.



Linda Silas

President of The Canadian Federation of Nurses Unions

Canadian Federation of Nurses Unions Member Organizations

Newfoundland & Labrador Nurses' Union	NLNU
Prince Edward Island Nurses' Union	PEINU
Nova Scotia Nurses' Union	NSNU
New Brunswick Nurses Union	NBNU
Ontario Nurses' Association	ONA
Manitoba Nurses Union	MNU
Saskatchewan Union of Nurses	SUN
United Nurses of Alberta	UNA
British Columbia Nurses' Union	BCNU
Canadian Nurses Students' Association	CNSA



Message from Dr. Judith Shamian, president of the Canadian Nurses Association

Experts and Evidence: Opportunities in Nursing is an outstanding exemplar of how research can be turned into knowledge and advice for decision-makers, policy-makers, elected officials and health care executives. Further, this synthesis of research on the impact of nursing on health care is a reminder of what kind of powerful information we can have as a result of Canada's investment in research. Two decades ago, we relied on research from member countries of the Organisation for Economic Co-operation and Development. Now, because of the foresight of federal, provincial and territorial research foundations, along with broader research funding, Canada's world-class scientists are providing evidence that can be used to benefit not only patients, providers and health care systems, but also the governments that constitute the main funders of those systems.

Nurses bring enormous benefits to both patients and the Canadian health care system when they have a positive environment in which to practise their profession. Recent excellent research guides us on what it takes for nurses to make a difference, improve care and reduce costs. The Canadian Nurses Association (CNA) congratulates the Canadian Federation of Nurses Unions (CFNU) for bringing, through *Experts and Evidence*, key information to the public and to Canada's health ministers on what makes an effective and sustainable health system.

CNA's own research, *Tested Solutions for Eliminating Canada's Registered Nurse Shortage* (2009), supports the conclusions that we must stop driving nurses out of the workforce and even out of the country, and that there are solutions for eliminating the shortage. In 2010, CNA, jointly

with the Registered Nurses' Association of Ontario, published another research study, *Nurse Fatigue and Patient Safety*. This report tells a compelling story of administrators and nurses trying to do the best they can but nurse fatigue continues to grow – to the point of increasing the risk to patient safety. Nurse fatigue is particularly distressing when we know that, in 2008, registered nurses in Canada reported working paid overtime that amounted to \$713.8 million (Canadian Federation of Nurses Unions, *Trends in own illness or disability-related absenteeism and overtime among publicly-employed registered nurses*). This is the equivalent of more than 8,000 full-time positions – ones that would relieve nurses' fatigue and increase the quality of practice environments. The fatigue research echoes many of the solutions proposed in *Tested Solutions for Eliminating Canada's Registered Nurse Shortage* – which are further highlighted by leaders in nursing practice, research and education with this new publication by CFNU.

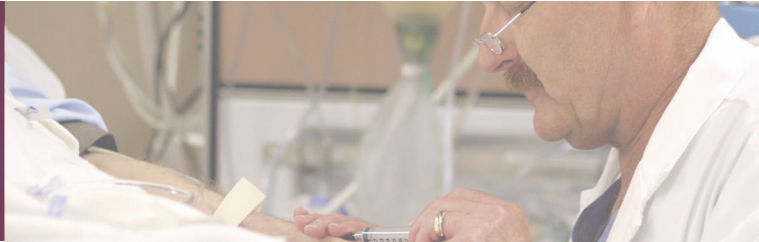
Concern for the best use of nursing resources in today's economic climate is the talk of health-care leaders across Canada – including nurses. *Experts and Evidence: Opportunities in Nursing* is a significant and excellent contribution to the national dialogue that Canada is having on nursing care delivery models. This collective effort is also another demonstration of how important it is for unions, academics, policy-makers, government officials, and health care and nursing executives to hammer out optimal solutions for achieving the best possible patient care and financial outcomes.

As the largest group of health care professionals in Canada, nurses stand on guard around the clock, every day of the year, for the well-being of Canadians. I hope that premiers, ministers of health, ministers of finance, deputies and many others pay serious attention to the solutions offered here.

CNA joins with CFNU in calling on health and political leaders to enhance nursing resources for a more effective health system. The evidence is clear: cuts to nursing are cuts to quality of care, and they actually increase costs to the system. Enhancing nursing will reduce adverse events, shorten length of stay, lower health care costs and bring positive solutions to issues of timeliness and access to care.

A handwritten signature in black ink, reading "Judith Shamian". The signature is fluid and cursive, with the first name "Judith" being more prominent than the last name "Shamian".

Dr. Judith Shamian
President of the Canadian Nurses Association



Introduction

These were supposed to be good years for nursing. After the downsizing and deskilling and restructuring of the 1990s, the message seemed to be getting through. Patients need nurses. One on one, yes, but also, inarguably, as a profession. The evidence was being carefully, meticulously assembled: care provided by educated, experienced nurses is better for patients, for organizations, for the health care system and for society as a whole. Care by nurses:

- reduces mortality
- reduces infections
- reduces hospital stays
- means fewer patients come back in a few days or weeks for the same problem
- leaves patients more satisfied

Nurses are at the heart of care, and themselves experts in evidence. During the past decade, as research into nursing continued to establish its benefits, the profession, for a time, seemed to be confirming its role as an essential part of collaborative health care teams.

As you'll see in the pages that follow, during the first decade of this century, nursing education was being rethought, to prepare life-long learners who understand that their profession will be a journey through knowledge, with patients and families and communities. Delivery of care is being rethought too, as the need for innovation and the imperative to benefit from nurses' knowledge and insights is leading employers to look for ways to turn every nurse into an innovation incubator.

During the same years, researchers, planners and administrators have been working together to create better practice environments for nurses — workplaces where their bodies won't get so sick and tired and hurt, and where their spirits won't burn out. Evidence has been accumulating: nurses need secure, full-time work; nurses need strong, supportive leadership at every level; nurses need to feel control over their work; nurses need to feel rewarded; nurses need to be part of teams; nurses need to feel valued. And after a decade of work, the evidence is there to show that work environments like that can be created.

But the evidence is also there to show that there are still not enough full-time jobs and there is still not enough job security, and as budgets come under pressure, new tactics are on the rise, like eliminating vacant jobs, and arbitrarily redefining needs, so that there is no official shortage of staff. Mandatory, often unpaid, overtime is increasing. Scrambles to reorganize new, smaller departments for new, smaller budgets are disrupting teams where collaborative team work was already a hit-and-miss affair.

Nursing is a target again, the low-hanging fruit to be taken first, again. But it's a different profession than it was in the 1990s, its work more advanced, its foundations well-established in science, its place in successful health care clear — as part of the team, at the forefront of innovation, the essence of supportive care for patients. This isn't the sentimentality of previous generations. This is fact. And we invite you to read for yourself about the research and practices that have transformed the value of nursing.

Canadian Patient Safety Institute

Patient safety is a major concern of the general public and all health care stakeholders. Research shows that higher RN ratios are associated with better patient outcomes, including fewer deaths, pressure ulcers, cases of pneumonia, post-operative infections, urinary tract infections, gastrointestinal bleeds and cardiac arrests. Higher RN ratios also lead to shorter lengths of stay, decreased failure-to-rescue rates, better organization and improved budgetary outcomes.

In an effort to understand the true financial costs of adverse patient events in Canada, CPSI is supporting research to explore the "economic implications" associated with patient safety. The economic value of programs which enhance the use of best practices will also be examined. The project, entitled The Economic Burden of Patient Safety, should be completed by June 2011.

Source: Canadian Patient Safety Institute. *How much do adverse events cost? Focused research to determine the economics of patient safety in Canada.* News release, June 7, 2010.



Canada's Nurses — Missing from Action

Researchers, administrators and planners go over the numbers again and again: this many working nurses, this many students, these ages, these options — to move, to quit, to retire, to take a different course in school. It adds up, inexorably, to a frightening total. A 2009 research report, commissioned by the Canadian Nurses Association and led by Dr. Gail Tomblin Murphy, predicts that Canada will have a shortage of 20,000 nurses by 2012, and up to 60,000 by 2022. Thousands and thousands of nurses needed to look after Canadians are not there.

Linda O'Brien-Pallas, a leading researcher in needs-based health human resources planning, says this didn't have to happen. "Planning is done, and put on a shelf, and never looked at again until the next crisis," she says. "Planning should be ongoing, repeated every time there is a shift — in people, in illness patterns...we could have the appropriate number of nurses to go where they are needed."

However, the unfortunate truth is, she says, "short-term realities trump HHR planning every time."

At a time when health care decisions seem to be based solely on budgets, and skill mix changes are being implemented blindly, it's worrisome that patient and nurse-positive outcome research, as well as serious concerns around role clarity and team work, have not made it to the planning table.

Vicki McKenna, First Vice President, ONA

Dr. O'Brien-Pallas, a University of Toronto professor and a co-investigator and co-founder of the Nursing Health Services Research Unit, does have plenty of ideas of how to attract and keep nurses.

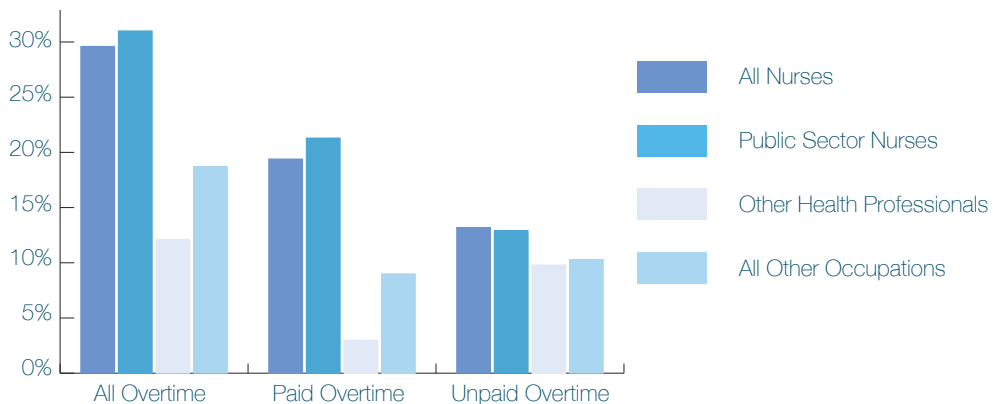
Much of her research has focused on the toll the work takes on nurses' health. She and her colleagues have shown that where nurses are healthier, patients do better, and nurses are healthier when they have a manageable workload and are not too tired (which means enough staff that they don't have to work hours of overtime). Like other professionals, nurses are healthier when they feel they have control over their work, when they have strong leadership and when workplace communication is good.

"I think a healthier workplace is one where workers speak openly to managers and know they have the senior management team's attention. I'm not saying they should all go and talk to

Overtime

In 2008, registered nurses in Canada reported working paid overtime that amounts to \$713.8 million. This is equivalent to more than 8,000 full-time positions.

Reported Overtime, Nurses and Those in Other Occupations, 2008, Annual Average



Source: Lasota, M. (2009). *Trends in own illness or disability-related absenteeism and overtime among publicly-employed registered nurses: Summary of key findings*. Prepared for Canadian Federation of Nurses Unions by Informetrica Ltd.

the CEO individually, but I think the CEO should be close enough to the ward to know what nurses are saying.”

Few Canadian hospitals offer nurses those ideal conditions, however. If they did, it seems unlikely there would be an average annual turnover among hospital nurses of 19.9% — which is what Dr. O’Brien-Pallas and her colleagues at the nursing research unit found in their sweeping study of nursing turnover.

That study, completed in 2008, estimated that each “voluntary termination” costs an employer an estimated \$25,000, says Gail Tomblin Murphy, a professor of nursing at Dalhousie University in Halifax and co-investigator on the study with Dr. O’Brien-Pallas.

“There are these huge direct and indirect costs for each nurse who turns over,” says Dr. Tomblin Murphy. The biggest direct cost is hiring temporary replacements for nurses who have left, but recruiting and teaching add to it; the largest of the indirect costs is lost productivity, since it takes eight weeks, on average, for a new hire to be fully up to speed on the job.

But the study showed turnover has even more serious non-monetary costs, because it disrupts communication and often leaves workers uncertain about who is doing what, and what their

Linda Aiken: Nurse-Patient Ratios

In 2004, California became the first state to implement minimum nurse-to-patient staffing requirements in acute care hospitals.

Research published in 2010 (led by Dr. Linda Aiken) demonstrates that:

Hospital nurse staffing ratios mandated in California are associated with lower mortality and nurse outcomes predictive of better nurse retention in California and in other states where they occur.

In addition:

When nurses’ workloads were in line with California-mandated ratios..., nurses’ burnout and job dissatisfaction were lower, and nurses reported consistently better quality of care.

Source: Aiken, L.H., Sloane, D.M., Cimiottie, J.P., Clarke, S.P., Flynn, L., Seago, J., et al. (2010). Implications of the California nurse staffing mandate for other states. *Health Services Research*. 45(4). 904-921.

own responsibilities are. And that leads to mistakes. The study found medical errors were 38% more likely for each 10% increase in the turnover rate.

“Where there isn’t clarity about people’s roles, and people aren’t working well in teams, care is not well-coordinated and there are increased medical errors,” Dr. Tomblin Murphy says. In contrast, on units with teams that have strong leadership and work well together, patients have shorter stays and fewer must return to hospital for the same problem.

It’s important to note that turnover of a position doesn’t always mean the loss of a nurse; in fact, the study by Dr. O’Brien-Pallas, Dr. Tomblin Murphy, Dr. Shamian and colleagues found that about 56% of nurses who left positions moved to another job in the same organization. But Dr. Tomblin Murphy believes the impact of those changes is underestimated. While the nurse’s skills and education time are not lost to the hospital, there are still costs to fill the position and the same issues of disruption, lost productivity and team breakdown.

Nurses who do leave the country have been the focus of recent research by Linda McGillis Hall, associate dean of research and external relations at the University of Toronto’s Faculty of Nursing.

There are 20,000 Canadian nurses working in the United States — a drop in the bucket compared to the country’s nursing population but enough to make a significant difference to

Close to two thirds of study participants indicated that the opportunity for full-time employment was the key incentive that North Carolina hospitals used to recruit Canadian nurses. Other important incentives included relocation assistance, salary incentives, career advancement opportunities, innovative scheduling strategies, signing bonuses, education subsidies and organizational reputation for good physician-nurse relationships.

...this study also highlights the importance of a hospital administration that supports and values its nurses. This finding is evidenced by flexible schedules that accommodate nurses’ needs, career advancement and continuing education opportunities, adequate staffing levels, control over practice and managers who listen to nurses’ concerns. An organizational climate that fosters good relationships with medical staff and collegiality and mentorship with peers are reasons for many of Canada’s nurses to remain in the United States.

McGillis Hall et al. (Gone south: Why Canadian nurses migrate to the United States)

Canada's nursing shortage if they had stayed. Dr. McGillis Hall is conducting a far-reaching study of 3,500 Canadian nurses working in the U.S., to find out why they left home — because, unless we understand why they left, we are unlikely to persuade others to stay.

In order to retain nurses, McGillis Hall says, "We want to focus on policies and initiatives... that have some teeth," she says. To prepare for the national study, she did a pilot project with colleagues at the University of North Carolina. Some 1,400 Canadian nurses work in the state and 678 responded to the survey.

The results show North Carolina to be a land of opportunity for Canadian nurses. Their number one reason for emigrating was to find full-time work, and another McGillis Hall study (comparing Canadian-educated registered nurses working in the U.S. with their American counterparts and Canadians working in Canada) shows they find it: in 2004, 51% of RNs working in Canada were working full time; in the U.S., 74% of Canadian-educated nurses were working full time.

Access to Full-Time Work

The Canadian Nursing Advisory Committee (CNAC) recommended a 70:30 ratio of full-time to part-time positions as optimum. CIHI reports that 42% of RNs and 51% of LPNs work in casual or part-time positions. There are substantial numbers of nurses who work for multiple employers (47,772 LPNs and RNs). Nurses who work in part-time or casual positions for multiple employers may exceed the number of hours full-time nurses work, but are unlikely to receive overtime rates.

- 31% of RNs and 34.6% of LPNs work in part-time positions; 10.8% of RNs and 16.4% of LPNs work in casual positions.
- There are 4,475 LPNs and RNs unemployed or working in fields other than nursing currently seeking employment in nursing.
- Increasing regular hours and full-time work has the potential to enhance continuity of care and reduce costs related to overtime and staff turnover. Two letters of understanding (in a recently adopted collective agreement between Alberta Health Services and the United Nurses of Alberta) commit to maintaining RN staffing levels and to hiring 70% of the province's new graduating RNs, helping to stabilize the workforce while providing more certainty for nurses and for patients.

Sources: Canadian Institute for Health Information. (2010). *Regulated Nurses: Canadian Trends, 2004-2008*, Updated February 2010. Ottawa: CIHI.
<http://www.una.ab.ca/negotiations/>

But they also go for more rewarding careers. There are more advanced-practice nursing jobs in the United States. There are nurse practitioners in Canada, but there are more of them, often doing more far-reaching work, in the United States. The U.S. also has had nurse-anesthetists for some time; Canada is just introducing a similar role: nurse practitioner in anesthesia. The scope of work for nurses in oncology, cardiology and specialties such as crisis teams can be much broader in the U.S. as well.

American employers also seem to value their nurses more, those surveyed said. They pay for membership for their employees in professional associations and offer plenty of opportunities for education and professional development. Nurses also said their input was important to their employers.

Of course, many of the Canadians working in the United States went there because there were layoffs and no new jobs opening in Canada at the time — a situation that's arising again, as budgets tighten. Some who would like to come back said they didn't trust a Canadian job to last, and others doubted their experience and skills would be fully acknowledged and put to use in a Canadian hospital.

Patient Safety

The World Health Professions Alliance Fact Sheet on Patient Safety reports that:

- Inadequate human resources present a serious threat to the safety and quality of health care.

They urge:

- Health professionals to take an active role in assessing the safety and quality of care in practice;
- Health care facilities to maintain adequate human resource levels; and
- Governments to develop evidence-based policies that will improve health care; mechanisms (e.g. accreditation) to recognize the characteristics of health care providers that offer a benchmark for excellence in patient safety.

The World Health Professions Alliance includes the International Council of Nurses, International Pharmaceutical Federation, and the World Medical Association.

Source: The World Health Professions Alliance. (2002). *Patient Safety World Health Professions Alliance Fact Sheet*. France: Author. Available from: <http://www.icn.ch> or <http://www.whpa.org>.

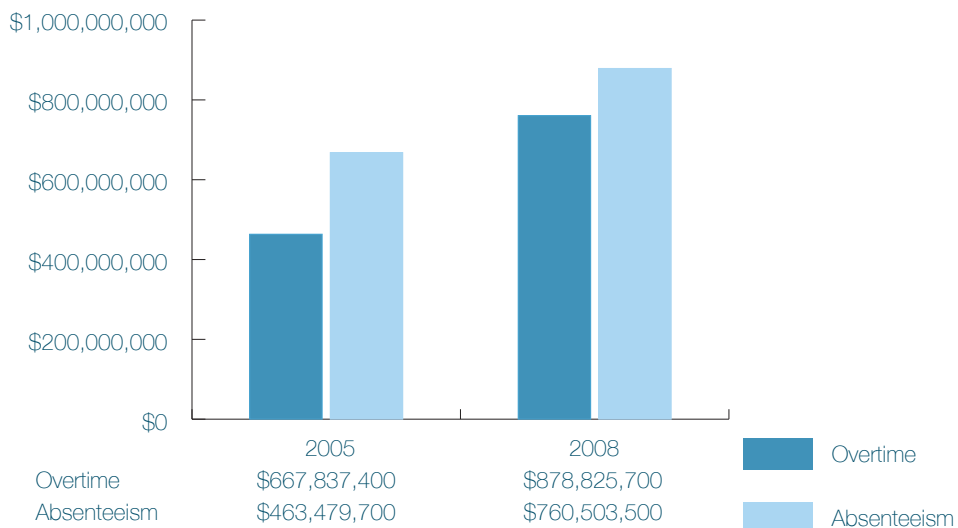
“We have to do something to change the image and perception they have that we don’t value them,” says Dr. McGillis Hall. “Let’s recognize how much the U.S. values them and let them know we do too.” There are some pretty basic things Canada could do to keep nurses working here, she notes, starting with giving them full-time, long-term jobs.

More difficult — but clearly not impossible, since at least some Canadian and U.S. employers manage — is to build an environment where careers flourish and nurses work collaboratively within multi-disciplinary teams. Professional development, education and a voice in workplace issues are also all known to attract and keep nurses on the job, Dr. McGillis Hall says.

In fact, study after study draws the same conclusions: patients do better and nurses work well when the working environment offers control, reward, strong leadership and stability. Will short-term realities keep on trumping that?

Not inevitably, according to Andrea Baumann, Dr. O’Brien-Pallas’s counterpart as director of the Nursing Health Services Research Unit’s McMaster University site. The research unit’s

Estimated Cost of Absenteeism Due to Own Illness or Disability and Overtime Public Sector Nurses, 2005 and 2008



Source: Lasota, M. (2009). *Trends in own illness or disability-related absenteeism and overtime among publicly-employed registered nurses: Summary of key findings*. Prepared for Canadian Federation of Nurses Unions by Informetrica Ltd.

work over the years shows considerable improvement in some of the problem areas they have identified in the past. Hiring practices are better, and careful orientation of new graduates to their permanent jobs is the norm now. In some jurisdictions, better equipment has cut down the number of injuries nurses get on the job.

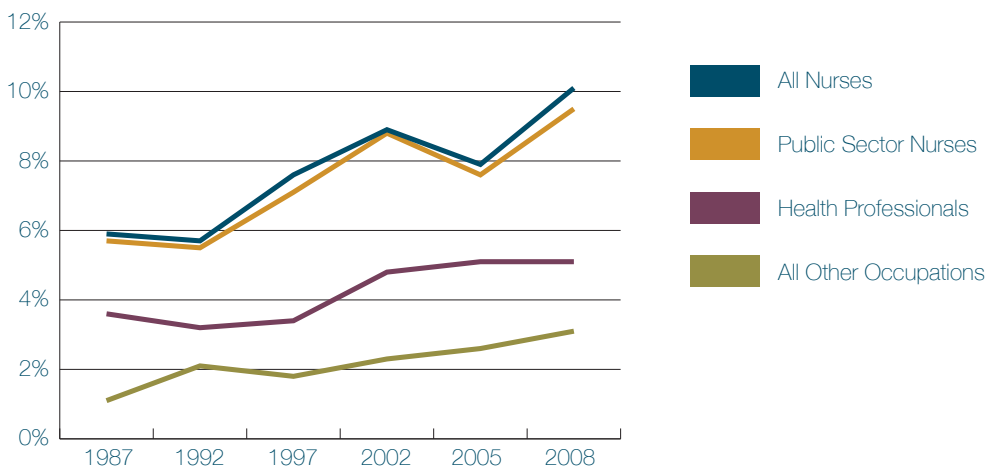
Still, multi-disciplinary education is far from universal, which doesn't help build collaborative practice, particularly in the larger hospitals where communication among disciplines and units remains a problem, Dr. Baumann says.

"In the clinical areas, I think there's a lot more respect for nurses, but the problem is, it's variable, unit by unit, and in some they have excellent working relationships, and in others it's really not there."

However, working conditions and job security are not improving in community care which is mostly provided by private companies who compete for government contracts, Dr. Baumann says.

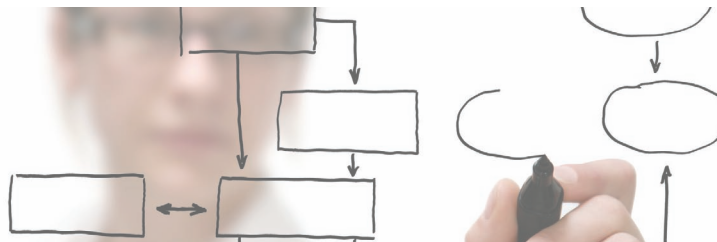
Rate of Own Illness or Disability-Related Absenteeism Full-Time Employees

Average Weekly Rate of Own Illness or Disability-Related Absenteeism, Selected Years



Note: The last two intervals are only three years rather than the previous intervals of five years.

Source: Lasota, M. (2009). *Trends in own illness or disability-related absenteeism and overtime among publicly-employed registered nurses: Summary of key findings*. Prepared for Canadian Federation of Nurses Unions by Informetrica Ltd.



Workplace Warning: What Does It Take to Keep Nurses on the Job?

We see the stories in the news again and again — mining disasters, industrial accidents, crashes — where one red flag after another was ignored, whether it was an exhausted crew, an official report warning of dangers, money worries driving pressure to produce. And the response was to do nothing, or to say there's nothing we can do. And then the disaster, the accident, the crash.

Nursing in Canada could be headed the same way, according to Victor Maddalena, an assistant professor of health policy and health service delivery at Memorial University in Newfoundland and Labrador. A former intensive care nurse and hospital administrator, he knows the problems of both his profession and the health care system. And they are serious.

“In the workplace right now, the demands far exceed the capacity for nurses to meet those demands,” he says. Units are consistently seeing capacity over 100%. “Rather than reducing capacity, they are simply taking nurses and running them harder,” Dr. Maddalena says.

While more research is needed, our work to date suggests that a comprehensive systems approach to promoting a climate of safety, which includes taking into account workplace organizational factors and physical and psychological hazards for workers, is the best way to improve the health care workplace and thereby patient safety.

Dr. Annalee Yassi, Chair, Scientific Committee on Health Care, International Commission on Occupational Health, and Professor, University of British Columbia

How much harder? It's becoming more common to have nurses — even in intensive care — work 24-hour shifts, their scheduled 12 hours and then 12 overtime hours, back to back. It's an extremely dangerous practice, Dr. Maddalena says. "If you were a pilot, or a long-haul truck driver, or operating heavy machinery, we would have no qualms whatsoever about saying that is unsafe," he says. The 24-hour shifts, he thinks, are a clear sign that strategies to compensate for Canada's nursing shortage are not working.

Nurses feel compelled to take the shifts, he says, because there is no one else to do it, though they know both that these shifts aren't safe for patients or nurses and that they result in fatigue, burnout and stress — problems that can lead to poor-quality care and often make nurses quit.

At a time when Canada and countries around the globe are facing a massive nursing shortage and the need for care keeps increasing, neither result should be tolerated. Working conditions in many organizations are preventing nurses from doing their work well, and many are suffering

Nurse Fatigue and Patient Safety Research Report

The Nurse Fatigue and Patient Safety Research Report, produced by the Canadian Nurses Association (CNA) and the Registered Nurses' Association of Ontario (RNAO), draws attention to the rising levels of nurse fatigue due to heavy workloads with ever-increasing cognitive, psychological and physical work demands. The report defines nurse fatigue as a multidimensional, subjective feeling of tiredness experienced by nurses that interferes with individuals' physical and cognitive ability to function to their normal capacity. Over 6,300 registered nurse participants were surveyed across Canada. Findings demonstrate that:

- 25.5% of participants had a second position, either on a casual, part-time permanent or temporary basis, and reported working up to 40 hours per week in the second position.
- 11.4% of participants reported having 8 hours or less between shifts.
- 55.5% of participants almost always felt fatigued during work and 80% almost always felt fatigued after work. Yet, 85.1% of nurses indicated that they almost never missed work due to fatigue.
- 90.4% indicated that their organization had not developed policies to address fatigue.

The research spotlights this rising problem and identifies specific solutions at the system, organizational and individual levels to guard against unsafe patient situations and to prevent the loss of nurses from the profession.

Source: Canadian Nurses Association & Registered Nurses' Association of Ontario. (2010). *Nurse fatigue and patient safety: Research report*. Ottawa & Toronto: Authors. Available from: <http://www.cna-aic.ca> and <http://www.rnao.org>

burnout. That's not just unpleasant, or unfortunate — it hurts patients and costs the health care system hugely in the long run.

That's what makes the question of how to keep nurses on the job, and fully engaged, such a compelling one for Canadian nursing researchers.

Sean Clarke is an associate professor and holder of the RBC chair in cardiovascular nursing research at the University of Toronto. His research on the environment in which acute care nurses work has shown hospitals with better work environments for nursing have lower mortality rates for patients.

A good environment can be as important as numbers of nurses or their education when it comes to how patients fare, according to Dr. Clarke. "It's the work environment that determines how good the nursing is. You can have plenty of nurses but if you have poor leadership and a bad environment, you can have lots of [patient] injuries."

The Quality Worklife — Quality Healthcare Collaborative – On Healthy Workplaces

A fundamental way to better health care is through healthier health care workplaces. It is unacceptable to work in, receive care in, govern, manage and fund unhealthy health care workplaces.

Members of QWQHC include:

- Accreditation Canada
- Academy of Canadian Executive Nurses (ACEN)
- Association of Canadian Academic Healthcare Organizations (ACAHO)
- Canadian College of Health Services Executives (CCHSE)
- Canadian Federation of Nurses Unions (CFNU)
- Canadian Healthcare Association (CHA)
- Canadian Health Services Research Foundation (CHSRF)
- Canadian Medical Association (CMA)
- Canadian Nurses Association (CNA)
- Canadian Patient Safety Institute (CPSI)
- Health Action Lobby (HEAL)
- Victorian Order of Nurses (VON)

Source: The Quality Worklife — Quality Healthcare Collaborative web site: <http://www.qwqhc.ca>

What constitutes a good environment for nurses to work in? Dr. Clarke and his colleagues describe “foundations for quality of care” including orientation programs, education on the job, professional development opportunities and a quality assurance program that gathers data and gives feedback on care. A good environment must also have good nurse managers, to create the atmosphere in which a front-line nurse can work well. Essential too, are collegial relations between nurses and physicians, appropriate staff numbers and educational training, as well as reasonable workloads.

In a study of 168 hospitals in Pennsylvania, Dr. Clarke and his colleagues found the likelihood of patients dying within 30 days of admission was 14% lower in hospitals with better care environments. They estimated that the number of patient deaths across the U.S.A. that could be prevented “by improved care environments, nurse staffing and nurse education is somewhere in the range of 40,000 per year.”

In the U.S., the American Nurses’ Credentialing Center, an affiliate of the American Nurses Association, awards “Magnet” status to hospitals that meet its criteria for creating a good work environment for nurses (and therefore attracting and holding them like a magnet). Magnet hospitals are recognized for treating nurses respectfully and involving them in research and advances in nursing practice. They have low staff turnover and excellent patient outcomes.

Dr. Clarke doesn’t think all aspects of the Magnet program could readily be expanded to Canadian hospitals because of its focus on using a special designation to improve

Nursing Best Practice Guidelines – Registered Nurses’ Association of Ontario

The RNAO Nursing Best Practice Guidelines are recognized globally among nurses and other health professionals. A number of initiatives and best practice guidelines address clinical practice, healthy work environments, long-term care, nursing research, smoking cessation, and preventing and managing violence in the workplace.

RNAO’s Best Practice Guidelines Program was launched in 1999, and information can now be accessed in three languages at: <http://www.mao.org>

Source: Registered Nurses’ Association of Ontario, Nursing Best Practice Guidelines,
<http://www.mao.org/Page.asp?PageID=861&SiteNodeID=133>

competitiveness of hospitals against each other — generally in Canada patients don't choose where they will get care, and many magnet hospitals have a business motive Canadian hospitals don't. But, he says, "the beauty of Magnet is it gave people some concrete things to focus on... it's about best practices in the management of nursing services." Those best practices and goals can be and many have been adapted to Canadian health care settings, he says. Both the Registered Nurses' Association of Ontario (RNAO) and Accreditation Canada are among the organizations that have worked to bring best practices in health care services to Canada.

Another University of Toronto researcher, Ann Tourangeau, agrees the work environment is a crucial factor for nurses when they are considering their future. Her research on what makes nurses think about leaving their jobs is aimed at easing nursing shortages by reducing turnover. In one study, she surveyed more than 8,000 Ontario nurses and found job satisfaction, good working relationships with colleagues and opportunities for involvement in the organization (such as serving on committees) made nurses less likely to quit.

Workplace violence is a serious and disturbing issue that affects staff and service providers across the health care continuum. Workplace violence is more common in health care settings than in many others. One quarter of all incidents of workplace violence occur at health services facilities.

The effects of workplace violence on staff are numerous and can range from decreased commitment and productivity to higher rates of injury and illness. Improving prevention strategies is crucial to the well-being of health care workers and clients.

In recognition of this, the Accreditation Canada Qmentum Program emphasizes workplace health and quality of worklife within the standards and has developed a new Required Organizational Practice which came into effect in January 2010. Client organizations will have to comply with eight tests of compliance in order to achieve accreditation in this area. As well as the required organizational practice, Accreditation Canada has put in place a mechanism to promote knowledge transfer of leading practices. Through our website, our clients learn and have the opportunity to communicate with other organizations that have successfully accomplished high-quality leadership and service delivery that could be implemented within other organizations.

We at Accreditation Canada truly believe that workplace safety should be at the forefront of Health Care.

Wendy Nicklin, President and Chief Executive Officer, Accreditation Canada

Since there is so much proof that a good working environment saves patients' lives, taking steps to build job satisfaction, encourage good team work and get nurses involved in planning and decision making can only be good for health care in the long run.

The trouble, Dr. Tourangeau says, is that when the economy is suffering, the people who plan budgets may not focus on the long run. "We are paying more attention to money than to matching personnel to the outcomes we want," she says. There's nothing new in that — it's the default position whenever money gets tight in health care. Dr. Tourangeau was a hospital administrator herself during the cuts of the 1990s, and says she was guilty of thinking it made sense to look at the bottom line because what you needed was more pairs of hands to do tasks.

The difference today is there's ten years of research to show that using less qualified workers hurts patients. The evidence isn't influencing decisions the way it should, however. "Nothing's changed. Money is still the most important outcome in health care," she says. "There are periods when it isn't the most important driver in the system, but right now it is."

That's a reality that grates on Dr. Heather Spence Laschinger, who holds the Arthur Labatt Family Nursing Research Chair at the University of Western Ontario. She says people who want to reduce the proportion of registered nurses are "ignoring the evidence because nurses are expensive. Well, of course they're expensive, they're a key resource," she says.

Occupational Health and Safety

A 2009 study commissioned by the CFNU reported that nurses had a rate of absence due to illness or disability 35% higher than other occupations. The rate of absenteeism due to own illness or disability among nurses increased by 33.6% in three years. A 2005 survey of nurses reported that 37% of nurses had experienced pain serious enough to prevent them from carrying out normal daily activities in the previous twelve months and nearly half of nurses in direct patient care had received a needlestick or sharps injury. Almost half of nurses in Canada are concerned about the effectiveness of existing personal protective equipment and about their own risk of contracting a serious disease at the workplace. Additionally, nurses are more likely to be physically assaulted on the job than a police officer or prison guard.

Sources: Lasota, M. (2009). *Trends in own illness or disability-related absenteeism and overtime among publicly-employed registered nurses*. Ottawa: Canadian Federation of Nurses Unions.

Shields, M., & Wilkins, K. (2006). *Findings from the 2005 National Survey of the Work and Health of Nurses*. Statistics Canada and Canadian Institute for Health Information. Catalogue no. 83-003-XPE ISBN 0-662-44484-1.

Dr. Spence Laschinger's research also looks at keeping nurses on the job. Her focus is employee empowerment and how it relates to work, determined by a combination of workload, the amount of control employees feel, whether they feel adequately rewarded for their work, whether they feel part of the work community and whether they feel fairly treated by their employer and in tune with its values.

In one study of new graduate nurses, Dr. Spence Laschinger and her colleagues found 66% of those surveyed felt high levels of burnout. That's a concern for several reasons. Young nurses have a high turnover rate, from job to job and even out of the profession — churn that gets in the way of good care for patients and can be expensive, as new nurses have to be continually recruited and trained for specific jobs. As well, 60% of experienced nurses are over 40 years old, and health care administrators are anticipating large numbers of retirements in the next few years.

Another study of Dr. Spence Laschinger's shows that nurses who are most satisfied with their jobs have the most independence and work in a "professional practice environment" that leaves them free to use all their knowledge and skills when they work.

What nurses need to feel effective and satisfied is pretty basic, Dr. Spence Laschinger says. They want to have a say in the way patients are cared for and the unit is run, and to be respected as integral to the workplace. "They have ideals...they want to be able to practice the way they were taught to practice."

However, for young nurses, the gap between what they learned in school and what they face on the job is often a terrible shock. The subject of a 1974 book called *Reality Shock: Why Nurses Leave Nursing*, young nurses' struggle to adjust to their jobs, is nothing new; but it is drawing renewed attention as the importance of keeping young nurses on the job increases.

Dr. Mélanie Lavoie-Tremblay is an assistant professor at the McGill University School of Nursing. She has been looking at how "Generation Y" nurses can be helped to adjust to the demands of work. In a study of turnover among young nurses she found 61.5% planned to quit the jobs they had for other jobs in nursing. The biggest factor affecting them — along

Strategies that focus on building respectful relationships at work may have tremendous capacity to promote nurse intention to remain employed.

Tourangeau et al. (*Determinants of hospital nurse intention to remain employed: Broadening our understanding*).

with 12% who said they wanted to quit the profession altogether — was the feeling the rewards they get do not match the demands they face (with rewards including praise and career opportunities as well as money). Those who wanted new nursing jobs were dissatisfied with working conditions and felt they lacked challenges.

Dr. Lavoie-Tremblay says new graduates in any profession face a reality gap, but “in nursing the shock is greater because they’re not allowed to make a mistake.” They see themselves as knowledge workers, and expect to be allowed to put that knowledge to full use right away. It’s important for employers with new nurses on staff to make them feel welcome, give them lots of opportunities to learn — and a lot of support.

“We have to be careful to coach them...they might think they have seen everything, but this is frontline and the senior nurses have to be there to remind them they have a lot to learn, and it’s still challenging.”

All the researchers agree that people who choose nursing as a profession welcome those challenges — they are bright and they want to help people. It seems clear that creating an environment that lets them do that rewards their commitment, shows compassion and care for patients, and benefits health care in the long run.

Working Conditions Key to Improving Health Care System

83% of Quebecers believe that the improvement of working conditions is likely to improve the health care system.

Régine Laurent, President of la Fédération interprofessionnelle de la santé du Québec

Source: The President's Blog. May 6, 2010. <http://www.fiqsante.qc.ca>.

Experts & Evidence *Opportunities in Nursing* Chapter Three



Educating New Nurses for a New Kind of Nursing

Medications are invented, treatments change, diseases emerge or mutate; it's said that nowadays, three quarters of the course content in nursing school is obsolete by the time a student graduates. That's why the most important thing student nurses can learn is how to learn. Nursing schools are recognizing that.

"Content is the context for the learning you need to do," says Marlene Smadu, associate dean of the University of Saskatchewan's College of Nursing. "Yes, they need the technical skills they can be taught, but they have to learn how to learn, they have to learn critical decision making."

Nursing Students' Bill of Rights and Responsibilities

The 2005 Canadian Nursing Students Association National Assembly adopted a *Nursing Students' Bill of Rights and Responsibilities*. Please visit the CNSA website for the complete list. Examples of students' rights include:

- Educational opportunities to develop critical judgment and engage in sustained and collaborative inquiry
- Current, accurate and credible evidence-based information and course content
- Supportive, educational and safe teaching and learning environments
- Study in an environment that promotes equal opportunities and a climate of mutual respect and understanding, free from harassment and discrimination

Source: Canadian Nursing Students Association, *Bill of Rights and Responsibilities*, available at: <http://www.cnsa.ca>.

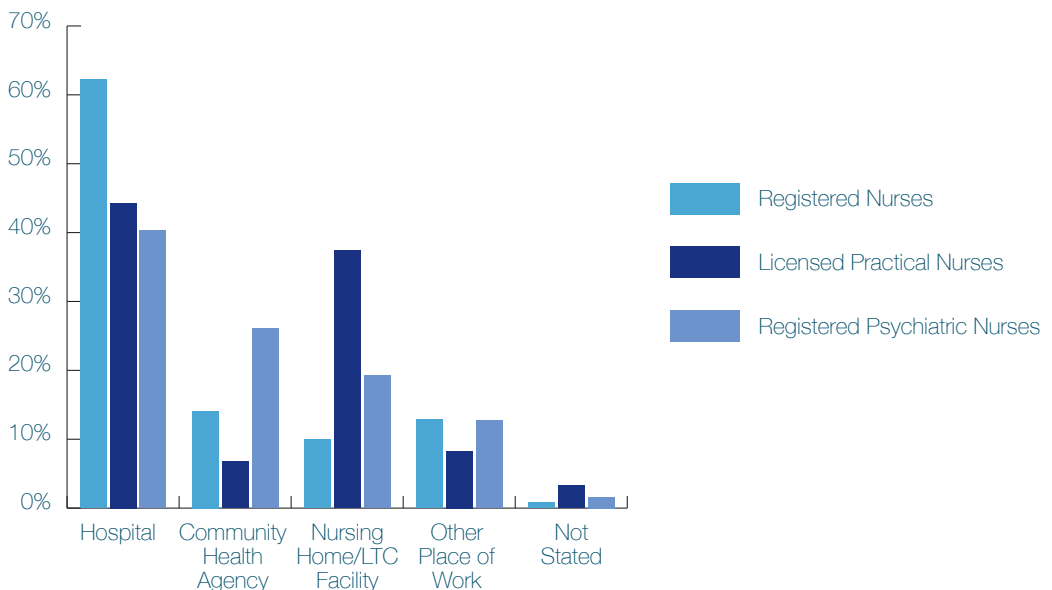
Dr. Smadu, who has been teaching nursing since the 1970s, has been deeply involved in redesigning the nursing program at the College. September 2010 will see the last class begin the joint nursing program run by the University of Regina, the First Nations University of Canada, the Saskatchewan Institute of Applied Science and Technology and the University of Saskatchewan.

In 2011, students at the University of Saskatchewan will enter the new Collaborative Bachelor of Science in Nursing program. It will take a different approach, starting with a “pre-nursing” first year, followed by three years of inter-professional education.

The pre-nursing year, it’s hoped, will reduce the high drop-out rate from the nursing program, by giving students a real understanding of what the profession is like at the beginning of the program. Then they will move on to build the foundation of knowledge that will help them care for people over the course of a career that will change profoundly over 25 years.

Critical thinking skills that let nurses analyze each patient’s situation and processes for keeping themselves and their patients up to date on their condition will be the focus of the new program.

Nurses’ Place of Work, 2008



Source: Canadian Institute for Health Information, C. Summary – Regulated Nursing Workforce by Place of Work and Province/Territory of Registration, Canada, 2008 (Summary Table A-M – Regulated Nurses), *Workforce Trends of Regulated Nurses in Canada, 2008*. Accessed July 30, 2010: http://secure.cihi.ca/cihiweb/en/statistics_nursing_2008_e.html

These skills are what will help nurses learn to relate to patients in a new way, as partners in care, rather than only in their roles as expert professionals, Dr. Smadu says. “The important thing is to be prepared for learning.” Nurses in the future, she says, will understand not knowing an answer is perfectly acceptable — so long as they know where to find it, and how to guide their patients as they learn as well.

Teaching students how to search for answers and never to stop learning is also the goal of the Université de Montréal’s approach to nursing education.

The traditional approach to teaching with hundreds of students listening to a teacher at the front of the room, doesn’t work well any longer, according to Francine Girard, dean of the nursing faculty.

Now the faculty wants to give students a broad-based spectrum of knowledge, focused on educating them to interpret, assess and plan for each patient individually. “You’re training them to think... they go back to what they know, ask the appropriate question and discover solutions. They are really prepared to find the answers,” Dr. Girard says. In order to achieve that, the Faculté des sciences infirmières introduced “competency-based learning” in 2004.

Students in the program work in small groups on problems or case studies given to them by the professors. They work together to research the issues contained in their case — figuring out what’s wrong with the patient, what should be done about it as well as broader implications for health, their institution and the health care system. As they do that, the students are developing the eight competencies that nurses must have.

(continued page 36)

The most resounding issue in nursing education that is being expressed by our members across the country is that of the availability of quality clinical placements. With increasing enrolment in nursing schools, it is becoming harder for schools of nursing to find relevant placements, as well as preceptors, for all their students. At some institutions, placement opportunities do not begin until the third year of a four-year program. Nursing students want placements beginning early in our programs so that we gain an appreciation for practice early and begin to build our skills in real life situations. Nurses can stand up against this challenge by volunteering to be a preceptor for nursing students and be actively involved in the education of the next generation of nurses.

Branden Shepitka, President, Canadian Nursing Students’ Association

Examples of Promising Practices from Across Canada

Many programs and initiatives that support the retention and recruitment of nurses exist across the country. Many of these are led collaboratively by governments, employers and unions — all aim to improve the worklives of nurses. Some do so by providing opportunities for continuing education, mentorship, or flexible scheduling; others work towards achieving excellence in safe staffing ratios, and occupational health and safety. This map highlights just a few of such programs and initiatives. Read more about them on the following pages.

Projects listed as RTA are part of CFNU's Research to Action: Applied Workplace Solutions for Nurses project. All RTA projects are workplace-based and have been developed in partnership with employers, unions, governments and other health care stakeholders in each jurisdiction along with

Nunavut

Research to Action: Building Nursing Capacity Through Development of Mentorship and Clinical Education Programs

Manitoba

The Nurse Recruitment and Retention Fund

Support for Internationally Educated Nurses

Research to Action: Orientation for Nurses New to Long-Term Care

Saskatchewan

Patients and Families First Initiative

80/20 Staffing Model

Research to Action: Nurse-Patient Ratios

Alberta

Research to Action: Evaluation of Nursing Retention and Recruitment Initiatives

Transitional Graduate Nurse Recruitment Program

British Columbia

The Employed Student Nurses' Program

Research to Action: Improving Retention and Recruitment in Smaller Communities — the 80/20 Project



generous financial support from the federal government. Designed to increase the retention and recruitment of nurses across the country, the ten RTA pilot projects apply existing research to the workplace to help nurses develop skills and expertise.

Projects such as these will contribute to the growing evidence that innovation in the nursing workforce makes a difference, not just for nurses, but for patients and all health professionals. Overarching federal leadership is needed to ensure that this map does not remain a patchwork of promising localized initiatives, but rather a comprehensive cross-country system where best practices guide nursing practice environments. The Research to Action initiative, in particular, has shown value in sharing findings across jurisdictions and among professions.



Examples of Promising Practices from Across Canada

Province	Initiative
British Columbia	The Employed Student Nurses' Program A British Columbia Nurses' Union program enabling nursing students to gain clinical experience in special paid part-time or part-year positions that are additional to the normal staff complement. http://www.bcnu.org
	Research to Action: Improving Retention and Recruitment in Smaller Communities — the 80/20 Project Nurses spend 80% of salaried time in direct patient care and 20% in other activities that will enhance patient care, like professional development and mentoring. http://www.thinknursing.ca
Alberta	Transitional Graduate Nurse Recruitment Program Providing 900 new nurses per year the opportunity to work in a supernumerary position for up to one year under the guidance of an RN, RPN, Clinical Educator or Clinical Supervisor. http://www.una.ab.ca
	Research to Action: Evaluation of Nursing Retention and Recruitment Initiatives A comprehensive evaluation framework was created to increase evidence-based research on new nurse workplace integration, pre-retirement programs, flexible scheduling and benefit eligible casual positions. http://www.thinknursing.ca
Saskatchewan	Patients and Families First Initiative With two \$10,000 prizes, this challenge encourages and supports nurses, patients and members of the public to develop sustainable innovations to improve patient-centered care. http://www.sun-nurses.sk.ca
	80/20 Staffing Model Extending this patient-centered model in Saskatchewan through a collaborative effort between the province, SUN, University Health Network, and Regina Qu'Appelle Health Region. http://www.gov.sk.ca
	Research to Action: Nurse–Patient Ratios This project helps identify the formal nurse-patient ratios that are required to ensure optimal patient, nursing and organizational outcomes. http://www.thinknursing.ca
Manitoba	The Nurse Recruitment and Retention Fund Support for continuing education, specialty program and project funding are included in a program designed to help nurses enter or remain in the workforce. http://www.gov.mb.ca
	Support for Internationally Educated Nurses The Manitoba Nurses Union offers programs to support internationally educated nurses preparing for licensure in Manitoba, or already working in Manitoba. http://www.manitobanurses.ca
	Research to Action: Orientation for Nurses New to Long–Term Care Nurses new to long-term care are matched with experienced mentors, participate in clinical workshops and an enhanced orientation period. http://www.thinknursing.ca
Ontario	Workplace Violence and Harassment Legislation Supporting the safety of nurses through protections from workplace violence and by addressing all forms of workplace harassment. http://www.labour.gov.on.ca
	Needle Safety Regulation Supporting the safety of nurses through requirements for safety-engineered needles in health care workplaces. http://www.healthforceontario.ca

Province	Initiative
	<p>Research to Action: Linking Nursing Outcomes, Workload and Staffing Decisions in the Workplace This project provides opportunities for RNs to be involved in outcome, workload and staffing decisions using Nurse Dashboard, a web-based tool that facilitates discussion between managers and frontline nursing staff. http://www.thinknursing.ca</p>
New Brunswick	<p>Provincial Health Bursary Program Bursaries target health occupations with high vacancy rates, with hard-to-recruit sectors and regions given the highest priority ranking. http://www.gnb.ca</p> <p>Mentorship for New Graduates A province-wide mentorship program was developed to ensure successful integration of new nursing employees into the workplace. http://www.gnb.ca</p> <p>Research to Action: Development of a Web-Based Orientation Program and Enhancing Senior Nurses Mentoring Skills This project redesigns orientation programs and simultaneously provides professional development opportunities for experienced nurses in the form of mentorship education. http://www.thinknursing.ca</p>
Nova Scotia	<p>Coalition Against Workplace Violence Provincial government and labour unions, including the Nova Scotia Nurses' Union, work collaboratively to address workplace violence regulations and legislation. http://www.stopworkplaceviolence.ca</p> <p>Research to Action: Late-Career Nurse and New Graduate Transition Project New graduate nurses are matched with an experienced nurse (mentor) to support the transition during their first year of practice. An 80/20 nurse staffing professional development model has been applied throughout the province. A centralized service to identify individual employment preferences, employee/employer needs and orientation requirements was developed. http://www.thinknursing.ca</p>
Prince Edward Island	<p>Mentorship for New Graduates A province-wide program supported by unions and employers to provide mentorship to new graduates. The program also provides continuing education and professional development funding nurse mentors. http://www.gov.pe.ca</p> <p>Research to Action: Development of Emergency and Critical Care Education Opportunities Increasing capacity by developing a PEI-based emergency and critical care nursing program that allows nurses to acquire certification without leaving the province. http://www.thinknursing.ca</p>
Newfoundland & Labrador	<p>Rural Nursing Student Incentive Program Providing travel-related funding assistance to nursing students in their fourth year of studies to undertake community placements in rural areas of the province during their course. http://www.nlhba.nl.ca</p> <p>Orientation Program Established in regional health authorities with provincial funding to help ease the transition to beginning practice for both registered nurses and licensed practical nurses. http://www.nlhba.nl.ca</p> <p>Research to Action: 80/20 Project in Long-Term Care Participating nurses use 20% of their time to develop leadership skills, engage in educational programs and to enhance the long-term care environment. http://www.thinknursing.ca</p>
Nunavut	<p>Research to Action: Building Nursing Capacity Through Development of Mentorship and Clinical Education Programs Ottawa clinical educators deliver specialized workshops to provide enhanced critical care education, mentorship opportunities, and support for graduate nurses in Nunavut. http://www.thinknursing.ca</p>

These eight competencies are:

- Practise clinical nursing judgment;
- Guide and support people, families and communities through health care;
- Ensure continuity of care;
- Encourage action to improve the overall health of the population;
- Approach all professional and disciplinary activities with scientific rigour;
- Act professionally;
- Collaborate with inter-professional teams; and
- Demonstrate clinical leadership.

Nursing Education Statistics in Canada

Nursing Education in Canada Statistics 2007-2008, a report produced by the Canadian Nurses Association, highlights the state of nursing education in Canada:

Entry-to-Practice Programs

- In 2007, 13,157 students were admitted to ETP programs, an increase of 2.2% (from 12,977) from 2006, continuing the upward trend of past years.

Lifelong Learning (Continuing Education)

Post-RN Programs

- Approximately 35% of schools (41 schools) offer one or more post-RN baccalaureate programs for diploma-trained nurses wishing to obtain a baccalaureate degree in nursing/nursing science.
- In 2008, 1,923 RNs graduated from post-RN baccalaureate programs, a 33.8% increase from a low of 1,437 in 2004

Master's and Doctoral Programs

- In 2008, 723 RNs graduated from master's programs, a 19.9% increase over the previous year.
- Admissions to doctoral programs increased 5.1% in 2007 from the previous year.
- Graduates from doctoral programs decreased 11.4% in 2008 from the previous year.

Nurse Practitioner Programs

- Admissions to NP programs decreased in every province and territory except for Nova Scotia and Ontario; in 2007, total admissions were down 7.8% from the previous year.
- In 2008, the number of NP graduates reported fell 17.8% from the previous year.

Source: Canadian Nurses Association. (December 2009). *Nursing Education in Canada Statistics 2007-2008*. Available online at: <http://www.cna-aic.ca>

The first students to complete the program graduated in 2007. Chief nursing officers and nurse managers who have hired students educated in the new method are very pleased with “the product,” Dr. Girard says.

In Quebec, any student in a baccalaureate program must already have attended either a two-year or three-year college program, so the Université de Montréal program has dispensed with large classes on physiology, pharmacology and the like; students have learned their basic science at college.

Instead, they begin spending time in real health care situations — in institutions and the community — in their first term. But before they start really working with patients, they get their initial education in simulation labs. There, through role playing and working with both volunteers and specially built dummies, the students practice their skills while being observed through two-way mirrors and videotaped for later debriefing as they first put their skills into practice.

Since 2007, the Université de Montréal has been home to the Centre for Innovation in Nursing Education, where teachers, researchers and others study the best ways of educating nurses. They are evaluating the university’s competency-based approach as well as other methods, because, as Dr. Girard says, “it is important to ensure the strategies utilized in the programs

Education of Nurses in Canada — CFNU Factsheet

There is a strong trend among nurses to graduate from baccalaureate programs rather than diploma programs in recent years. Until 2003, more RNs graduated from diploma programs. By 2008, this trend had reversed such that three times as many RNs graduating that year did so with a baccalaureate rather than a diploma. 21.5% of RNs in 2008 had earned a baccalaureate prior to entering practice.

Nurses are also returning to school to upgrade their skills in large numbers. By 2008, 37,841 RNs who had graduated with a diploma returned to school to obtain a baccalaureate. This brings the total percentage of practicing RNs with a baccalaureate to 34.7%. Nurse practitioners have the highest representation of master’s and doctorates at 36%. 3% of RNs have either a doctorate or a master’s degree. 97.7% of LPNs had obtained a diploma, while the remaining 2.3% had equivalencies.

Source: CFNU Fact Sheet, The Nursing Workforce, available at <http://www.nursesunions.ca>, prepared with data from Canadian Institute for Health Information, *Regulated Nurses: Canadian Trends 2004-2008 Report*, December 2009.

will produce better nurses. When compared to the more traditional programs, the competency-based approach is more complex to organize and the costs are higher.”

At the University of Alberta’s Faculty of Nursing, a similar approach to teaching is called “context-based learning,” which is not always popular with students, according to Greta Cummings, a professor at the Faculty of Nursing.

“Some students don’t like it, because they are expected to have so much initiative to learn on their own and with peers,” she says. “But once they’re in the workplace, they realize how many skills they’ve had to master and how much they need them in everyday practice.”

The faculty’s approach is to provide opportunities for students to learn a wide variety of concepts and approaches, in the context of patients’ health, care outcomes and settings that will serve nurses no matter where they wind up working. Dr. Cummings’ own research focuses on leadership — an often vaguely defined concept that is nevertheless identified over and over again as a key part of successful nursing, in everything from mortality rates to staff turnover.

Leadership can be taught, Dr. Cummings says, and the crucial first step is for students to learn how to see themselves. Self-assessment is often not a strong point in people who are, officially, leaders — “Most people think they are pretty good leaders when they’re not,” says

Nursing Workforce Education for the 21st Century

A new report by the Canadian Association of Schools of Nursing reports that the “future of our health system is dependent upon the availability and quality of health human resources, especially to under-served populations” and that education at the baccalaureate level or higher for registered nurses is critical to meeting the health needs of the population. The report also reviews how “in today’s increasingly complex health care environment, research demonstrates unequivocally that patient safety and outcomes are dependent on the educational preparation of professional nurses.” The report identifies three pressing priorities for action:

- 1) Investing in nursing faculty supply and nursing program infrastructure;
- 2) Fostering innovative initiatives to sustain an appropriately prepared nursing workforce; and
- 3) Investing in nursing research and knowledge translation.

Source: Canadian Association of Schools of Nursing (2010). *The Case for Healthier Canadians: Nursing Workforce Education for the 21st Century*. The full report can be downloaded at: <http://www.casn.ca>

Dr. Cummings. That means learning leadership begins with self-assessment — reflecting on questions such as: *how do I react in an emergency? How do I relate to others?*

Equally important is to know your own values — and the key to discovering your values is your behaviour, because behaviour is values in action.

Once students have mastered themselves, they are able to lead others, Dr. Cummings says. “The next thing is being able to visualize the future for what it could be, to see today for what it really is, and to analyze what is going on in the current context that makes today what it is and what the preferred future could be. Then it is time to take action to create that preferred future.”

Getting to the goal of the preferred future is where leadership comes in, Dr. Cummings says. Goals can be set within a single shift, or over a much longer period, but the ability to observe, analyze, see a better way and involve others in it, is leadership.

Simple steps — such as context-based learning, where goals have to be shared and set and students are not spoon-fed information — may help build leadership abilities sooner.

Dr. Cummings also thinks the University of Alberta’s “BScN After-Degree” program will draw more people with leadership abilities into nursing. The program is open to people who already have a university degree, who can earn their nursing degrees in two years instead of the usual

Internationally Educated Nurses in Canada — CFNU Factsheet

8.4% of RNs employed in Canada graduated from an international nursing program. British Columbia (15.8%), Ontario (12.3%) and Alberta (9.6%) had the highest concentrations of internationally trained graduates. Newfoundland and Labrador and New Brunswick had the lowest at 1.5%. The United Kingdom (17.9%) and the Philippines (30.2%) were the countries of graduation for almost half the internationally trained nurses practicing in Canada. The United States was the source for 7.3% of the internationally trained graduates in the RN workforce. Of the LPNs employed in Canada, 98% graduated from a practical nursing program in Canada while 2% graduated from an international program.

Source: CFNU Fact Sheet: The Nursing Workforce available at <http://www.nursesunions.ca>, prepared with data from Canadian Institute for Health Information, *Regulated Nurses: Canadian Trends 2004-2008 Report*, December 2009.

four. The assumption is that earlier academic training has given them critical thinking and analytical skills which blend with their career and life experience to make them excellent candidates for nursing careers.

“They are very different students from 17-year-olds right out of high school,” Dr. Cummings says. “I think we’ll have a different breed of nurse...more independent, assertive, and more confident in the workplace. These skills are necessary to respond to individual patient needs and to preserve patient safety in every health care sector.”

A 2009 Partnership Agreement between the provincial government in New Brunswick and the New Brunswick Nurses Union focuses on the retention and recruitment of new nurses in the province. A forgivable loan program is an important piece of this because, in the midst of a shortage, it creates an incentive to make New Brunswick an attractive option by helping to alleviate student debt. The Agreement also provides incentives for nurses to choose to work in hard-to-recruit areas of the province. Retention is addressed through the Agreement by programs that aim to improve quality of worklife through healthy positive workplaces, including improved orientation for new nurses, opportunities for mentorship and ongoing support in the workplace. Retention and recruitment go hand in hand and are fundamental to resolving the nursing shortage and improving access to high-quality health care.

Marilyn Quinn, President, New Brunswick Nurses Union

Experts & Evidence *Opportunities in Nursing* Chapter Four



Innovation in Nursing

What if curiosity were a job requirement for nurses? What if nurses felt free to ask about everything — the patient's needs, the treatment, the unit, the organization? To ask every shift, every hour, what could be done to make things better for the patient, make things work more efficiently, make the organization and the public healthier?

That's what Judith Ritchie wants to see. Dr. Ritchie is associate director for nursing research at the McGill University Health Centre and her goal is to create "a culture of curiosity" in the hospital — that is an environment that encourages and expects its nurses to think about practices; to challenge routines; to ask questions about why things are done or how they're happening the way they are.

It's not enough any longer for nurses just to do what they were trained to do, to act as they've always acted, Dr. Ritchie says. Her very serious message is that nursing must be reinvented

The Centre for Innovation in Research and Knowledge to Action in Nursing's mission is "to be recognized as a world leader in evidence-informed nursing by linking clinical and administrative practices with theoretical and research results to improve patient care and outcomes while created in a magnet environment that recruits, retains, and retrieves nurses. The Centre's research clusters will obtain high-value research grants and contribute to enhancing nursing education at the undergraduate, graduate and continuing education levels.

Ritchie & Lynch (Centre for Innovation in Research and Knowledge to Action in Nursing)

for the 21st century. There have been, she says, many changes in little things around nursing — mostly the result of new treatments and equipment — but at the same time nurses cling to rituals, like taking blood pressure over and over, tasks that mostly do nothing for health and can keep the people who are busy with them from seeing the big picture.

A culture of curiosity should change that. If thinking about practice and looking for the impact of care is the norm and — even more important — if it is encouraged and supported by every level of staff and management, then nurses have a tremendous opportunity to improve the work they do, and patients, organizations and the overall system should all benefit.

What kind of difference can it make? Dr. Ritchie points to McGill's "safe transfer communication tool." It was developed by nurses worried about the well-known fact that patients often suffer setbacks while being transferred from one part of the hospital to another — such as from the emergency department to an inpatient unit. The brief, two-page tool lists essential issues such

Releasing Time to Care

Releasing Time to Care was developed by Britain's National Health Service Institute for Innovation and Improvement. Based on "Lean" methods originally developed by Toyota to improve productivity, Releasing Time to Care focuses on organizing workspaces and improving processes to give nurses more time to spend with patients — that is, "releasing time to care."

Releasing Time to Care is a carefully structured program leading units through step-by-step reviews and reforms of how they deliver care, from how supplies are stored to how medications are delivered.

Although international evaluations of Releasing Time to Care have demonstrated positive impacts on both patients and nurses post-implementation, the importance of ongoing critical assessment of the development and application of any new quality improvement initiative cannot be understated. Ensuring consistency in the way clinicians provide care and are supported in their practice should be an ongoing priority for all health care stakeholders.

Furthermore, major changes in processes can only be sustainable if they involve front-line workers. Failure to do so has resulted in the negative uptake of potentially beneficial innovations. When everyone works together to gather and interpret evidence, plan, introduce and evaluate reforms, uptake is much more successful and results in safer practice environments.

Sources: National Health Service: <http://www.institute.nhs.uk>

Health Quality Council. Releasing time to care: The productive ward. <http://www.hqc.sk.ca>

as what tests have been done or still need to be done, level of pain, medications being used and other essential patient information to highlight several potential hazards.

McGill University Health Centre (MUHC) is not working in isolation on these issues. Programs giving nurses the lead in innovation include “Releasing Time to Care” developed by Britain’s National Health Service. It is well underway in Saskatchewan and is being tested in pilot programs in Ontario as well. There is also “Transforming Care at the Bedside,” a program of the Institute for Healthcare Improvement in the U.S., designed to improve care on medical/surgical units in hospitals.

These programs emphasize the importance of taking baseline measurements, then using proven best practices to improve care that doesn’t meet standards. Continuous measuring and feedback are used to make sure goals are reached and high-quality care is maintained. At MUHC, they started with a program using evidence-based best practices to reduce the number of pressure ulcers, falls and uncontrolled pain. While people initially grumbled about having to gather data, the improvements the program brought (including a 50% reduction in severe pressure ulcers and an 85% reduction in falls that caused injuries) soon persuaded people of the importance of quality-improvement projects based on evidence.

One of the straightforward changes that led to the reduction in injuries due to falls was to distribute a simple environmental scan checklist to nurses, to look for tripping hazards. Nurses

United Kingdom Commission on the Future of Nursing and Midwifery

The 2009 Commission explores how nurses and midwives can be involved in improving health outcomes, the quality of care and the experiences of patients. Front Line Care, the Commission’s report, asserts that:

- Poor practice is not solely the responsibility of individual nurses and midwives.
- Organizational and team improvements are necessary in the practice environment.
- Health service boards and managers should take corporate responsibility for care and ensure that nurses and midwives are involved in every level of health care design and delivery.
- Creating a culture that values these professions and welcomes innovation and excellence is of utmost importance to both nurses and patient safety.

Source: The Central Office of Information. (2010). *Front Line Care: the future of nursing and midwifery in England. Report of the Prime Minister’s Commission on the Future of Nursing and Midwifery in England 2010*. London, England: The Prime Minister’s Commission on the Future of Nursing and Midwifery in England.
The report is available at: <http://www.parliament.uk>.

were so used to things like medication carts and laundry baskets in the halls or a walker left between the bed and the bathroom, they just dodged them. Weak, confused patients, however, often fell because of them.

“In some ways, you think ‘this is just basic management,’ but what happens is, everyone is paying attention to what they have to do and no one is paying attention to the big things,” says Dr. Ritchie. With a culture that encourages nurses to really see the workplace, and really focus on ways to make it safer, better places are found for those laundry baskets and meds carts — and they’re always put back where they belong.

It is important, according to Dr. Ritchie, to formalize change by building it into hospital systems, with full support from management. Change done more casually, unit by unit, with no overall structure and corporate commitment, is much less likely to be sustained. That’s why the Releasing Time to Care program makes it mandatory for top executives to visit wards regularly and requires them to order all departments — from finance to maintenance — to support quality improvement by responding quickly to requests for changes.

Canada’s largest hospital is also tapping into the resources of nurses to make innovations. At the University Health Network (UHN) in Toronto, Mary Ferguson-Paré, vice-president of Professional Affairs and chief nurse executive, says, “We are on a path here to find new ways for nurses to help the health care system be sustainable, by liberating them in the direction of self-directed, client-centred care.”

In practice that means creating a work environment where nurses are treated as “knowledge workers and scholar practitioners.” UHN encourages and supports its nurses to plan their career trajectories, whether that means getting a master’s degree or training for a specialty.

“We are a research hospital trying to be one of the top five in the world. We have to have a culture of evaluation; that’s why it’s everybody’s business in this organization to be thinking up ideas for better care,” she says.

The value of the advanced practice role of the Nurse Practitioner is being felt across our province. From isolated communities on the coast of Labrador to primary health care settings in rural communities to emergency rooms, nurse practitioners are making their mark.

Debbie Forward, President, Newfoundland and Labrador Nurses Union

Because research money is limited, the hospital must run competitions to fund proposals for research projects, which are all peer-reviewed. Dr. Ferguson-Paré says it's noticeable that proposals from nurses, just as high-quality as those from academics, are nevertheless very practical and patient-oriented. Surgical nurses, for example, proposed a study of what it's like to have surgery cancelled on the day it was to happen; their findings completely changed how the hospital prepares patients for surgery and handles breaking the news of a cancellation.

The University Health Network has drawn wide interest in its remarkable 80/20 program. This innovative professional development program was a response to research that showed learning

80/20 Staffing Model

Research on the 80/20 model by Bournes et al. has demonstrated a higher degree of productivity on study units and significant decreases in overtime. Nurses in one 80/20 study say that since their participation:

I feel that I am a more knowledgeable, competent nurse. I trust myself—that I have current knowledge because I have time to research information that I need to know.

I feel as though my nursing practice has become what I always hoped it to be.

Patients and families also reported:

The care has been far more attentive than the last time I was here. Far more people are far more interested in doing things that I need done.

Although there was an increase in costs on the 80/20 study unit from the baseline period to the implementation period (which is to be expected with the addition of 20% more nurses to accommodate for the study model), variable costs increased at a slower rate on the 80/20 study unit than on the other units after the implementation period. Overall, this demonstrates a higher degree of productivity on the 80/20 study unit in comparison to the control units.

Overtime decreased significantly more on the 80/20 study unit relative to the two control units. It is important to note that the closure of beds on control unit 3 due to staffing shortages accounts for the significantly lower overtime hours in relation to the other two units. (Bournes et al., p. 11)

Sources: Bournes, D.A. & Ferguson-Paré, M. (2007). Humanbecoming and 80/20: An innovative professional development model for nurses. *Nursing Science Quarterly*, 20(3), p. 237-253.

Bournes, D.A., Ferguson-Paré, M., Plummer, C., Larrivee, D., & LeMoal, L. (2009). *Innovations in nurse retention and patient-centered care: The humanbecoming/80-20 study in Regina*. Final Report to Saskatchewan Ministry of Health, p. 1-29

opportunities are crucial in creating a good, supportive working environment characterized by camaraderie, which would keep them from leaving their jobs.

In 80/20, participants spend 80% of their work time doing their regular work. The remaining 20% of their salaried time is for professional development work. 80/20 was launched as a pilot project that included teaching nurses Dr. Rosemarie Parse's "humanbecoming theory," which profoundly changes how nurses relate to their patients. In essence, patients guide the care they receive, rather than have a framework of treatment, activity and values imposed on them. Nurses spend more time focusing on the patient and families, and less on pre-determined tasks.

The results from the 80/20 pilot showed sick time and overtime went down, there was no turnover in nursing staff, and falls by patients decreased. Staff satisfaction increased, and, while overall patient satisfaction did not change, people said they felt nurses were more available and they could feel more confident in them.

Another University Health Network innovation designed to manage the supply of nurses around the hospital, is also proving to be a moneymaker. NursesforTomorrow (N4T) is a tool for analyzing supply and demand for nurses at every level from individual units to regions. It was developed to gather and standardize information — like maternity and education leaves, plans to change jobs, retirements — that unit managers may know about, but which rarely come to the attention of human resources until payroll gets a note. That leads to unfilled positions, disrupted care, and spending for agency nurses and overtime.

N4T also aims to eliminate other fallout from poorly managed human resource information, including "hiring frenzies" when there's a scramble to find anyone even vaguely capable to take a job, and the creation of the kind of unstable working environment that makes nurses quit.

Models of Care

The Prince Edward Island Nurses' Union explains why new models of care must not only maintain, but improve current RN staffing ratios:

(There is)... concrete evidence that models of nursing care that advance both continuity of care and continuity of caregiver ensure safe, high-quality patient-centered care.

Source: Letter sent to Premier Robert Ghiz, May 5, 2010, from the PEINU.

N4T charts everything from details on a unit's patient load to the personal characteristics of staff (how many nurses are novices, for instance, and what the sick time is). It's all gathered through the "unit staffing analysis template," a web-based questionnaire that is used to forecast staffing changes. Armed with its data, decisions to hire now for vacancies that will arise in five months can be made. N4T has already been marketed to a health region in Saskatchewan; producing monthly reports for that client generates income for UHN.

Innovation, however, can be in the eye of the beholder, which is what Mary Ellen Gurnham, executive director of learning, is finding at the Capital District Health Authority in Halifax. It is part of her job to work with nurses on a new model of nursing care to provide the appropriate number and blend of registered nurses, licensed practical nurses and assistive personnel to give the best care in various kinds of wards.

It's a response to Nova Scotia's Collaborative Care Model, introduced in 2008 to deal with the future health care needs of Nova Scotians and anticipated shortages of all types of health care providers. According to a booklet on the plan, released in October 2008, "New roles and processes are necessary to meet the changing needs for care, to reduce inefficiencies, and to improve the health status of the population. They will also go a long way toward boosting the morale of a dedicated group of professionals who wish to find career and personal satisfaction by working to their full potential."

The plan is essentially reinventing the practice model, and understandably this has many professions very nervous, Ms. Gurnham says, at the prospect of having their jobs broken up and divided among unlicensed personnel. "We have to look at whose role is what in decision making and the needs of the patient population...what we committed to as a province is to optimize the roles of RNs and LPNs to impact nurse-sensitive patient outcomes — and to optimize their roles, you have to give them help."

The NursesforTomorrow (N4T) nursing resource analysis has proved to be an efficient and effective method for making nursing resource allocation decisions and for proactive strategic planning and targeted recruitment.... The challenge for the future in nursing human resources planning is to move all health care managers and leaders to an investment mindset and to combine use of the N4T nursing resource analysis process with aggressive recruitment and retention campaigns and policies that ensure that health care has nurses for tomorrow.

Bournes et al. (NursesforTomorrow: A proactive approach to nursing resource analysis)

The crucial point, Ms. Gurnham says, is that any decisions about staff mix be made only in the context of the patient population, with care teams taking part. Their focus should always be to improve patient outcomes, and they must include ongoing evaluation of the quality of care.

The levels of staff needed on any unit depend on a number of factors. A properly designed staffing plan can free nurses from tasks that otherwise keep them from coordinating care and getting patients ready for discharge. Ms. Gurnham says the plan is not intended simply as a redivision of labour; it's a "differentiated practice model," designed to refine roles and make effective use of every worker. But models of care remain a concern for many nursing organizations, whose experience over the past two decades links such changes with poorly planned efforts at restructuring, which have had grave consequences for patients, professionals and the whole health care system. Change in health care never stops, but past mistakes make it clear why frontline workers and the organizations who represent them must be involved at every stage of restructuring.

Changing Models of Care

Similar to any novel development, we should be cautious in the implementation of emerging models of care. This is especially important when initiatives involve fragmentation of care, where there is a high probability of impact on nurse-sensitive patient outcomes.

Doris Grinspun, RNAO, explains:

Today, riding on budget cuts and a recession, certain consulting firms are making profits with a return to the past, promoting RN replacement and team nursing. They propose that health care organizations treat every vacant RN position as one that could potentially be filled by an RPN or a PSW. They couch their recommendations in sophisticated rhetoric when the real intent is to change skill mix and nursing model of care delivery. Claiming that an all-RN staff is inefficient, and that primary nursing or total patient care – hallmarks of continuity of care and caregiver – are outdated, they promote models with positive sounding titles such as "Inter-Professional Care Model." Once you peel back their rhetoric, you find a blatant reversion to "team nursing," a model discredited in the 1970s because it delivers fragmented care, and deprives patients of the continuity of care and caregiver they need and deserve. It also deprives RNs (working with complex patients) and RPNs (working with stable patients with predictable outcomes) from participating and being accountable for the entire care process, elements that are essential to quality patient outcomes and nurse satisfaction. It is a step backwards, and one taken against all available scientific evidence.

Source: Executive director's dispatch: Ringing alarm bells on changing models of care delivery. (2009).
Available from <http://www.mao.org>



Conclusion and Recommendations

It's unlikely there's anyone in Canada who hasn't been touched by the good nurses do. And it doesn't take much effort to go beyond that and imagine what demands the job puts on nurses: trying to meet constant needs, putting in long hours, dealing with people who are ill, frightened and in pain.

Fair enough — that's what they sign on for. No one goes to nursing school looking for regular hours and uneventful days. But this paper, giving a quick look at the growing body of Canadian nursing research, shows what a toll increasing demands, job insecurity and feeling undervalued takes on nurses. It also shows the damage doesn't stop with them. When the conditions aren't in place for nurses to do their jobs well, patients suffer and health care costs go up.

The extent of patient suffering is hard to quantify — but there's proof that a lack of high-quality nursing keeps people in hospital longer, makes it more likely patients will return to hospital for more care and increases their chance of death. The costs to the system may be easier to measure — every turnover in a nursing position costs a hospital \$25,000, for example — but what's the cost of not encouraging nurses to come up with innovative ideas? What do we spend on the education of nurses who burn out or move away? What is the price of having physically and emotionally exhausted nurses on the job? What is the long-term cost of caring more for the bottom line than for quality of care?

It's high. Too high, given the made-in-Canada research evidence this paper highlights. Still, with commitment and planning, most of the recommendations we've explored in this paper could be done both quickly and affordably. The Canadian researchers and experts we talked to for this paper have a wealth of ideas for transforming nursing, as the list below shows. No single person or entity can put them all in place, of course; but as they are tested and adopted across the country, patient care and the health care system as a whole can only improve.

To keep nurses on the job:

Employment

Give nurses full-time, long-term jobs. The number one reason nurses moved to the U.S. was in search of full-time work.

Control

Let nurses have more control over their jobs, and independence to use all their knowledge and skills. Many who have left Canada wanted to take on more advanced practice — such as being a nurse practitioner.

Development

Offer professional development and education choices to nurses, as well as organized career paths and a role in research. Learning new things motivates nurses.

Rewards

Value nurses' work with recognition, support and a central place in the organization community. Nurses who feel adequately rewarded are less likely to burn out. Nurses, including new nurses, expect to have their efforts acknowledged.

Burnout

Hire enough nurses so they have manageable workloads and work reasonable hours with limited overtime. Fatigue, overwork, lack of control over their jobs and lack of respect from their employers are all reasons so many nurses report feeling burned out — which can lead to poor-quality care.

Research

Find out why nurses leave their jobs — either through research studies, or with exit interviews — then take action to change things. More than a decade of research makes it clear what works to keep nurses on the job; it just needs to be put into practice.

To create a good working environment:

Communication

Keep information flowing. Part of feeling in control is being up-to-date on the organization's plans. Feeling they are listened to and contributing to those plans makes nurses feel respected and more satisfied with their jobs.

Safety

Make occupational health and safety a central focus of education and operations. Nursing is a hard physical job, but the right working conditions — including continuing education and the right equipment — can keep nurses safe and healthy.

Orientation

Integrate nurses into new jobs gradually. Orientation programs and mentorship programs (especially for new graduates) reduce turnover and cut the stress that can lead to burnout.

Quality

Evaluate outcomes and report on the effectiveness of care. Nurses want a feedback loop, so care can be improved.

Goals

Set clear, measurable targets for improving work conditions for nurses, such as a percentage of staff to be involved in research, hospital committees or professional development programs.

Leadership

Promote leaders who can analyze situations, see solutions and involve staff in improvements. Leadership strongly affects nurses' feelings about their jobs.

Planning

Improve human resources management by gathering information on an ongoing basis from across the organization (and beyond) to allow for shifts in needs and staff availability. The upheaval caused by poor planning for staff changes disrupts nurses' work and can lead to bad communication, gaps in care and mistakes.

To prepare today's students for tomorrow's nursing:

Learning

Teach students that learning will be an essential part of their work as nurses throughout their careers. Breakthroughs in science and care mean nurses have to continually update their knowledge and acquire new skills.

Decisions

Teach student nurses to make decisions based on evidence. Working independently, or as part of a team, requires nurses to be able to identify what they need to know, as well as where to look for answers and how to weigh evidence.

Integration

Prepare students for new approaches to health care with multidisciplinary education. Collaborative teams work better when they have shared foundations.

To turn nurses into innovation incubators:

Curiosity

Encourage nurses to question, evaluate and test established practice every day. Challenging the status quo makes nurses' work more interesting and benefits patients when it leads to better approaches to care.

Support

Budget adequate funds to support innovation — including enough money for other staff to cover nurses while they develop tests and studies. Make sure organization leaders support curiosity and welcome innovation.

Safety

Build concern for safety issues into every activity. Regularly measuring the results of care, giving and getting feedback, trying changes and auditing the results improves patient safety.

These ideas have been suggested before. They have been tested and proven effective. And yet they are not universally applied. These basic steps to give nurses the practice environments they need to deliver safe, efficient, innovative care would benefit patients and improve the health care system. Nurses deserve no less; Canadians deserve no less.



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Experts & Evidence *Opportunities in Nursing*



About the Experts

Andrea Baumann, BScN, MScN, PhD

Dr. Baumann is Associate Vice-President of the Faculty of Health Sciences at McMaster University and Scientific Director of a multidisciplinary health services research unit funded by the Ontario Ministry of Health and Long-Term Care, that focused on health human resources and health services. She has been with McMaster's School of Nursing since 1988 and has served as the Associate Dean of Health Sciences (Nursing) from 1990 to 2005. Dr. Baumann is also a co-investigator in a CIHR team grant in community care and health human resources. She has been a member of various journal editorial boards and grant reviewer on three multi-disciplinary councils. Dr. Baumann's recent publications focus on supply and production of health care workers and rural policy implications. In addition to her research, Dr. Baumann has directed several international projects in relation to capacity-building and higher education for women.



Andrea Baumann

Debra Bournes, RN, PhD

Dr. Bournes is Director of Nursing, New Knowledge and Innovation at University Health Network. Her work in nursing theory-guided practice and research, health services research and leadership has been widely presented and published, sparked international interest, led to collaborations among provincial health care organizations and nursing unions, been cited as a promising practice by the Canadian Health Services Research Foundation and been named a national best practice



Debra Bournes

by the Canadian Council on Health Services Accreditation. As one of the developers of the humanbecoming 80-20 professional development model for nurses, Dr. Bournes has helped this nursing theory-based model to gain widespread attention and utilization in several health care organizations and provinces. Dr. Bournes has received the University of Toronto Bloomberg Faculty of Nursing Award of Distinction (2008), the Ontario Hospital Association Award of Excellence in Nursing Leadership (2008) and the RNAO Leadership Award for Nursing Research (2009).

Sean Clarke, RN, PhD, FAAN



Sean Clarke

Dr. Sean Clarke holds the RBC Chair in Cardiovascular Nursing Research at the University of Toronto and the University Health Network. Dr. Clarke's research deals primarily with organizational aspects of acute care nursing (with a particular emphasis on staffing levels, work environment factors, patient outcomes and nurse occupational health) and nurse workforce issues. He has authored or co-authored 80 articles, 15 book chapters and co-edited a volume on medication safety for nurses. He serves on the editorial boards of a number of journals and is currently Associate Editor of the *Canadian Journal of Nursing Research* and a deputy editor for the leading health services research journal, *Medical Care*. A fellow of the American Academy of Nursing, Dr. Clarke holds adjunct appointments at the Université de Montréal and the University of Pennsylvania, and visiting appointments at University College Dublin and the University of Hong Kong.

Greta Cummings, RN, PHD



Greta Cummings

Dr. Cummings joined the Faculty of Nursing at the University of Alberta in 2004 following 15 years of senior administrative leadership experience in hospital, regional and provincial health services. She established the CLEAR Outcomes research program of leadership science in health services, which focuses on the leadership practices of health care decision-makers and managers to achieve better outcomes for providers and patients. Dr. Cummings holds two investigator awards, and since 2003, her research has resulted in over 65 peer-reviewed publications. She recently completed four years as President Elect and then President of the Canadian Association of Nurses in Oncology and is currently President of the International Society of Nurses in Cancer Care. Dr. Cummings's work has been recognized nationally and internationally through several prestigious research awards, including the Canadian Nurses Association Order of Merit for Research (2010) and the CASN Award for Research Excellence (2008).

Francine Girard, RN, PhD

Dr. Girard is Dean and Associate Professor in the Faculty of Nursing Science at Université de Montréal. She has been appointed Chairperson of the Quebec Task Force on the Working Conditions of Nurses. In her roles as First Vice-President and Director of Nursing for the Calgary Health Region, and as Principal Vice-President for Professional Practice and Research, she developed partnerships and helped to establish a strategy for the promotion of clinical research, as well as research in nursing retention and health human resources. Dr. Girard is a regional director for the Victorian Order of Nurses and has held positions as Vice-President and Chief of Practice of this non-profit, charitable home and community care organization. She has experience as a health care consultant on a national scale.



Francine Girard

Mary Ellen Gurnham, RN, MN

Ms. Gurnham is the Executive Director of Learning and Chief Nursing Officer (CNO) for the Capital District Health Authority which is comprised of 11 facilities, employs 8500 staff, and provides primary, secondary and tertiary services. Over the past 25 years, she has held a variety of senior clinical administrative positions in health care. As Executive Director of Learning, her mandate is to create a strategic plan for learning in an academic health district, clinical professional development, organizational learning and related supports. As CNO, her mandate is to provide strategic direction and leadership to strengthen and support nursing practice and to address recruitment, retention, practice, and worklife issues. Ms. Gurnham leads several initiatives to redesign care delivery models with the following objectives: 1) to create patient- and family-centred approaches to care which maximize scope of practice, 2) to foster interdisciplinary collaboration and 3) to identify and track patient outcomes.



Mary Ellen Gurnham

Mélanie Lavoie-Tremblay, RN, MScN, PhD

Dr. Lavoie-Tremblay is an assistant professor in the School of Nursing at McGill University and McGill representative for the nursing services administration training center, FERASI. She is a FRSQ Junior 1 Career Award recipient for 2007-2011 and is leading research funded by FRSQ, FQRSC, CIHR and CHSRF. Through her postdoctoral work, she has been involved with the nursing resources planning committee in Quebec to improve the use of research results in developing recommendations on retention policies for nurses. Dr. Lavoie-Tremblay is a regular



Mélanie Lavoie-Tremblay

researcher at the Centre de recherche Fernand Séguin and associate researcher at the MUHC Research Institute and Douglas Hospital. Her research interests include: retention of nurses, orientation programs for new nurses, organization of care and work, nursing workforce, program evaluation, knowledge exchange among managers, and participatory action research.

Victor Maddalena, BN (Post-RN), MHSA, PhD



Victor Maddalena

Dr. Maddalena is Assistant Professor in Health Policy and Health Service Delivery in the Faculty of Medicine, Division of Community Health and Humanities at Memorial University. He has completed two Post-Doctoral Fellowships in palliative and end-of-life care. Dr. Maddalena is the former Administrator of Sacred Heart Hospital in Cheticamp, Nova Scotia, and the former CEO of the Western Regional Health Board in Nova Scotia. He is a member of the Editorial Advisory Board for Leadership in Health Services. His research interests are in the areas of qualitative research in vulnerable populations, palliative and end-of-life care, health human resources, governance and accountability, and health policy. Dr. Maddalena's accomplishments at Dalhousie University include: Recognition of Outstanding Sessional Faculty (2008), two Excellence of Teaching Awards (2003, 2004) and Professor of the Year Award (2000).

Linda McGillis Hall, RN, PhD, FAAN



Linda McGillis Hall

Dr. McGillis Hall is a professor and Associate Dean of Research and External Relations at Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. She is a recognized leader in nursing health services and systems research, was the first Canadian to be inducted as an American Academy of Nursing International Fellow (2007) and is the inaugural recipient of the Canadian Nurses Association Order of Merit for Nursing Research in Canada (2008). She holds a Nursing Senior Career Research Award from the Ontario Ministry of Health and Long-Term Care (2009-2012) in the area of Workforce and Work Environments. Her research has also earned her a CIHR New Investigator Salary Award (2002-2007) and a Premier's Research Excellence Award from the Government of Ontario (2003-2008). Dr. McGillis Hall has developed a research program focusing on health human resources, the nursing work environment and how this influences nurse migration and nurse's health, and patient safety outcomes of nursing practice.

Linda O'Brien-Pallas, RN, PhD, FCAHS

Dr. O'Brien-Pallas is a professor in the Faculties of Nursing and Medicine at the University of Toronto and also co-founder and co-investigator of the Nursing Health Services Research Unit, University of Toronto site. She has completed over 85 research projects, helping to lay the foundation for a science-based nursing profession. Dr. O'Brien-Pallas is known globally for her pioneering and innovative research in health human resources modeling, quality of work life and nursing workload measurement. Her expertise is sought by governments and stakeholders in Canada and throughout the world. She has been frequently called upon by the World Health Organization and the International Council of Nurses to provide consultation on matters including midwifery and health human resources planning. Dr. O'Brien-Pallas provided leadership to many boards and committees and received numerous awards, including the Canadian Nurses Association's prestigious Jeanne Mance Award (2006) for her research and other contributions.



Linda O'Brien-Pallas

Mary Ferguson-Paré, RN, PhD, CHE

Dr. Ferguson-Paré is Vice-President of Professional Affairs and Chief Nurse Executive at the University Health Network in Toronto, and she is Associate Professor at the University of Toronto's Faculty of Nursing. Her previous experiences include progressive senior nursing management and executive positions in both acute care and long-term care sectors; nursing education; and institutional and community nursing experience in psychiatry, addictions therapy, Victorian Order of Nurses, family practice and student health. She produced a report and recommendations on innovations in nursing service delivery, improving the patient experience and outcome measurement, based on her sabbatical learning derived from a journey through Europe. Dr. Ferguson-Paré is the recipient of the Distinguished Alumni Award from the University of Toronto's Faculty of Nursing, the Award of Excellence in Nursing Leadership from the Ontario Hospital Association and the National Nursing Leadership Award from the Canadian College of Health Service Executives.



Mary Ferguson-Paré



Judith Ritchie

Judith Ritchie, RN, PhD

For more than 30 years, Dr. Ritchie has worked to link nursing practice and nursing research. As Associate Director for Nursing Research at the McGill University Health Centre, her research



Marlene Smadu

has focused on knowledge translation and nursing services administration; she collaborates with her leadership colleagues in practice, administration and the university to foster those linkages. Her current research projects are related to implementation of practice guidelines and the contextual variables influencing successful implementation of evidence-based practice. She is one of the co-leaders of the MUHC Nursing BPG Implementation Program. Throughout her career, Dr. Ritchie has created and promoted the use of evidence to strengthen the quality of care provided to patients. In February 2010, she was awarded the inaugural Excellence through Evidence Award by the Canadian Health Services Research Foundation for her critical leadership role in implementing evidence-informed innovations in health care.

Marlene Smadu, RN, EdD

Dr. Smadu is Associate Dean of the Southern Saskatchewan Campus and International Student Affairs for the College of Nursing at the University of Saskatchewan. She has served as the Assistant Deputy Minister of Health and Principal Nursing Advisor for the government of Saskatchewan and as Education Consultant and Executive Director at the Saskatchewan Registered Nurses Association. Dr. Smadu is Chair of the Saskatchewan Health Quality Council and is the facilitator for the Saskatchewan Union of Nurses – Government of Saskatchewan Partnership Table that addresses nursing retention and recruitment. Having served as President of the Canadian Nurses Association, Dr. Smadu is now the third Vice-President of the International Council of Nurses. Dr. Smadu's research program includes health human resource planning and development, Aboriginal health, the development of quality workplaces, quality improvement, health policy, knowledge transfer and leadership.

Heather K. Spence Laschinger, RN, PhD, FAAN, FCAHS

Dr. Laschinger is Principal Investigator of a program that examines the impact of work environments on nurse empowerment, health and well-being, and the role of leadership in creating empowering working conditions. She has served on numerous advisory groups in relation to healthy workplace issues and is currently a Healthy Workplace Champion for the Ontario Ministry of Health and Long-Term Care. Dr. Laschinger is the Nursing Research Chair in Health Human Resources Optimization and will lead a five-year research program focusing on new graduate nurses' successful transition to practice and on workplace violence. Dr.



Heather K. Spence Laschinger

Lashinger has received the Hellmuth Prize (2010) for top research honour and the Distinguished University Professor Award (2007) at the University of Western Ontario, been inducted as a Fellow in the American Academy of Nursing (2009), been elected to the Canadian Academy of Health Sciences (2008) and received the Award for Excellence in Research (2003) from the Sigma Theta Tau International Honor Society of Nursing.

Gail Tomblin Murphy, RN, PhD

Dr. Tomblin Murphy is a professor in the School of Nursing at Dalhousie University and a co-investigator in the Nursing Research Unit at the University of Toronto. She is Director of the newly-designated WHO Collaborating Centre on Health Workforce Planning and Research at Dalhousie University, which is mandated to build capacity for needs-based health human resources planning in Canada and abroad. She has made important academic contributions in developing a conceptual model for health human resources (HHR) planning and in establishing and implementing methods to conduct “needs-based planning”, which was adopted in 2006 as the guiding framework for Pan-Canadian HHR policy and planning. Dr. Tomblin Murphy is also a member of the Board of Trustees of CHSRF and Chair of the Nova Scotia Health Research Foundation Capacity Building programs, where she works to build capacity in Health Service Research.



Gail Tomblin Murphy

Ann Tourangeau, RN, PhD

Dr. Tourangeau is an associate professor, the Bloomberg Professor in Patient Safety, and Chair of the Graduate Program with the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto. She holds a Senior Nurse Researcher award from the Ontario Ministry of Health and Long-Term Care (2010-2013). Her program of research focuses on developing knowledge of determinants of patient safety, nurse and organizational outcomes such as patient mortality, and nurse retention. This knowledge is particularly relevant for health care organizations, policy makers and professional nursing organizations. She incorporates data from large administrative and clinical databases to answer questions related to the contribution that nursing care and nursing work environments make to patient and organizational outcomes. Before her academic career, Dr. Tourangeau held appointments as a health care administrator in the provinces of Ontario and Alberta.



Ann Tourangeau

About the Author

Jane Coutts



Jane Coutts runs Coutts Communicates, a consulting firm specializing in plain-language writing, editing and knowledge transfer. The business grew from her years as a journalist (including 10 years at *The Globe and Mail*, five of them as the health policy reporter) and her time with the Canadian Health Services Research Foundation, where she worked with researchers to get their findings used in the health care system.

Jane works with national and provincial organizations and researchers to produce plain-language versions of research that are useful and accessible for a wide range of audiences. Jane also teaches popular workshops on plain-language writing, on campuses and for research organizations across the country. She toured Australia giving workshops in 2005.

Born and raised in Toronto, Jane has a degree in English literature from the University of Toronto and one in journalism from Ryerson University. She has worked at newspapers in Ottawa, Hamilton and Toronto.