Discussion Paper on Quality Workplace Environments: Why, what, and how?

> "What is apparent in all this work is the need **not** to repair nursing, but rather to renew and repair the work environments in which nurses practice." (Canadian Nursing Advisory Committee, 2002)

Purpose

The purpose of this discussion paper is to introduce the reader to key elements of a quality work environment that promote recruitment and retention of nurses. By using the paper as a foundation for other discussion papers the professional practice portfolio, Capital Health hopes to facilitate ongoing dialogue enabling the generation of an effective strategy to improve the work place environment and the ability of health professionals to practice to the full scope of their licensure

The discussion paper outlines:

- The issue
- The problem
- Background information
- Magnet hospitals
- Does Capital Health have magnet hospitals
- Where do we go from here?
- Conclusions
- Questions

The issue

Looming shortages across all health professions, physically and mentally exhausted staff, recruitment and retention problems, unsafe workplace environments, lack of or ineffective managerial support and leadership are facing health care institutions nationally and internationally (Baumann et al, 2001; McClure & Hinshaw, 2002). All of these issues translate to compromised patient outcomes (Clarke & Aiken, 2003; Aiken et al, 2002; Canadian Nursing Advisory Committee, 2002). Strategies to enhance the work environment, improve recruitment and retention, address human resource shortfalls, facilitate scope of practice re-development within emerging non-physician clinical roles, and encourage appropriate staff mix must be revisited by government, professional organizations and bodies, and health care institutions.

The problem

Nursing workforce issues are multifaceted and complex involving many stakeholders including government (both federal and provincial), employers, professional associations, unions and educators. A concerted collaborative effort by all is required to effect change not only for recruitment and retention issues but to ensure growth through education and training of new health professionals.

Canadians, as a whole believe that that there is a nursing crisis. Human resource issues highlight the problem with projected shortages of 59,000 nurses by 2011 and 113,000 by 2016 (Canadian Nurses Association, 2002). Estimates for other health professionals are equally as bleak with some sectors pointing to a reduction in the work force of up to 50% within the next five years. Nurses comprise approximately 35% of all health professionals in Canada; a shortage of nurses has and will continue to have a direct impact upon the ability to deliver quality care, patient outcomes, the health of care providers and the public's confidence in the health care system (Advisory Committee on Health Human Resources, 2000) unless effective solutions can be found.

Strategies focusing on recruitment and retention must be addressed collectively as a nation, not in isolation at the provincial, regional or municipal levels. Currently, provinces and territories look across provincial borders to their neighbors for the purpose of attracting nurses and health professionals. This only serves to compound the shortage problems and pits provinces and territories against each other. Nor does international recruitment solve the problem. Canada has looked and continues to look abroad to recruit nurses and physicians. Foreign trained nurses are expected to add an additional 11,700 new nurses to the RN pool by 2011 (Canadian Nursing Association, 2002). International medical graduates comprise 50% of Saskatchewan's practicing physician complement (Kirby, 2002). This only serves to compromise systems (national and international) already pushed to the limit.

It should be noted that shortages are not necessarily the direct result of a decrease in absolute numbers. Nurse have left the profession for a variety of reasons from burn-out to lack of career opportunities to an inability to practice to the full scope of their licensure.

Background

The release of both the Romanow and Kirby reports in late fall 2002 affirms a Canadian health care system in crisis. The ability to sustain the system as it currently exists cannot continue given the evidence; a system wherein health professionals are leaving in increasing numbers, recruitment poses significant challenges across all provinces and territories, a population presenting with increasingly more complex and acute health concerns, an aging population, expensive technology, insufficient funds and a public whose demands and expectations supercede resources. Recommendations should provide the impetus to reform, renew and improve the Canadian health care system. Of importance was their identification of a need to 'invest in health care providers' (Romanow) or support 'health care infrastructure and infostructure' (Kirby). This does not come as news to health professionals on the front lines that have been struggling to accomplish more with fewer resources over the past two decades.

Nursing has been hit particularly hard with much of the cutbacks and upheaval occurring in the early 1990's in an attempt to address financial constraints. Historically, the approach has been to reduce the number of employees as a mechanism for cost reduction under the rubric of restructuring or re-engineering (Ritter-Teitel, 2002; Canadian Nurses

Association, 2002; Advisory Committee on Health Human Resources, 2000). Decision-makers have reorganized patterns of nursing practice at will with little or no input from nurses. Nurse administrators and administrative support have been cut shifting a greater burden onto frontline nurses leaving less time for patient care.

> Tinkering with the boundaries while failing to examine the core of what health workers do and how they do it is like rearranging the deckchairs on the Titanic. Allocating the tasks differently is the easy bit, and that is hard enough. The division of labour may have changed dramatically over the years, but the core assumptions about how professionals work have remained very largely intact.
>
> Romanow, 2002, p106.

Despite a directional change towards an integrative, collaborative interdisciplinary health care practice, the various health professions have continued to protect rather than relinquish duties within their specific disciplines. Alternative practice patterns such as a greater emphasis on primary care, appropriate staff mix in the acute care setting, and a review of the public health sector are required and should include a re-examination of traditional scopes of practice.

Reductions in the numbers of full-time positions, shifts to part-time and casual nursing, cost-reduction policies, exodus of nurses to the United States and abroad along with reduced availability of seats within educational institutions have resulted in a system that can no longer meet need let alone demand.

Examination of the numbers produces some very disconcerting facts. As of 2001, Canada had 252,913 RNs registered with their professional associations, the largest age cohort employed falling between the ages of 45-54. Based on age group distributions Canada can expect to lose 50,000 nurses by 2011. Human resource projections point to a deficit of 78,000 RNs in Canada by 2011 and 113,000 by 2016 based upon current health care needs.

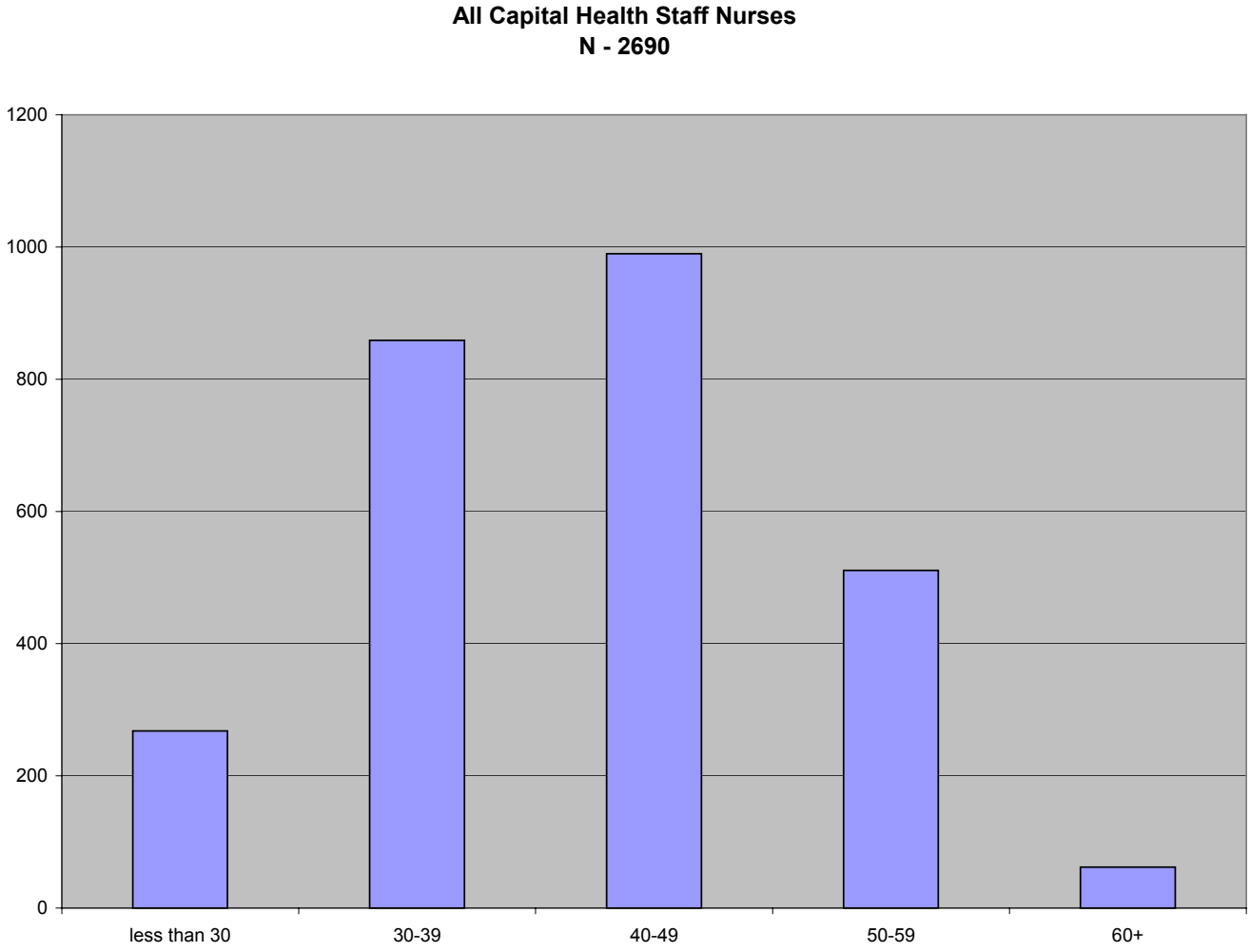
In response to a recommendation from the Advisory Committee on Health Human Resources (2000), the Canadian Nursing Advisory Committee (CNAC) was established to formulate policy to improve the quality of the workplace for nurses [nurses refers to Licensed Practical Nurses (LPN), Registered Psychiatric Nurses (RPN), and Registered Nurses (RN)], provincially, territorially and federally. Sixteen members formed this committee headed by Michael Decter. Representation was from across the country and included professional bodies, unions and government. Six papers/reports were commissioned to extensively explore current strategies for healthy workplaces, absenteeism and overtime, workload, nursing satisfaction, respect and autonomy and organizational structures that facilitate communication and interaction between patients, nurses and doctors.

Fifty-one recommendations were developed within 3 broad categories targeting the creation and maintenance of a stable quality work environment. The recommendations were designed to address operational issues and maximize use of available resources;

create professional practice environments focuses on recruitment and retention; and monitor activities, generate and disseminate information. Essentially, increase the number of nurses, improve education, maximize scope of practice and improve working conditions.

Some significant findings from the CNAC report (2001) include the following:

1. Average age of nurses nationally is 43.3 years with approximately half of nurses 45+years and 30% of nurses in this category 50+ years (CIHI, 2001). Capital Health age distribution for nursing mirrors this with the majority of staff nurses falling in the 40-49 years cohort. Data on the average age for Nurse Managers and Nurse educators is not available at this time from Capital Health. Nationally, the average age of a Nurse educator is 49years. Average retirement for nurses is 55 years.



Given the age patterns we are currently seeing for nursing cohorts within Capital Health a serious concern should be raised with regard to who will serve as preceptors

and mentors for new nurses entering the profession as the older nurses leave? Some units have minimal staff in the 30-39 age group and small numbers in the under 30 category. Can we realistically expect a handful of experienced staff to continue to function as mentors/preceptors as well as maintain their current workload? Additionally, with the average age of the new nursing graduate increasing we are seeing older nurses without the requisite years of experience typically associated with that age cohort further compounding the problem.

2. Nurses suffer the highest levels of stress of all health professionals (Sullivan, Kerr & Irahim, 1999). Long periods of job strain impact on personal relationships, increase sick time, increase turnover rates, and increase workplace injury and inefficiency (Baumann et al 2001).

3. Canadian Registered Nurses work almost ¼ million hours of overtime every week, which is the equivalent of 7000 FTE jobs/year (CLBC, 2002)

4. 7.4% of all Registered Nurses are absent from work due to injury, illness, burnout or disability in any given week (CLBC, 2002)

5. Over the course of a year more than 16 million nursing hours are lost to injury and illness which is the equivalent of 9000 FTE jobs (CLBC, 2002)

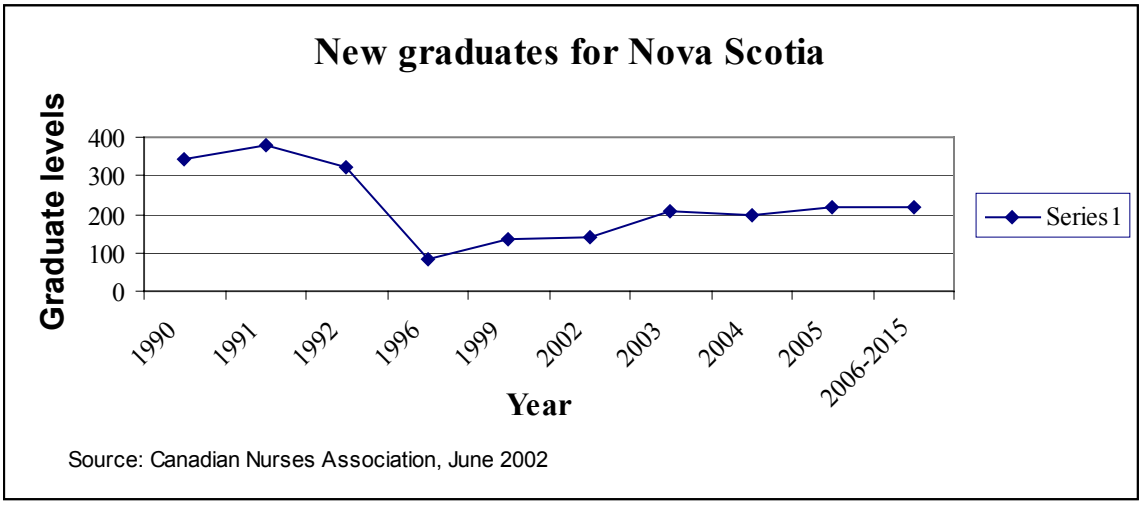
6. 45% of nurses work part-time or casual (CIHI, 2001). This may be due to a variety of reasons. One example may be nurses opting for part-time or casual employment as a means of controlling their work environment.

Looking at the statistics one has to ask, "what has been and is currently taking place in the work environment to drive the numbers around illness, injury and burnout?" Our ability to recruit and retain will remain difficult until we address the underlying factors within the workplace that impact on quality of work life for nursing.

Increasing the number of educational nursing seats has been suggested and movement in this direction has already taken place. Increasing the total number of graduates should not and cannot be viewed as the solution to a multifactor complex problem such as the nursing shortage. Nor should a return to the diploma-based program be considered and implemented. The shift to a greater complexity and acuity of patient care requires an in-depth knowledge and theoretical understanding that goes beyond the ability to perform core skills.

An infrastructure that includes professors, leaders, mentors and institutional placement availability must also be present. Currently, these resources are inadequate to meet the rising demand for nursing seats in universities. Even with the increase in enrollment numbers it is unlikely that our current education system will adequately meet this demand in light of the fact that approximately 60% or less of nursing students will complete the program (Canadian Nurses Association, 2002). Without addressing underlying factors, simply increasing the number of nurses we turn out will be doomed to failure. We will

continue to see high numbers of burnout, injury, illness and stress, and exodus from the profession, all of which impact adversely on quality patient care and outcomes.



In the figure above we can clearly see the downward trend and slow increase in nursing graduates. The transitional year for the shift from diploma to degree programs occurred in 1996 although the trend downward had begun around 1991 with the most precipitous drop occurring between 1993 and 1996. With increases in quotas from both Dalhousie University and St. Frances Xavier, the numbers have slowly increased. In 1999 Dalhousie increased their quota to 155 (135 Halifax, 20 Yarmouth) from 110. St. Frances Xavier has increased their seats from 75 to 100 and added an additional 25 with the introduction of the nursing program at the University College of Cape Breton. This brings the total number of seats available to 280. The number is expected to remain constant through 2015 (Canadian Nurses Association, 2002). It is important to note that even with an increase in educational seats the numbers remain less than those of the early 1990's. Overall seats had been reduced prior to the shift as part of a response to what was perceived as a surplus of nurses.

Magnet hospitals

What makes a particular health care institution more attractive than another? How are these same hospitals able to retain nurses in a climate where shortages, restructuring and lack of sufficient leadership and support are endemic?

The inability to recruit and retain nurses poses a significant threat to the health care system.

> "Since nurses provide 95% of the care that patients receive while hospitalized (American Hospitals Association, n.d.), these essential care needs will not continue to be met unless hospitals can solve the 'nursing shortage problem' – that is, their inability to attract and retain competent, experienced professional nurses" (McClure, Poulin, Sovie, et al, 2002).

Adequate nurse-patient ratios correlate with positive patient outcomes and overall satisfaction. Additionally, decreased numbers on the front line equate to increased burn-out, stress, work related injuries, decreased level of nursing care and job satisfaction, and increased patient morbidity and mortality rates (Mesmer, Gracia, Rosillo, 2002; Aiken, 2002; Baumann et al, 2001; Advisory Committee on Health Human Resources, 2000).

Over 20 years ago the American Academy of Nursing appointed a task force to examine the problem of nursing shortages in the United States. Their task was to identify what variables in hospital organization and nursing service created a magnetism that attracted and retained professional nurses and what combinations of variables produced models of hospital nursing practice wherein nurses received professional and personal satisfaction. Work spearheaded by Linda Aiken identified hospitals that had succeeded in creating nursing practice environments that served as "magnets" for nurses; they were able to recruit and retain nurses, and consistently provide high-quality care (McClure, Poulin, Sovie et al, 2002). The hospitals were regarded as "exemplars for practice, policy, and administration" (ibid).

What was different about 'magnet' hospitals permitting them to succeed where others had failed? All hospitals appeared to share a core set of organizational traits:

- A nurse executive who was a formal member of the highest decision-making body in the hospital
- Nursing services organized as a flat rather than hierarchical structure – decreased layers of bureaucracy
- Care units as the centers of decision-making related to organization of care and staffing appropriate to patient needs
- Supportive administrative structures pertaining to nurses' decisions about patient care
- Good communication between physicians and nurses

(Havens & Aiken, 1999)

All of the core traits facilitate quality patient care, nurse autonomy, education and a drive for excellence.

The organizational support provided within the institutions empowers nurses to use their professional knowledge and skills to the full scope of their licensure on behalf of their patients. The elements of a professional nursing practice model associated with empowering work environments include three core features:

- Professional autonomy over practice [define autonomy]
- Nursing control over the practice environment
- Effective communication between nurses, physicians and administrators

(Havens & Aiken, 1999)

When these features are present a synchrony occurs between authority and responsibility facilitating the employment of professional judgment by nurses.

Nurses surveyed in the magnet hospital studies identified eight essentials of magnetism:

- Working with clinically competent nurses
- Good nurse-physician relationships and communication

- Nurse autonomy and accountability
- Supportive nurse manager-supervisor
- Control over nursing practice and practice environment
- Support for education (in-service, continuing education, etc.)
- Adequate nurse staffing
- Concern for patient paramount

(Kramer & Schmalenberg, 2002)

Dissatisfaction expressed by Canadian nurses in relation to their work place mirror the findings of the magnet studies. Nurses need to "know that they can have a positive role in directing improvement for themselves and their patients. And in the end, they need to experience improvement that reflects the core values and standards of their profession" (Thomson, 2002, p36).

Magnet hospitals: do they exist in Capital Health?

What current data we have at Capital Health points to ongoing recruitment and retention concerns within Capital Health. Anecdotal information suggests that health professionals do not feel valued, listened to or that they have sufficient autonomy or control of their work environment and decisions pertaining to care delivery.

The strategic direction for Capital Health includes focusing on the current work environment and how to improve overall quality making it a healthier workplace for all employees. To support the development of a quality workplace two portfolios have been created, Professional Practice and Healthy Workplace. Incomplete data sets within Capital Health have made it difficult to obtain a complete picture of the underlying factors driving recruitment and retention problems.

By acknowledging the problem, Capital Health can begin the process towards effective change which includes a practice environment supportive of both patient, significant others and health providers alike.

Where do we go from here?

As a District, Capital Health should continue to build on their current strategies to address staff shortages and the work environment. This includes the development of goals that reflect concern for health professionals as providers of care. Within the framework processes should be put in place that will examine and facilitate enhancement, improvement or reform around issues such as mentorship and preceptorship programs, affiliate placement slots, leadership programs, staff mix, scope of practice and professional advisory committees (to promote a voice for health professionals at the executive or senior leadership level). Linkages with the academic community are key to ensure research, knowledge transfer, evidence-based practice and a sustainable human resource population of competent and skilled health professionals.

Furthermore, an important component of reform or change should include the development of databases where relevant indicators may be captured. Data collection

must be linked to outcomes, which serve to reinforce change processes, provide information for the purpose of evaluation and track trends as well as support optimal patient care delivery.

Baseline information related to what health professionals perceive as barriers or facilitators to a good work environment that supports their ability to practice to the full scope of their licensure, autonomy, control over their work environment, decision-making and problem solving, and job satisfaction

All work must reflect a collaborative approach with all stakeholders present from inception through to completion. The development of a magnet hospital does not occur in isolation and brings with it a cultural shift in the way we think and work individually, as teams and as an organization and district.

Conclusion

To have a magnet hospital means to have a practice environment that recognizes:

- The scope of practice
- Education for and
- Continuing competency of health professionals

Recognition of these qualities acknowledges a sound foundation of academic and experiential knowledge as building blocks to optimal patient care and the recruitment and retention of health care professionals.

Implementation of health care reform without taking into account key features influencing the work environment of care providers is unlikely to promote long-term sustainability. The characteristics of magnet hospitals can provide a vehicle to promote the changes necessary in nurses' and other health professionals' work environments essential to continued growth and development of the professions and more positive outcomes for patients accessing the system.

References

Will be supplied upon request

Questions

Your feedback on this discussion paper is encouraged and welcome. The comments, suggestions, and support will help guide the professional practice portfolio's next step as we work to improve the health care environment in Capital Health for all health professionals.

Thank you for taking the time to share your thoughts and ideas.

Section A	
General Demographics Please indicate which category you are currently employed within Nursing □ Director □ Manager □ Educator □ Staff Nurse Health Professional □ Director □ Manager □ Staff (provide discipline) _____ Site (hospital/facility) _____	
1. Do you find discussion papers a useful strategy to begin dialogue with others?	□ Not useful □ Somewhat useful □ Useful □ Very Useful
2. Did you find the discussion paper informative?	□ Not informative □ Somewhat informative □ Informative □ Very informative

3. Are you likely to use this discussion paper to talk with your colleagues?	□Yes □ No Why or why not? _____ _____ _____ _____
4. Would you like to have another setting within which to discuss issues raised in the discussion paper?	□ Yes □ No If yes, what forum would you like? (please rank them in order of preference) □ Focus group □ Regular discussion group (regularly scheduled meeting to facilitate discussion of a variety of topics arising from discussion papers) □ List-serv (electronic discussion groups) □ Other _____
5. Would you like to continue to have access to health care issues through discussion papers?	□ Yes □ No
Section B	
6. What factors (qualities or features) would help support you in practicing to the full scope of your licensure within your workplace?	Please list all factors you consider important to help you _____ _____ _____ _____

7. What do you believe are the greatest issue(s) or concerns in your workplace?	Please describe _____ _____ _____ _____ _____ _____

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