

# The Pulse of Renewal:

## A Focus on Nursing Human Resources



Published as a special report by the *Canadian Journal of Nursing Leadership*  
with the kind support of the Office of Nursing Policy, Health Canada

May 2005

**This report is about renewal. Authors have used debates and rigorous, insightful analysis to come up with important ideas. These need to be nurtured, protected, faithfully tended to, and then introduced into the real world at the right time. There are a lot of ideas here with the strategies that will see them take flight.**

# **The Pulse of Renewal:** **A Focus on Nursing Human Resources**

Published as a special report by the *Canadian Journal of Nursing Leadership*  
with the kind support of the Office of Nursing Policy, Health Canada

May 2005

The full report is available on our website at  
[www.nursingleadership.net/renewal](http://www.nursingleadership.net/renewal)

**Key findings indicate no shortage of applicants interested in nursing education ...**

## From the Editor

In its first report to Canadians (*Healthcare Renewal in Canada: Accelerating Change*, January 2005), the Health Council of Canada listed the renewal of health human resources (HHR) as an urgent priority. Health Canada's Office of Nursing Policy concurs, and supports the fundamental assertions that "renewing and strengthening healthcare is an important issue for Canadians" and that "without sufficient providers of care working together, all other efforts will flounder."

The Health Council also recognizes that healthcare professionals and providers are working to develop new and innovative approaches to meet the complex health service needs of Canadians. The *Canadian Journal of Nursing Leadership* is pleased to present the results of six commissioned papers on nursing human resource issues.

Nurses are often the first health professionals to interact with patients. They are vital to our healthcare system, yet we fail to provide consistent support for their roles and responsibilities, which are designed to maximize the outcomes of care.

All nurses have a desire to help and care for people, and all student nurses start out with this mission. They soon realize, however, that workplaces often do not support them, and they drop out, seeking other opportunities or choosing other professions to realize other dreams.

Even in school, student nurses encounter serious issues that can impede their ability to provide quality care after graduation and prevent them from having successful, fulfilling professional lives. If this situation is not addressed today, the nursing shortage will only be exacerbated and the future of the healthcare system will be in jeopardy.

### **What is the background to this report?**

The work completed by the Canadian Nursing Advisory Committee (CNAC) in 2002 was this report's impetus. The CNAC's 51 recommendations provided a framework for action. This was an ambitious undertaking with broad implications for the nursing profession: the collaboration that CNAC demands involves schools, hospitals and nurses. Such cooperation is vital to the renewal that will ensure Canadian patients the quality of nursing care they need.

Following the initial work of the First Ministers' Accord in 2003, the need for health

human resource planning and management was clear. If Canadians are to be guaranteed access to healthcare providers now and in the future, we must begin today to redesign the role of nurses in processes of care. A systematic transformation is key to this renewal.

In 2003, funding was put aside to support this HHR initiative over five years. The funding endorsed six projects consistent with health human resources. The project's completion date was March 31, 2004, and the budget allocation was \$2.2 million. Those instrumental in this project include a collaboration of nursing associations led by the Canadian Nurses Association, Canadian Policy Research Networks, Gail Tomblin Murphy, Linda O'Brien-Pallas, Dorothy Pringle, the Registered Nurses Association of Ontario and the Canadian Council on Health Services Accreditation.

### **Who should read this report?**

This report has been compiled for

- nurses who want to understand the complex issues surrounding health human resources and the nursing profession;
- policy think tanks and governments responsible for participating in the renewal of healthcare; and
- academic institutions looking for insight into attrition and student perspectives.

The goal is to reduce student attrition rates, respond to student needs and increase the number of successful nursing graduates. These strategies will eventually reduce the critical nursing shortage.

Finally, those who want to gain valuable knowledge and insight into the impact of health human resources on patient care, management and academics will find these research papers and discussions important.

### **Who are the contributors?**

The project had many supporters, including professionals, academics and policy makers – all leaders of the future, carving out recommendations that will influence how healthcare is delivered.

Everyone who has been involved in this project has a personal interest in ensuring that nursing remains the integral first line of healthcare. Implementing the 51 CNAC recommendations will influence the delivery of care and revolutionize Canadian nursing.

*Sandra Devlin, RN, MScN, CHE, Editor*

**The project had many supporters,  
including professionals, academics  
and policy makers — all leaders of  
the future ...**

**... will require leaders in the healthcare sector to develop creative programs to ensure an adequate labour supply in a labour-intensive sector.**



# Contents

## From the Editor — 3

## Report Overview — 11

*The Pulse of Renewal: A Focus on Nursing Human Resources* is a report of work commissioned by Health Canada's Office of Nursing Policy and is focused on strategies for augmenting and enhancing nursing human resources. The research covers a diverse spectrum including: progress on implementing the 51 recommendations of the 2002 Canadian Nursing Advisory Committee; attrition from schools of nursing; the quality of nurses' work life; nursing utilization and human resource planning in hospitals; dissemination of best practice guidelines; and issues related to educational preparation, leadership and workforce objectives.

## The Pulse of Renewal: Commissioned Reports — 13

Available at: [www.nursingleadership.net/renewal](http://www.nursingleadership.net/renewal)

### I Progress to Date — 15

The Office of Nursing Policy at Health Canada was interested in learning what actions had been taken across the country to implement the 2002 Canadian Nursing Advisory Committee recommendations. It engaged the Canadian Policy Research Networks (CPRN) in late 2003 to undertake this study. The study reviews the activities of nursing stakeholder organizations and describes trends in how implementation has progressed. Based on this work, barriers to implementation and supports required to complete it were identified.

### II In the Beginning: Attrition from Schools of Nursing — 17

This report sets the tone early by saying attrition is a fact of life in educational programs. But we are in a period of nursing shortage and it is important to retain as high a proportion as possible of students who select nursing as their profession. This study explores the reasons students leave RN, RPN and LPN programs prior to graduation and identifies potential interventions to reduce attrition from all three types of programs.

**III Work Life: A Dimension of Quality and Accreditation Standards — 19**

In 2001, the Canadian Council on Health Services Accreditation (CCHSA) incorporated work life as a key dimension of quality in its standards and accreditation program. After having tested this quality element and its standards for several years, several advisory groups convened to advise CCHSA on future directions about work life.

**IV Utilization: Implications for Nursing Human Resource Planning in Hospitals — 21**

This work, undertaken by Gail Tomblin Murphy and Linda O'Brien-Pallas, estimates the association between the number of hospital days and patient outcomes in acute care hospitals in Canada.

**V Best Practice Guidelines: Dissemination and Uptake across Canada — 25**

With Health Canada support, the Registered Nurses Association of Ontario (RNAO) broadened its dissemination and uptake of the nursing best practice guidelines (NBPG) to all provinces and territories in Canada.

**VI Educational Preparation, Leadership and Workforce Objectives — 27**

A collaboration led by the Canadian Nurses Association, and including the Academy of Canadian Executive Nurses, the Canadian Association of Schools of Nursing, the Canadian Federation of Nurses Unions, the Canadian Healthcare Association, the Canadian Practical Nurses Association and the Registered Psychiatric Nurses of Canada, sets a strategic framework in support of implementing the CNAC recommendations in the following 11 reports.

1. Educational Preparation Objective A: Student Selection Processes — 27
2. Educational Preparation Objective B: Student Attrition — 29
3. Educational Preparation Objectives C & D: Clinical Placements — 31
4. Educational Preparation Objective E: Nurse Educator Careers — 32
5. Leadership Objective A: CNA Preceptorship and Mentoring Project — 34
6. Leadership Objective B: The Economic Value of Nursing:  
A Conceptual Framework and Identification of an Analytical Strategy — 35

7. Leadership Objective Objectives C & D: Competencies Required of Nurse Managers — 37
8. Workforce Management Objective A: Assess Use, Compliance and Efficacy of Nursing Workload Measurement Tools — 39
9. Workforce Management Objective B: Equipment Needs of Canadian Nurses: Report of a Survey of Senior Nurse Executives — 41
10. Workforce Management Objective C: Phased Retirement (Enablers and Barriers) and Other Programs for the Retention of Older Healthcare Workers — 43
11. Workforce Management Objective D: Evaluation Framework to Determine the Impact of Staff Mix Decision-Making — 45

**More work is needed ... between governments and academic institutions ... to match the future vision of a reformed health system.**

# Report Overview

In its first report to Canadians (*Healthcare Renewal in Canada: Accelerating Change*, January 2005), the Health Council of Canada identified the need for modernizing our provision of healthcare services and broadening the services provided. More work is needed, the report says, between governments and academic institutions to accelerate changing models of undergraduate education and training opportunities for health professions to match the future vision of a reformed health system.

*The Pulse of Renewal: A Focus on Nursing Human Resources* is a report of work that is already promoting such modernization. It is part of a body of research recognized by the Health Council in this way: "... Healthcare professionals and providers have given advice and are working to develop new and innovative approaches to meet the complex health service needs of Canadians." The *Canadian Journal of Nursing Leadership* is publishing this abstract and the full report with the kind support of the Office of Nursing Policy, Health Canada. The full report is available on our website at [www.nursingleadership.net/renewal](http://www.nursingleadership.net/renewal).

## Background

The Canadian Nursing Advisory Committee (CNAC) prepared a Final Report in 2002 entitled *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses*. The CNAC report contained 51 recommendations with goals to improve the quality of work life for nurses. In addition, it articulated designated timelines and roles for governments, employers, unions, professional associations, regulatory bodies, educators and the research community. One year later, Health Canada's Office of Nursing Policy (ONP) set out to determine the progress that had been made in response to these recommendations.

The six followup projects commissioned by the ONP had similar goals: to study one aspect of the nursing world, to effect change, to increase our knowledge about the healthcare system and, specifically, to show how nursing is positioned within the system. This extensive research will compel nursing leaders, healthcare administrators and academics to look for new and innovative solutions to problems that have plagued nursing for decades. The work included the following studies:

### I. Progress to Date

In 2003, the Office of Nursing Policy at Health Canada engaged Canadian Policy

Research Networks (CPRN) to investigate the actions that had so far been taken across the country to implement the 51 recommendations contained in the Final Report of the Canadian Nursing Advisory Committee, *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses* (CNAC, 2002).

## II. In the Beginning: Attrition from Schools of Nursing

This report, prepared by Dorothy Pringle of the Faculty of Nursing, University of Toronto, found attrition to be a fact of life in educational programs. Because Canada is in a period of nursing shortage, we must retain as high a proportion as possible of students who select nursing as their profession. This study explores the reasons students leave RN, RPN and LPN programs prior to graduation and identifies potential interventions to reduce attrition from all three types of programs.

## III. Work Life: A Dimension of Quality and Accreditation Standards

In 2001, the Canadian Council on Health Services Accreditation (CCHSA) incorporated work life as a key dimension of quality in its standards and accreditation program. After testing this quality element and its standards for several years, various groups convened to advise CCHSA on future directions about work life.

## IV. Utilization: Implications for Nursing Human Resource Planning in Hospitals

This research, undertaken by Gail Tomblin Murphy and Linda O'Brien-Pallas, examines the association between number of hospital days and patient outcomes in acute care hospitals in Canada.

## V. Best Practice Guidelines: Dissemination and Uptake across Canada

With Health Canada's support, the Registered Nurses Association of Ontario (RNAO) broadened its dissemination and uptake of the nursing best practice guidelines (NBPG) to all provinces and territories in Canada.

## VI. Educational Preparation, Leadership and Workforce Objectives

A collaboration led by the Canadian Nurses Association and including organizations representing all aspects of nursing work set out a strategic framework in support of implementing the CNAC's recommendations.

Overall, this multimillion-dollar commission is consistent with government themes and priorities, concentrating on healthcare renewal in Canada and the need to accelerate the pace of change.

**The Pulse of Renewal: [Focus on Nursing Human Resources](#)  
Commissioned Reports**







# I. Progress to Date

## Canadian Policy Research Networks (CPRN)

The Canadian Nursing Advisory Committee (CNAC) released its Final Report, *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses*, in August 2002. This report was widely viewed as helpful in distilling the complex issue of nursing shortages into a menu of practical strategies. Late in 2003, the Office of Nursing Policy, Health Canada, engaged Canadian Policy Research Networks (CPRN) to investigate the progress achieved across Canada towards implementing the CNAC's 51 recommendations.

The CPRN's report, prepared by Lisa Maslove and Cathy Fooks, reviews the activities of nursing stakeholder organizations and describes trends in implementation. Based on this work, barriers to implementation and supports required to complete it were identified.

For a few CNAC recommendations, such as increasing the number of education seats for RNs, LPNs and RPNs, implementation has been widespread. But on most issues, progress appears to have been made in pockets. For example, individual employers across the country are implementing Workload Measurement Systems (WMS), increasing the number of full-time positions, examining absenteeism, hiring nurse mentors and piloting flexible scheduling systems. But assessing the impact of implementation nationwide is more difficult. Many respondents observed that changes are likely to be concentrated in acute care facilities rather than community, long-term care or other settings.

Despite the complexity of the policy issues addressed by CNAC, some common barriers to implementation emerge, including the following:

- *Accountability:* While many of the recommendations identify specific organizations to carry out implementation, the ultimate responsibility for implementation remains unclear to nursing stakeholders.
- *Resources:* Employers require stable funding to plan for workplace improvements and create stable jobs.
- *Collective bargaining:* A number of the workplace issues addressed by the CNAC

recommendations are introduced at bargaining for collective agreements, raising questions about how work life issues are weighed against salary issues in this context.

A number of policy-level supports have facilitated implementation of CNAC's recommendations, including

- provincial/territorial Nursing Advisory Committees and leadership positions for nursing;
- targeted funding for investments in nursing work life;
- monitoring mechanisms such as surveys and accreditation that identify problems, clarify underlying human resource issues and highlight where implementation has and has not led to improvements at the bedside;
- evidence to support decision-making, including university-based research, employer-level administrative data, pilot project evaluations and repositories of initiatives that have been implemented across Canada;
- integration of nursing work life issues with wider health system reform or population health issues.

On the whole, there are signs that quality of nursing work life is improving but that changes are not widespread. Systemwide change requires that the barriers and supports identified in this study be addressed.

## II. In the Beginning: Attrition from Schools of Nursing

Dorothy Pringle, *University of Toronto*

This report states that attrition is a fact of life in educational programs. In a period of nursing shortage, however, retaining as high a proportion as possible of students who select nursing as their profession is a critical priority. The study explores the reasons students leave RN, RPN and LPN programs without graduating and identifies potential interventions to reduce attrition from all three types of programs.

Students leave schools of nursing for many different reasons, and those who do start to think about leaving early in their programs. The major reasons for leaving relate to

- **complaints about the programs and lack of support from faculty members;**
- **costs of the programs, and insufficient funds to cover tuition and living expenses;**
- **disillusionment with nursing as a career; and**
- **academic failure.**

Students in RN and LPN programs face different problems. Disillusionment is an RN student problem; LPN students more often report failure and inability to manage the demands of programs. More RN than LPN students complain about courses and programs, but both groups report receiving less faculty support and encouragement than they needed, and both are led to withdraw by costs and lack of financial resources. Other reasons for withdrawal that have been identified as significant in previous studies – personal problems, stress, illness and family responsibilities – were identified by only a few students in this study. The fact that these factors were identified by only a very few respondents should not diminish the important role they played in these students' decision to withdraw. A sizeable percentage of students who leave find it a difficult decision, particularly LPN students; many, also particularly LPN students, regret having made it. High school averages that are considerably lower than the class average may serve as an indicator of students at risk for withdrawing from RN programs, but not LPN programs.

**Call to action!**

The results of this study suggest that schools of nursing can take action to mitigate attrition. **Today's nursing students need to have the state of the healthcare system explained to them, including the effects of reduced funding and restructuring on nursing as a profession and on nurses' career satisfaction.** While it is important to recruit the best students available, it is equally important that they enter a nursing program knowing there is dissatisfaction within the profession about nurses' role in the healthcare system. Students also need to know that the state of the healthcare system and of nursing will be topics of ongoing discussion and debate throughout their program, along with discussions of policies and practices to improve the system.

A related issue is the degree to which the clinical environments where students practise are "student-friendly." Clinical practice is anxiety-provoking enough for students without their having to cope with unhelpful or actively hostile staff. Since most organizations that provide clinical practice opportunities for students undergo accreditation, **the accrediting bodies should add "quality of environment for student learning" to their list of areas for review, and develop standards for such assessment.**

Schools must also look at the extent to which faculties support students and at whether courses and individual classes are meeting the needs of mature students and other groups, particularly in RN programs. **Strategies and programs must be directed towards ensuring that students receive the support they require, particularly early in their programs.** Students cannot be relied upon to recognize that they need support and to seek it out; it will have to come to them.

Many students in nursing programs will not succeed without sources of funding. Because the number of clinical hours nursing students must work is significant, they have little time available to earn money for living expenses. This constraint puts many under more financial pressure than students in other university programs. **Nursing needs to address this problem by developing solutions that allow more students to work fewer extracurricular hours and, hopefully, succeed in their programs.**

While eliminating attrition entirely may not be possible, every effort should be made to reduce it to a minimum, because the costs are so high. Attrition costs students who withdraw a year or two of earning power and can devastate their sense of self-worth. It costs schools of nursing effort and resources without producing a reliable pool of graduates. For every student who does not complete a program, one fewer nurse is available to Canada's healthcare system.

# III. Work Life: A Dimension of Quality and Accreditation Standards

## Canadian Council on Health Services Accreditation

In 2001, the Canadian Council on Health Services Accreditation (CCHSA) incorporated work life as a key dimension of quality into its standards and accreditation program. After several years of testing this quality element and its standards, various nursing groups convened to advise CCHSA on future directions.

The results of a National Consensus Meeting and subsequent surveys are being used to

- revise the CCHSA's work life dimension and descriptors;
- improve nursing work life standards;
- enhance the requirements for information from organizations prior to the accreditation survey; and
- develop guidelines for surveyors to evaluate these standards in health service organizations.

The four brief reports from the CCHSA included here summarize the results of a Work Life Advisory Committee meeting, the National Consensus Meeting on Work Life Indicators, a series of educational Work Life Regional Seminars, and a pulse survey to monitor work life indicators in healthcare organizations.

The Work Life Advisory Committee's discussion revolved principally around the need for

- a model to conceptualize CCHSA's approach to work life through its accreditation program;
- appropriate and meaningful indicators to support health service organizations to monitor improvements in work life practices; and
- revision of CCHSA's current work life dimension and descriptors to reflect the increasing body of evidence on work life in the field, as described in the literature review.

**Call to  
action!**

**Call to action!**

The National Consensus Meeting on Work Life Indicators recognized the value of CCHSA's accreditation program to support improvements in work life in health service organizations. Six specific actions were targeted and undertaken in 2004:

1. Development of a model that conceptualizes CCHSA's approach to work life;
2. Refining CCHSA's work life dimension and descriptors;
3. Enhancement of work life standards and criteria across standards sections (e.g., Leadership and Partnerships, Support Services, Client Services);
4. Enhancement of requirements for information from organizations prior to the accreditation survey;
5. Development of a set of guidelines for surveyors to evaluate these standards in health service organizations; and
6. Development and delivery of educational programs to promote understanding of the relevance of work life to patient/client and systems outcomes.

With regard to action #6, eight Work Life Regional Seminars were delivered across Canada between March 24 and May 31, 2004. The target audience included accredited health service organizations. The purpose was to build awareness of work life from different perspectives, identify strategies and tools to address work life at the organizational level, obtain information about CCHSA's initiatives to support quality of work life and identify how the accreditation standards could be enhanced to address work life issues.

Also in 2004, CCHSA partnered with the Ontario Hospital Association to develop and implement a pulse survey tool to measure a key set of work life indicators in healthcare organizations. CCHSA anticipates and encourages partnership with other stakeholder groups and Health Canada's Office of Nursing Policy to advance the quality of work life in Canadian health service organizations.

Finally, CCHSA supports development of a comprehensive National Work Life Strategy. Such a long-term agenda would enable CCHSA to determine priorities and set goals to ensure continuing and sustainable improvements in work life through its accreditation program.

## IV. Utilization: Implications for Nursing Human Resource Planning in Hospitals

Gail Tomblin Murphy, *Dalhousie University*  
Linda O'Brien-Pallas, *University of Toronto*

This work extends the researchers' 2003 study, "Health Human Resource Planning: An Examination of Relationships among Nursing Service Use, an Estimate of Population Health, and Overall Health Status Outcomes in the Province of Ontario." The primary objective of the present study was to assess whether patient outcomes were sensitive to differences in the observed minus expected number of hospital days after controlling for age, sex and chronic health conditions.

The study focused primarily on the relationship between resource deployment and patient outcomes in order to provide an evidence base for the impact of policy on availability and use of healthcare inputs. In particular, two questions were raised:

1. How does health vary as a function of relative levels of inputs (days of hospital care and, by proxy, exposure to nursing care)?
2. How does the expected utilization of hospital services per capita vary across provinces and territories as a function of differences in the provincial populations?

Evidence from the researchers' previous work suggests that after controlling for other system, patient and population factors, hospitals with lower average lengths of stay have higher levels of nurse utilization per patient.

From this study, it is clear that

- significant differences exist among the provinces, both in terms of health service utilization (in the form of hospital days) and in expected demand for these services; and
- factors other than age, sex, income, education, location type, employment status,

living arrangement and chronic conditions can be strong predictors of health utilization.

For example:

- Younger females (aged 18–34) were significantly more likely to have had a hospital stay than males of the same age groups, possibly reflecting hospitalization associated with childbearing.
- Out-of-workforce respondents were significantly more likely than employed respondents to have had an overnight stay, probably because such people may be experiencing illness, disability or injury requiring hospitalization.
- People living outside census metropolitan areas (CMAs) were significantly more likely to have had an overnight hospital stay than those living in CMAs. This finding may reflect clinicians' tendency to identify people with marginal health status and reduced access to other services and admit them for observation.
- There is an inverse relationship between level of education and overnight hospital stays, perhaps because educated people have more knowledge about their health status and have developed better means of access.
- Among respondents who had at least one overnight stay, the rate of hospital days per year was greater in young women of childbearing years and in older men. This finding implies that familial obligations influence the number of hospital days per stay and suggests the need for resources in the community to support families or deliver care at home. It also highlights the need for special discharge planning with these groups.
- Higher levels of depression were associated with more days of stay per year than lower rates of depression.

The researchers' 2003 study, carried out in Ontario, concluded that increased nursing intensity (measured by increased nurses per bed-day) reduced length of stay but not at the expense of system and health outcomes. This study supports that finding: there was no evidence that fewer nights of stay were associated with lower levels of health status after controlling for other population-based factors. In fact, the opposite was true; once in hospital, the more hospital days a patient has, the lower the self-reported health status and the lower the person's probability of having a Health Utilization Index greater than 0.8.

One of the key results of this analysis was that for each day in hospital longer than the stays predicted by the researchers' model, a patient's odds of self-reported improved health status decreased by 5%. Given that more hospital care was associated with poorer health status (after controlling for other factors), it is important to consider factors that might explain the longer than expected hospital stays.



In particular, relative shortages of other healthcare inputs (such as nursing human resources) may lead to delays in the rate of recovery of patients and, hence, delayed discharge. In other words, inadequate levels of such inputs as nursing services may account for both the higher than expected number of hospital days and lower health status. This result may also relate, in part, to increased exposure to iatrogenic effects of hospitalization with increased hospital bed-days and/or to some aspects of health needs not captured by the researchers' model.

The findings of this study have important policy implications:

1. There was no evidence that fewer nights in hospital were associated with lower levels of health status after controlling for other population-based factors. The researchers' 2003 study found that shorter lengths of stay were associated with higher levels of nursing input.
2. Populations that have higher rates of chronic conditions (e.g., diabetes and heart disease) have more hospital days, and numbers of hospital days differ by jurisdiction.
3. Significant investment is needed to create and maintain readily accessible databases and methods that allow HHR researchers and planners to compare differences between and across jurisdictions in order to understand the health needs of populations and to determine whether the system is meeting these needs efficiently and effectively.
4. HHR planning should be based on the health needs of the population in the context of availability of other healthcare human and nonhuman resources, and it should consider as many factors as possible that affect use of healthcare services (e.g., social, political, geographical, technological and economic factors).
5. HHR planning cannot depend on simple solutions to provide short-term answers. A comprehensive approach demands partnerships that include policy makers and researchers who have different perspectives.
6. Intensive preventive initiatives may reduce overall hospital admissions and lengths of stay for people suffering from chronic conditions and/or depression.

**Call to  
action!**

**... there is readiness across the country for a concerted effort in providing supports for day-to-day clinical practice issues**

## V. Best Practice Guidelines: Dissemination and Uptake across Canada

### Registered Nurses Association of Ontario

With Health Canada's support, the Registered Nurses Association of Ontario (RNAO) broadened its dissemination and uptake of the nursing best practice guidelines (NBPG) to all provinces and territories in Canada. The work comprised three major initiatives:

1. *Workshops:*

The purpose of the one-day workshops was to orient nurses to evidence-based practice, introduce the published NBPG and provide a preliminary understanding of knowledge transfer and NBPG implementation in practice settings. These workshops were well received; some 1,400 individuals were left on the waiting list. RNAO is prepared to conduct further workshops of this nature, provided appropriate support is secured.

2. *French translation of BPG and Health Education Fact Sheets (HEFS):*

In order to ensure accessibility of the BPG and HEFS to French-speaking nurses and patients, five high-demand best practice guidelines were translated into French:

- Client Centred Care
- Establishing Therapeutic Relationships
- Assessment & Management of Pain
- Risk Assessment & Prevention of Pressure Ulcers
- Assessment & Management of Stage I to IV Pressure Ulcers

In addition, 12 Health Education Fact Sheets were translated: Putting Patients First; Taking the Pressure Off: Preventing Pressure Ulcers; Gaining Control of Your Pain; Deciding to Quit Smoking; Understanding Crisis; Constipation: Prevention is the Key; Incontinence: Breaking the Silence; Reduce Your Risk

for Falls; The Goal is Asthma Control; Breastfeeding – The Best Start; Recognizing Delirium, Dementia, Depression; Taking Care of Your Legs.

3. *Partnerships with Best Practice Spotlight Organizations outside Ontario:*  
In Ontario, seven healthcare organizations have partnered with RNAO to implement multiple BPG through a strategic and structured approach, and to evaluate their impact on patients' health, clinical outcomes and system/financial impact. Funding from Health Canada allowed RNAO to expand this opportunity beyond Ontario, and two organizations from Quebec were designated as additional Best Practice Spotlight Organizations. Both Quebec Spotlight Organizations have developed plans for the second phase of the initiative, which will continue the work of capacity development and focus heavily on implementation.

## Call to action!

The RNAO concludes that there is readiness across the country for a concerted effort in providing supports for day-to-day clinical practice issues. The response of nurses should demonstrate to governments at all levels the value of investing generously in implementing evidence-based clinical practice through dissemination and application of the nursing best practice guidelines.

## VI. Educational Preparation, Leadership and Workforce Objectives

Academy of Canadian Executive Nurses, Canadian Association of Schools of Nursing, Canadian Federation of Nurses Unions, Canadian Healthcare Association, Canadian Nurses Association, Canadian Practical Nurses Association and Registered Psychiatric Nurses of Canada

This multiagency collaboration produced 11 reports on implementing the CNAC's recommendations. The recommendations contained in these reports are those of the authors and do not necessarily reflect those of the collaborating organizations on the project Steering Committee.

### VI-1. Educational Preparation Objective A: Student Selection Processes

#### Authors:

Pauline Paul, *University of Alberta*

Rene Day, *University of Alberta*

Jeanette Boman, *University of Alberta*

Wendy McBride, *Canadian Association of Schools of Nursing*

Dina Idriss, *Canadian Association of Schools of Nursing*

This project examined student selection processes in Canadian programs (diploma and degree) that lead to registration in any of the regulated professions: registered nurse (RN), licensed practical nurse (LPN) and registered psychiatric nurse (RPN). Information was collected through electronic surveys and telephone interviews.

Key findings indicate no shortage of applicants interested in nursing education; however, the quality of applicants and the availability of resources to devote to the selection process are at times an issue. Nonetheless, programs did not go below their advertised grade-point average (GPA) in admitting the 2003 cohort. Academic performance is key to admission in the majority of baccalaureate programs, while a significant proportion

of LPN programs rely on a “first come, first served” approach. Few programs use interviews, letters of reference or other methods of selection. Some respondents indicated a desire to use these as complementary methods. All types of programs asked for similar prerequisite courses, and many respondents provided a rationale for using them. These rationales were akin to those found in the literature and comparable to what was found in a survey of other disciplines.

Although a relatively small number of programs reserved seats for Aboriginal students, few were able to fill these seats. The intent to admit these students does not translate into significant numbers. Although few seats were reserved for students from rural and remote areas, this fact did not seem to concern study participants. It may be that students from these areas are present in nursing programs and that, like male students, they are competitive with other applicants. International students are admitted in a large proportion of baccalaureate programs and in some LPN programs. Although the absence of a question addressing admission of new Canadians is unfortunate, the authors suspect that programs would have been unable to answer such a question, as provincial human rights regulations make it difficult to collect these data. Anecdotal evidence suggests that new Canadians regularly face challenges because of language barriers.

The following recommendations arose from this study:

1. Baccalaureate programs should continue to use GPA, the commonly used prerequisites (English, biology, chemistry, physics and French) and grades in prerequisites as central admission criteria.
2. LPN programs should seriously consider the addition of chemistry as a prerequisite in light of LPNs’ increasing level of responsibilities in the area of medication administration.
3. The practice of admitting on a first come, first served basis should be abolished in all types of nursing programs. (Parent institutions often impose this policy.)
4. Considering the limitations described in recommendation 3, above, national organizations should encourage all provincial nursing education regulatory bodies to admit all students on merit rather than use chance practices such as lotteries.
5. National nursing associations should seek funding to evaluate the use of complementary methods in the admission process. For example, it would be useful to offer additional resources to selected faculties/schools located in each region in Canada. With these, schools could carry out a common, structured interview process and systematically study the extent to which this screening method increases retention in nursing programs. Conducting a multisite study would be efficient and could lead to a quality-based evaluation of conducting admission interviews.

6. A national effort should be made to increase the number of Aboriginal students in nursing programs, and measures should be taken to ensure that these students receive adequate funding and support.
7. More research should be done on the admission of new Canadians into nursing programs. A systematic national effort should be made prior to admitting new Canadians to nursing programs to provide them with the language skills needed for success in the profession.
8. In light of the difficulty encountered by some programs in attracting “quality applicants,” national organizations should make concerted efforts to increase awareness about the rigour of nursing education.

## VI–2. Educational Preparation Objective B: Student Attrition

### Authors:

Pauline Paul, *University of Alberta*

Rene Day, *University of Alberta*

Jeanette Boman, *University of Alberta*

Wendy McBride, *Canadian Association of Schools of Nursing*

Dina Idriss, *Canadian Association of Schools of Nursing*

This study examined student attrition from Canadian registered nurse (RN), licensed practical nurse (LPN) and registered psychiatric nurse (RPN) programs using information collected through electronic surveys, telephone interviews and focus groups. Data were grouped for baccalaureate programs and LPN programs; owing to the small sample size, results were combined for RN diploma programs and the one RPN program that responded.

A key finding was the lack of a common definition of attrition. Further, institutions offering nursing programs may not collect the types of information this survey sought. Between 50% and 75% of all nursing programs investigate the reasons for attrition.

Students leave nursing programs, mainly during the first two years, because of lack of financial resources, weak academic skills and added levels of personal responsibility. Other issues cited are health and stress. Some students leave because of the nursing program’s structure and lack of academic support: although nursing programs and their parent institutions provide a wide range of support services, students underuse them. From a professional or career perspective, students withdraw because they feel unsuited to nursing, and because of negative impressions from practising nurses and their treatment in clinical settings. All these reasons are of concern to the nursing profession.

Between zero and 25% of students who leave nursing programs return to their studies within one year of withdrawing.

Exit interviews of students leaving nursing programs are completed by 56.7% of baccalaureate programs and 37.5% of both LPN and RN diploma programs and the RPN program. Seventy-three percent of the nursing programs surveyed support adopting a Canada-wide, standardized exit interview.

The following recommendations arose from this study:

### Call to action!

1. Develop a standardized definition of attrition for all types of nursing programs and use that definition to calculate attrition rates. (Institutional policies will make this a challenging but not impossible step.)
2. Develop and implement a Canada-wide, standardized exit interview for all students leaving nursing programs.
3. Study attrition more systematically from three perspectives:
  - a. Students: Their reasons for withdrawing from nursing programs; services they need for success, and why they do not use available services.
  - b. Nursing programs: Whether or not programs manage attrition by admitting students beyond the quota; whether the size of clinical groups and the instructor-to-student ratio in clinical practice bear on attrition rates.
  - c. Nursing profession: Whether the output of nursing programs is enough; what the profession is doing to retain new graduates.
4. Address, through the Canadian Nurses Association (CNA), the Canadian Association of Schools of Nursing (CASN) and provincial nursing associations, how to help prospective nursing students understand nursing, and the rigour of nursing programs and nurses' work. This effort could take the form of a national website as a common source of information and could address the main reason for leaving nursing programs, namely, students' perceived "poor fit" with nursing.
5. Study, through CNA, CASN and provincial nursing associations, the negative impressions that practising nurses perceive and the treatment of nursing students in clinical practice, both of which factors contribute to withdrawal from nursing programs. Other health disciplines have a long-standing commitment to mentor their students and new graduates. Nursing training needs to improve in this area.
6. Study, through selected sites and types of nursing programs, the effectiveness of specific strategies to decrease attrition.
7. Develop and test strategies to retain new Canadians in nursing programs (e.g., ways to test and increase language competency in English and support socialization to nursing and Canadian values).



8. Study how nursing programs can support and mentor Aboriginal and international students, and students from rural or remote areas, so that these students complete their programs.

### VI-3. Educational Preparation Objectives C & D: Clinical Placements

#### Authors:

Elizabeth Diem, *University of Ottawa*

Betty Cragg, *University of Ottawa*

Denise Moreau, *University of Ottawa*

Sylvie Lauzon, *University of Ottawa*

Jocelyne Blais, *University of Ottawa*

Wendy McBride, *Canadian Association of Schools of Nursing*

Dina Idriss, *Canadian Association of Schools of Nursing*

#### Researchers:

Alwyn Moyer

Janet Ansong-Danquah

#### Contributors:

Arlene Galloway-Ford, *Vancouver Island Health Authority*

Mary Lougheed, *University of Victoria*

Pierrette Guimond, *University of Ottawa*

Mary Anne Krahn, *Fanshawe College*

Jane Milliken, *University of Victoria*

Dianne Symonds, *Kwantlen University College*

This study examined clinical placement opportunities for students, barriers against placements and factors that determine appropriate clinical placements. It identifies new and emerging models for clinical education, and includes the perspectives of schools of nursing, students and healthcare institutions in identifying the costs and opportunities associated with improving clinical education for nursing students.

Data were collected through a literature review, surveys of students and members of schools of nursing and healthcare organizations, and interviews with directors of schools of nursing. The literature review and surveys with the three populations indicated similar perspectives across the country:

- There is a dearth of data on the efficiency and effectiveness of different clinical

- education strategies in nursing and other healthcare professions;
- Schools of nursing and organizations providing clinical placements state that capacity has been reached;
  - Teaching resources are in short supply;
  - Stress on the system from increasing numbers of students contributes to fewer student placement opportunities;
  - Students experience both financial and psychological costs from clinical education;
  - Baccalaureate students have high confidence and low stress in year 1; then, confidence decreases and stress increases until year 3; and
  - Opportunities exist for clinical education in the community if the lessons learned from clinical education in institutions are taken into account.

Recommendations from this study:

1. Fund research that includes a national research network on nursing clinical education, and which has the following qualities: a focus on outcomes; randomized control trials on multiple sites; and investigations of new models of clinical education, supervision and issues identified in the literature.
2. Establish a program-specific data collection system and a periodic environmental scan to identify possible systemic changes and pressures.
3. Devise a model to estimate the capacity of the health systems within regions to provide clinical education.
4. Establish a task force to identify the costs of clinical education as it pertains to educational institutions, to clinical agencies providing placements and to students, and seek to address the costs in an equitable manner.
5. Place priority on adequately supporting, evaluating and researching the preceptor model.
6. Initiate multisite projects to investigate the use and effectiveness of community health nursing clinical education.

**Call to  
action!**

#### **VI-4. Educational Preparation Objective E: Nurse Educator Careers**

**Authors:**

Ellen Rukholm, *Laurentian University*

P.H. Bailey, *Laurentian University*

Sharolyn Mossey, *Laurentian University*

Craig Duncan, *Laurentian University*

Wendy McBride, *Canadian Association of Schools of Nursing*

Dina Idriss, *Canadian Association of Schools of Nursing*

This project examined Canadian nurse educator programs (diploma and degree) that lead to registration in nursing-regulated professions – registered nurse (RN), registered psychiatric nurse (RPN) and licensed practical nurse (LPN) – using data and information collected through surveys, telephone interviews, focus group discussions and document reviews. It identifies incentives for and barriers against careers in nursing education delivery.

Key findings indicate that common barriers centre on salary, resources, professional development and workload. Incentives include a love of teaching and a commitment to the development of the profession. Nurses and graduate students most often identified salary as the factor most requiring intervention to make nursing education more attractive. This finding is paralleled in the narrative data, in which prospective nurse educators most often identified salary, workload, opportunities/support for professional development, availability of full-time employment and infrastructural support as factors that influence the choice to enter the nurse educator profession.

Nurse educator leaders identified salary, workload, opportunity for professional development and full-time employment as disincentives. Many indicated grave concern about anticipated shortages and difficulty in recruiting qualified nurse educators, especially when the system is faced with financial challenges. Other challenges in recruiting and retaining clinical teachers include competing salaries, shortages of nurses in the workplace and issues that vary slightly from province to province. The nurse educator interviews elicited a sense that nursing, nursing education and nursing educators are generally devalued or undervalued.

The authors conclude that current nurse educators are hard pressed to continue in their roles, and prospective nurses express reluctance to become nurse educators, because of low salaries, heavy workload, few professional development opportunities and lack of full-time employment. Also, individual nurse educator leaders cannot implement the changes necessary to retain and recruit. A concerted effort is required at the national, provincial and local levels.

The following recommendations arose from this study:

1. Replicate the study with a larger, randomly stratified sample representative of nurse educators who are preparing LPNs, RPNs and RNs.
2. Provide incentives for professional development, including funding for graduate and doctoral studies.
3. Provide travel and accommodation grants for those living far from graduate programs.

**Call to  
action!**

4. Facilitate the development of more accessible doctoral programs (distance and Web-based doctoral programs).
5. Develop a coordinated national/provincial/local strategy with other key partners in the government, practice (all sectors) and educational institutions to address workload issues such as overload, full-time versus part-time positions, undervaluing or devaluing of the nurse educator role and clinical teacher shortages.
6. Develop a national marketing strategy to emphasize nursing roles, the value of nursing and the dedication and commitment required to educate tomorrow's nurses.
7. Develop a national/provincial/local strategy to address salary inequities between practice and education, colleges and universities, full- and part-time positions, and across regions. Salaries are a major issue for current and prospective nurse educators, as well as for their nursing administrative leaders.

#### **VI-5. Leadership Objective A: CNA Preceptorship and Mentoring Project**

**Author:**

Nancy E. Watters, *Consultant and Project Manager*

The scope of this work included:

- validation of competencies for preceptors;
- development and validation of competencies for mentors; and
- further development of a resource guide.

The Preceptorship Competencies Validation Tool was created to rate each of the draft competencies and their headings on a 3-point Likert-type scale as to what extent the item statement was relevant, important, realistic and clear. The tool was distributed via email to nurses, and approximately 50 surveys were returned. Item completion rate was over 90%, and all response categories were used. There was clear consensus about which competencies should be retained as they were and several areas that were subsequently revised to reflect respondents' concerns.

Next, a meeting of nurse-experts was held to develop a draft list of competencies for mentors. The list was incorporated into a Mentoring Competencies Validation Tool survey that was distributed by email, and which 31 nurses completed. This draft list also was revised based on respondents' comments and concerns.

Data from both surveys indicate that the mentoring role for nurses is less well understood

than is preceptorship. This finding is supported by the literature, which suggests that mentoring programs are relatively new to nursing, having come from the more familiar corporate setting and business model. Key behaviours related to leadership, risk-taking, creativity and innovation are well supported for the mentoring process by both the literature and also by the expert working group, whose members were directly involved in mentoring programs for nurses.

CNA nursing policy staff had completed a literature review and several draft articles on preceptorship, mentoring and coaching, including an extensive bibliography and several appendices, as an update to the *1995 CNA Preceptorship Resource Guide*. These draft documents were edited and combined, along with the final lists of competencies for preceptors and mentors developed through the current project, into an overall Draft Guide on Preceptorship, Mentoring and Coaching. After further development based on reviewers' feedback, CNA published the final document, *Achieving Excellence in Professional Practice: A Guide to Preceptorship and Mentoring*, in October 2004.

**Call to action!**

## **VI-6. Leadership Objective B: The Economic Value of Nursing: A Conceptual Framework and Identification of an Analytical Strategy**

### **Authors:**

Stephen Birch, *McMaster University*

Amiram Gafni, *McMaster University*

Assessing the value of human resource inputs to the health sector and the economy is uncharted territory. Economics suggests three underlying principles for such assessment:

- *scarcity*, where there may be insufficient resources to satisfy all possible uses;
- *choice*, where a lack of availability requires a choice of how to use resources; and
- *opportunity cost*, whereby a decision to use a resource in a certain way implies a cost for not using that resource in an alternative manner, although it is preferable that the value of the choice be at least as great as the alternative.

To relate these economic principles to nursing, it is first necessary to determine the value associated with various health services. In the health sector, external forces are important to this calculation.

Most people prefer to go through life without consuming healthcare services. Thus, demand is forced on individuals either through illness or a desire to prevent illness.

In the provision of services (meeting the demand), healthcare providers have some influence over the demand for further services. Often this increased demand is forced on those individuals who are least able to pay for the services, resulting in minimal pricing.

Because of the potential influences of illness and disease on those other than the person directly affected, the provision of services to individuals can affect more than just those to whom they are supplied. Thus, to assess the economic value of nurses or any other contributor to the production of health services, more than simple market observation is required.

This paper proposes a mathematical representation or framework of such healthcare service, where

- H is the health outcome/product of the healthcare service;
- N is the number of nursing hours;
- B is the number of hospital beds;
- C is the acuity level of the patients;
- ... represents the many other potential resources;
- T is the technology (methods of production used);
- P represents other factors influencing the probability of episodes of care leading to health improvements (e.g., local environmental factors, socioeconomic conditions); and
- $H = f(N, B, C, \dots, T, P)$ .

This conceptual framework provides a methodology for identifying the different ways in which nurses contribute to the population's well-being. The framework can be applied to complement research on the economic costs of nurses, providing an evidence base for policy makers concerned with human resource planning in the health sector.

Under this framework, the economic value of nurses might be measured through considering whether a change in the number of nurses employed is related to

- changes in the other resources (e.g., substituting nurse time for physician time, or substituting nurse time for performing non-nursing tasks);
- changes in the quantity of services provided, where except for the number of nursing hours, all other factors are unchanged; and

- changes in the health outcomes resulting from the services delivered for the same patient mix (e.g., as measured through such factors as patient mortality, readmission and satisfaction with care).

## **VI-7. Leadership Objectives C & D: Competencies Required of Nurse Managers: Identifying the Skills, Personal Attributes and Knowledge Required of Nurse Managers, and the Enablers and Barriers for Nurse Managers to Acquire and Sustain These Competencies**

### **Authors:**

Mary Ellen Jeans, *Canadian Nurses Association*

Kathleen M. Rowat, *Canadian Nurses Association*

This project addressed the required competencies of nurse managers and the enablers and barriers affecting the acquisition and maintenance of these competencies. Competencies were defined as skills, knowledge and personal attributes. Nurse managers were defined as individuals in a first-level management position who manage nurses (and others) who provide direct care. Nurses included registered nurses (RNs), licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs).

The research methods included a pan-Canadian approach that was as inclusive as possible given tight timelines. Methods of data collection included a review of relevant literature, key informant interviews, a Web-based survey, an analysis of job postings and 10 focus group discussions. Altogether, 629 nurses participated in the project.

The results were overwhelmingly similar through all research methods and across the various groups sampled. The main findings are as follows:

- There were no discernible differences in responses between RNs, LPNs and RPNs.
- There was a high level of agreement among nurse executives, nurse managers and nursing staff on the top five competencies judged important for nurse managers.
- The top five competencies were: accountability for professional practice; communication (verbal); team-building; leadership skills; and conflict resolution. Staff nurses included knowledge of ethical and legal issues in the top five competencies important for nurse managers.
- None of the 44 competency statements was rated “not at all important.”
- The five most important enablers/barriers to the acquisition of competencies were similar for nurse executives, managers and staff. These were: supportive

work environment; clear and reasonable expectations; balanced work/life; reasonable workload; and accessibility to management education programs. Staff nurses included accessibility to a mentor in their top five ratings.

- Focus group results highlighted difficult and stressful working conditions for nurse managers.
- All groups sampled recommended more support for front-line nurse managers.
- The importance of the nurse manager's role to the integrity of healthcare was emphasized.

The following recommendations arose from this study:

### Call to action!

1. Healthcare employers should invest in front-line managerial positions. This study and the related literature suggest that a visible, knowledgeable front-line nurse manager can improve the quality and efficiency of patient care, the morale and motivation of staff and patient safety and satisfaction.
2. Employers should provide technical and clerical support to front-line managers to give them time to work with staff, patients and families.
3. Healthcare employers should provide support for managers and potential managers to access educational programs to increase and strengthen competencies. A supportive work environment was found to be the most important enabling factor for managers to acquire and maintain competencies.
4. National and regional mentorship programs should be supported to ensure adequate numbers of qualified front-line managers to sustain the healthcare delivery system. According to this project's findings, staff nurses did not aspire to be managers, whom they perceived to be overworked and removed from patient care.
5. Given that employers require more complex competency profiles for front-line managers, local educational programs should be available to support the development of these competencies. The analysis of job descriptions for nurse managers suggested a growing trend towards requiring more complex conceptual skills and knowledge. If these competencies are important, training should be readily available.
6. Healthcare employers and educators should consider interdisciplinary educational programs to teach core healthcare management/leadership competencies. These competencies include communication, team-building and resource management. Several beneficial outcomes may result from having different healthcare professionals learn together; working better together would be one of them. More intensive mentorship programs for nurse managers could provide discipline-specific competencies, such as managing nursing care.



## VI-8. Workforce Management Objective A: Assess Use, Compliance and Efficacy of Nursing Workload Measurement Tools

### Authors:

Fran Hadley, *Canadian Nurses Association*

Kathleen Graham, *Canadian Nurses Association*

Mary Flannery, *Canadian Nurses Association*

The objectives of this project were

- to assess utilization, compliance and efficacy of nursing Workload Measurement System (WMS) tools for registered nurses (RNs), licensed/registered practical nurses (LPNs) and registered psychiatric nurses (RPNs) across hospital and community healthcare settings; and
- to identify elements of effective WMS tools for nurses.

A pan-Canadian approach was selected to compile this WMS tool report. Research methods included an extensive literature review, key informant interviews, a Web-based survey of front-line staff and managers, and focus groups with front-line staff.

Findings from the survey, focus groups and key informant interviews were consistent with the information gathered through the literature review. In specific assessments of the utilization, compliance and efficacy of WMS tools, survey participants repeatedly reported dissatisfaction with WMS tools and the belief that current tools are outdated and do not reflect changes in hospital-based healthcare, care needs of the evolving patient profile, increased proportion of higher acuity in inpatients and adequate tracking and measures of complexity, multitasking and staff mix elements of nurses' work environment.

This WMS tool study generated several recommendations, the order of which here is not intended to imply importance or priority:

- *Data, information and decision-making:*
  - Select and standardize data elements and data collection to permit valid comparisons and benchmarking (“Information Highway,” minimum data sets). Software must match specifications for integration into the Information Highway.
  - Create a clearinghouse to share the tools, information and network to support decision-makers. This clearinghouse might be national or international, given the market and use of WMS in other countries.

**Call to  
action!**

- Investigate whether WMS could be sufficiently standardized and validated so that they can be included in formulas for case weights; obtain adequate resources.
- Create, pilot and disseminate decision-support models that address and evaluate changes in patient mix and staff mix.
- Critically evaluate and develop a generic business case to substantiate an investment of scarce resources (time, money, forgone opportunities) in the WMS to benefit patients and nurses. Nurse leaders could use and adapt this business case to support both institution- and system-based decisions (e.g., CIHI). Everyone needs a clear return on investment – staff nurse, manager, hospital, administration, patient, funders and taxpayers.
- *Acceptance by practitioners:*
  - Develop a comprehensive strategy to address unfavourable past experiences with WMS and the notable gap in understanding the internal and external validity of the tools. Hopefully, this recommendation will influence critical reflection about the current preference for retrospective tools and the perceived need for highly specific, unit-based tools.
  - Investigate an interdisciplinary tool that captures the holistic aspects of patient care needs.
  - Ensure that WMS report clear results and that appropriate resources are provided in response to results (funding to adjust staffing, adequately trained and resourced nurses, adequately trained and resourced administrators).
  - Ensure human and IT resources for support (dedicated staff, tool orientation, computer skills training, ongoing monitoring, audits for reliability/validity and hardware and software).
  - Ensure adoption of electronic solutions by addressing possible aversion to computers through use of intuitive systems, training and support.
  - Implement and sustain change. The plan must involve staff in all phases within organizations as part of promotion and marketing strategies. It should also include a strategy for embedding WMS into the organizational fabric so that there is ongoing support and review.
  - Develop tools that are sensitive to issues that nurses identify as affecting their workload: (1) patient frailty or acuity index, or a system that recognizes care differences between patient profiles; (2) nurse indexes sensitive to the aging workforce, lack of equipment, staff mix issues, etc.

**Call to action!**

## VI-9. Workforce Management Objective B: Equipment Needs of Canadian Nurses: Report of a Survey of Senior Nurse Executives

### Author:

Ken Hoffman, *The Alder Group Inc.*

The purpose of this survey was to describe healthcare equipment needs and priorities from the perspective of nurses. This survey was developed to answer the following questions:

- What are the most important equipment needs?
- For what main reasons is this equipment required?
- What input does direct care nursing staff have into decisions regarding equipment purchases?
- Do healthcare organizations have adequate capacity to maintain their healthcare equipment?

The target group for this survey was senior nursing executives (SNEs) (i.e., Directors of Nursing or their equivalents) in healthcare organizations across Canada, including facility-based and community-based organizations as well as regional health authorities. A total of 300 SNEs completed a Web-based survey on several issues, of which Direct Care Equipment Needs was one component. The questionnaire was developed based on input from the Canadian Nurses Association.

Following the survey, a reference group was conducted with senior representatives of nursing unions to provide their perspective on the findings.

Based on the results of the survey, the following conclusions were reached:

- *High priorities for equipment purchase:*
  - A majority of all respondents rated the following categories of equipment as “high priorities”: patient comfort; basic assessment and monitoring; mobility; and sharps and needles.
  - In addition, a majority of respondents from teaching and community hospitals identified the following categories as additional high-priority needs: medication administration; nutrition and hydration; respiratory therapy; and advanced assessment and monitoring.
  - In addition to the categories mentioned in the first point, above, a majority of respondents from District/Regional Health Authorities identified security equipment as an additional high-priority need.

- In addition to the categories mentioned in the first point, above, half the long-term care respondents identified basic care equipment as an additional high-priority need.
- *Criteria influencing equipment purchase:*
  - The six most influential criteria influencing purchase of any type of equipment were: patient safety; employee health and safety; reliability; quality of patient care; improved efficiency/productivity; and cost. This survey did not attempt to differentiate criteria for purchase decisions among categories of equipment or among types of organizations.
- *Input from direct care providers:*
  - Almost all respondents (95.2%) indicated that direct care providers had input into decisions related to the purchase of equipment in their organizations, with 55.8% rating the amount of input as “considerable.” A small majority (52.8%) of respondents indicated their organization had a formal process for gathering input from direct care providers for equipment purchasing decisions. Long-term care organizations were less likely to have such a formal process in place, compared with other types of organizations.
  - The vast majority of respondents (85%) were satisfied or very satisfied with the criteria and processes used in their organizations to make decisions regarding equipment purchases.
- *Repair and maintenance of equipment:*
  - Many respondents (85.7%) felt their organizations required additional resources for proper maintenance or repair of their equipment. This opinion was expressed most strongly by those working in long-term care (56.6% in strong agreement), followed by facility-based (53%), community-based (50%) and teaching and community hospitals (49%).

The following recommendations arose from this study:

1. **Federal and provincial/territorial governments should develop a strategy to fund equipment needs identified as “high priority” for Canadian health organizations in this study, i.e., patient comfort, basic assessment and monitoring, patient mobility and sharps and needles. The funding strategy should be expanded for teaching and community hospitals to cover the following additional categories of high-priority equipment: advanced assessment and monitoring, nutrition and hydration, respiratory therapy and medication administration.**

**Call to action!**

2. Federal and provincial/territorial governments should include, in any equipment funding strategy, additional resources specifically to ensure proper maintenance and repair of equipment (including human resources and supplies), as well as resources for inservice training on new equipment.
3. The sponsors of this initiative should collect, evaluate and disseminate examples of best practices for involving direct care providers in equipment purchasing decisions. Front-line nurses must be involved in the process of identifying and developing best practices, as their participation in decision-making is a significant issue in organizational health.

### **VI-10. Workforce Management Objective C: Phased Retirement (Enablers and Barriers) and Other Programs for the Retention of Older Healthcare Workers**

#### **Authors:**

Conrad Ferguson, *Morneau Sobeco*

The purpose of this study was to identify the enablers and barriers to phased retirement programs and best practices of programs for the retention of older workers.

Demographic data indicate that projected labour shortages will coincide with the aging of a Canadian population that will likely require higher levels of services. This convergence will require leaders in the healthcare sector to develop creative programs to ensure an adequate labour supply in a labour-intensive sector. Population surveys also show a significant interest on the part of baby boomers to phase out of the workforce gradually as opposed to retiring abruptly. Phased retirement programs to retain older workers may improve the availability of labour.

The principal objective of a phased retirement program is to allow workers to continue to be productive in a reduced capacity while continuing to accrue pension credits for full retirement. Current legislation does not favour development of attractive phased retirement programs, particularly for workers who have long service and a good early retirement pension. In effect, for those who want to continue to work in a reduced capacity, it is more attractive to retire and find work with another employer. To ensure optimal retention programs for older workers, we need to examine the rationales and approaches underlying pension legislation and collective agreements, and come up with recommendations that are practical, attractive and economically viable for all parties.

The Canadian Federation of Nurses Unions needs to develop a formal position on retention programs better suited for older nurses, supported by hard evidence developed from further study of the recommendations of this report.

Ultimately, there is no “one size fits all” solution to the retention of older workers, including nurses. To be effective, the design needs to fit the culture of the organization and its workers, to recognize the implications of the pension plan in place, to be financially viable for both workers and employers and to have a relatively manageable administrative framework. Further study of the views of workers and employers is required to clarify the shape and benefits of such programs.

The following areas of additional work are specifically recommended:

### Call to action!

1. Survey or gather additional credible data on intentions and preferences of older workers in the healthcare sector to determine whether retention programs are likely to add to the available labour pool or lead to earlier retirements.
2. Survey healthcare workers to find out if their desire for early retirement would override any interest in a properly designed phased retirement program that is at least financially neutral in their case. In other words, if a phased retirement program were in place such that workers incurred no financial loss relative to full retirement and accrued a better pension at the end of phase-out, would they prefer early retirement or phase-out?
3. Obtain more information on the views of employers about the potential desirability and effectiveness of retention programs for older workers.
4. Obtain information on the productivity of older healthcare workers relative to younger workers.
5. Analyze the potential economic value of retaining older workers as a result of their mentoring and training value, and reduced recruitment costs.
6. Develop recommendations for an administrative framework to accommodate more flexible work schedules for older workers.
7. Develop a position on the legislative changes required to facilitate the introduction of effective retention programs, particularly phased retirement, using benefits from pension plans currently in place.
8. Develop recommendations on an effective phased retirement model, taking into consideration pension plans in place, current or future desired legislative framework, required collective agreement provisions and availability of other group insurance benefits.
9. Identify from the list of other retention programs those that may be well suited to the healthcare work environment and study them further.

## VI-11. Workforce Management Objective D: Evaluation Framework to Determine the Impact of Staff Mix Decision-Making

### Authors:

Norma Freeman (Project Manager), *Canadian Nurses Association*

Micheline Jaworski, *Canadian Nurses Association*

Nancy Field, *Canadian Nurses Association*

Karen Power, *Canadian Nurses Association*

This study sought to develop an evaluation framework for determining the impact of staff mix decisions to help employers maximize the scope of practice of nursing staff. The project included a review of relevant literature, a national survey of senior nurse executives across Canada as to the use of a staff mix decision-making tool, and a consensus meeting of representatives from the three national associations of regulated nursing groups in Canada (CNA, CPNA and RPNC).

The literature review examined evidence and research related to nurse staff mix decisions based on regulated care providers (registered nurses and licensed practical nurses). No research was found on registered psychiatric nurses in relation to the determination of staff mix.

The national Web-based survey that addressed the use and effectiveness of staff mix decision-making tools was developed for senior nurse executives. Seventeen hundred letters of invitation were distributed; there were 293 respondents (17% response rate). While 51 respondents indicated that they used a tool, only one tool was submitted. CNA solicited additional tools for review. A limitation is that followup with other respondents was not possible owing to the confidential nature of the survey.

The joint evaluation framework to determine the impact of staff mix decisions was developed as a working document at a consensus meeting held in Ottawa, March 16–17, 2004. Participants included representatives from the national associations of the three regulated nursing groups.

This framework fits within a model of staff mix decision-making based on relevant literature pertaining to staff mix decisions and their outcomes. It is divided into three components: structural issues, process of staff mix decision-making and outcomes of staff mix decisions. The outcome component is addressed from the perspectives of client, nurse and system.

The following principles guided development of the framework for determining the impact of staff mix decision-making:

- Client needs and quality care are central to any staff mix decision-making process.
- An evaluation framework is most likely to be useful if it is comprehensive and user-friendly, and appears credible to both nursing and non-nursing audiences.
- Recognition of and respect for the value and contribution of each regulated nursing group is central to an effective evaluation framework.
- Flexibility and utility across all sectors and client populations are necessary characteristics of an effective evaluation framework addressing staff mix decision-making.

The framework consists of a series of questions organized according to the three recognized components of an evaluation framework: structure, process and outcomes. The questions reflect the model of staff mix decision-making. They identify those elements of structure and process that are part of an effective staff mix decision-making process and which affect client, nurse and system outcomes.

The following recommendations arose from this study:

1. **The Canadian Nurses Association, the Canadian Practical Nurses Association and the Registered Psychiatric Nurses of Canada should consult within their respective nursing jurisdictions for comment and support.**
2. **These three associations should collaboratively consult with other stakeholders, including the Canadian Healthcare Association.**
3. **Health Canada should provide funding for further meetings to refine the framework and consult with other stakeholders.**

**Call to  
action!**



**... help employers maximize the scope of practice of nursing staff.**

## The Pulse of Renewal: A Focus on Nursing Human Resources

Published as a special report by the *Canadian Journal of Nursing Leadership*  
with the kind support of the Office of Nursing Policy, Health Canada

May 2005

### Editor-in-Chief

Sandra Devlin, RN, MScN, CHE

### Editorial Advisor

Dorothy Pringle, PhD

### Managing Editor

Dianne Foster-Kent

### Design and Production

Esther Hart

### Copy Editors

Francine Geraci, Wayne Herrington, Frann Harris

### Translation

Adelaide Translations

Cover photographs by PhotoDisc

The *Canadian Journal of Nursing Leadership* is published four times a year. The journal is refereed and published primarily for nurse administrators, managers and educators by the Academy of Canadian Executive Nurses.

All manuscripts are reviewed by the editors and a panel of peers appointed by the editors on the advice of the editorial advisory board.

The *Canadian Journal of Nursing Leadership* is indexed in the following: *Cumulative Index to Nursing and Allied Health Literature*, *Nursing Citation Index* and *Nursing Abstracts*.

### How to reach the publishers and editors

Telephone: 416-864-9667

Facsimile: 416-368-4443

E-mail: [NursingLeadership@longwoods.com](mailto:NursingLeadership@longwoods.com)

### Addresses

All mail should go to:

Longwoods Publishing Corporation  
260 Adelaide Street East, No. 8  
Toronto ON M5A 1N1 Canada

For deliveries to our studio:

18 Eastern Avenue, 1<sup>st</sup> Floor  
Toronto, Ontario M5A 1H5 Canada

**NursingLeadership.net:** Abstracts, JobSite, conferences, news and more.

### Subscriptions

Individual subscription rate for one year (print+online) is [C]\$95 a year in Canada and [US]\$95 a year elsewhere. Institutional subscription rate for one year (print+online) is [C]\$355 a year in Canada and [US]\$355 a year elsewhere. Subscriptions are payable in advance.

For subscription information contact Barbara Marshall at:  
Telephone: 416-864-9667 ext. 100  
E-mail: [bmarshall@longwoods.com](mailto:bmarshall@longwoods.com)  
For institutional subscriptions please contact  
Susan Hale at: Telephone: 416-864-9667 ext. 104  
E-mail: [shale@longwoods.com](mailto:shale@longwoods.com)

To subscribe online go to: [NursingLeadership.net](http://NursingLeadership.net)  
and click on "subscriptions."

### Reprints/Back Issues

For reprints and back issues please contact  
Barbara Marshall at: Telephone: 416-864-9667 ext. 100  
Email: [bmarshall@longwoods.com](mailto:bmarshall@longwoods.com)

An additional 7% Goods and Services Tax (GST)  
is payable on all Canadian transactions.  
Our GST# is R138513668

### Editorial

To submit material or engage our editors in a dialogue  
please contact: Dianne Foster-Kent, Managing Editor, at  
Telephone: 416-864-9667 ext. 106  
E-mail: [dkent@longwoods.com](mailto:dkent@longwoods.com)

### Advertising

For advertising rates and inquiries, please contact  
Susan Hale at: Telephone: 416-864-9667 ext. 104  
E-mail: [shale@longwoods.com](mailto:shale@longwoods.com)  
Anton Hart at: Telephone: 416-864-9667 ext. 109  
E-mail: [ahart@longwoods.com](mailto:ahart@longwoods.com)

Published by the Academy of Canadian Executive Nurses  
and Longwoods Publishing Corporation

ISSN No. 1481-9643

Publications Mail Agreement No. 40069375

Return Undeliverable Canadian Addresses to

Circulation Department, 260 Adelaide Street East, No. 8  
Toronto ON M5A 1N1 Canada

The full report is available  
on our website at  
[www.nursingleadership.net/renewal](http://www.nursingleadership.net/renewal)

Published as a special report by the *Canadian Journal of Nursing Leadership*  
with the kind support of the Office of Nursing Policy, Health Canada



**Longwoods Publishing**  
*Enabling Excellence*

**ACEN**