

From Promise to Practice: Getting Healthy Work Environments in Health Workplaces



COMMENTARY

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ABSTRACT

The two lead papers examine what makes the health workplace healthier, one from the perspective of workers and the other from the perspective of patients. Patients demand effective teamwork. Workers demand a range of initiatives, from occupational health and safety to professional development opportunities. Whereas patients' and workers' perspectives on healthy workplaces appear quite discrete as discussed in these papers, they are two sides of the same coin.

Both lead papers recognize that unhealthy work environments result in unhealthy workers and reduced health outcomes for patients. Both review research documenting effective change and some progress in acceptance of proposed solutions at the policy level. Most importantly, both call for a greater effort in making these changes a reality in Canadian health workplaces.

The papers themselves offer up some strategies for getting from yes to real. This commentary focuses on these and other strategies for moving forward and getting real change in the workplace, changes that workers and patients will talk about.

MUCH HAS BEEN written about the need for healthy workplaces and more effective teamwork in the healthcare sector. The authors of the two lead papers do a good job of summarizing research, policy development and action to date on these topics. Both articles make the needed point that there must be less talk and more action. As the saying goes, “When all is said and done, much more has been said than done.”

In October 2006, Ontario Premier Dalton McGuinty visited an Ajax hospital on the third anniversary of his election victory to glad-hand over his election promise to hire 8,000 more nurses. A part-time nurse on duty told him that she, herself, has not seen much evidence of the government’s investment in healthcare. How do we make sure there is evidence of positive change at the front lines, in health workplaces across the country? That topic is the subject of this commentary.

Both papers, “Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice” and “Effective Teamwork in Canadian Healthcare: Research and Reality,” provide ample documentation that there is a gap between the recognition of good ideas in research and policy and their implementation. How can we work together to get from *yes* to *real*? This commentary elaborates on three strategies mentioned in one or both of the papers, which I will call (1) “bottoms up” – micro-innovation; (2) the three “ates” – coordinate, evaluate and replicate – macro-resources; and (3) new and improved accountability architecture.

Prior to these elaborations, it is important to reiterate how critical it is to move from promise to practice in regards to improving health workplaces for workers and patients:

- Canada will be short about 35% of its nursing workforce in 10 years if retention and recruitment are not radically improved (Canadian Nurses Association 2002). The United States is expecting a shortage of one million nurses (US Bureau of Labor Statistics 2005).
- In order to offset the retirement of nurses, assuming nurses work until age 65 years, enrolment rates would have to be 41,314. Canada currently has about 12,000 nursing seats (Nursing Sector Study Corporation 2005).
- Nurses worked an equivalent of 10,054 full-time jobs in overtime last year (Jenssen and McCracken 2006).
- The odds of patient mortality increase by 7% for every additional patient added to an average nursing workload (Aiken et al. 2002).
- Canada lags far behind other countries except the United States in effective primary healthcare for patients, including the use of multidisciplinary teams to treat chronic illness (Commonwealth Fund 2006).

In short, we can and must do better if we are to improve workplaces and health outcomes in Canada.

Bottoms Up: Micro-innovation

To date, researchers have studied the workplace and the worker and patient dynamic, and have made healthy workplace recommendations to policy-makers. Policy-makers have, to some degree and in some places, changed policy. This top-down approach to change in the workplace is not working at the needed speed. The future lies in a bottom-up approach, with evidence to inform policy coming more from the workplace. As suggested in the paper by Dave Clements et al., those who can make it

happen should be engaged from the onset, providing feedback, input and buy-in.

Innovation at the workplace, or micro-innovations, can be found, particularly if one looks in Ontario. As noted by Shamian and El-Jardali, Ontario is introducing the 80-20 model province-wide. It has also established nurse mentorship programs in 45 healthcare organizations across the province. Through the Registered Nurses' Association of Ontario (RNAO), seven workplaces have been designated Best Practice Spotlight Organizations in recognition of their continuous effort to disseminate, implement and evaluate RNAO's Best Practice Guidelines. Related to teamwork, Ontario has opened the first nurse practitioner primary healthcare clinic in Canada, which will employ up to six nurse practitioners and a multidisciplinary team that will include a dietitian, a social worker and physician partners.

From the National Survey on the Work and Health of Nurses

61% of nurses reported taking time off for health reasons in the previous year. Nurses who were absent missed on average 23.9 days (about a month) a year.

http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1588_E&cw_topic=1588

By building partnerships, a strong foundation is being laid for micro-innovation pilot projects outside of Ontario. The imperative for these projects grew out of research on retaining and valuing experienced nurses, which involved a literature review, surveys and focus groups (Wortzman 2006). This research identified 24 retention strategies, including opportunities to mentor and

upgrade skills. The Canadian Federation of Nurses Unions (CFNU) is working on establishing at least one workplace project in every province, such as the two pilot projects under consideration for support from the federal government's Workplace Skills Initiative program. One project, in Cape Breton, will provide the opportunity for 24 nurses currently employed to upgrade their skill sets to meet the serious shortage of critical care nurses. This will be done by bringing a revised workplace skills development program to the region to allow nurses to stay in their home rural communities while upgrading their skills. The other, in Saskatchewan, will offer new graduates additional support to allow them to gain necessary workplace skills to be successful in their careers, while valuing the expertise of seasoned nurses by creating a train-the-trainer model for mentoring. The need for macro-resources to support micro-innovation is discussed in the next section.

Efforts are also being made to find sites to test nurse-patient ratios (NPRs) in a Canadian context. In 2005, the CFNU published a discussion paper on NPRs (Tomblin Murphy 2006). It concluded that mandated NPRs are not a panacea for workload issues; however, experience indicates that they are an effective method to improve working conditions, quality of care and patient safety. Pilot projects on NPRs in Canada will add to existing evidence to support NPRs.

Micro-innovation can flourish if stronger partnerships are developed between government, employers, professional associations and unions – all working toward healthy work environments that retain workers. It is only by working together and by sharing positive experiences that occur in the workplace that we will ensure an appropriate and adequate labour force in the healthcare

sector and work to build inter-professional teams. Teamwork in healthcare is a prerequisite at the unit level. We need teamwork in more settings, as is shown in the paper by Clements et al. What we also really need is teamwork among stakeholders to ensure micro-innovation for positive change.

The Three “ates”: Coordinate, Evaluate and Replicate

Macro-resources are required to build the partnerships needed for micro-innovation – resources to coordinate, evaluate and replicate change. A key challenge identified in the paper on effective teamwork is that of planning across multiple jurisdictions and among many stakeholders. The paper identifies the need for a pan-Canadian strategy, involving healthcare workers, employers, unions, associations and all levels of government – those who can make it happen. It suggests various components to the pan-Canadian strategy: an inventory or clearinghouse for innovation and data analysis, funding and infrastructure for an independent coordinating body.

A pan-Canadian health human resources (HHR) strategy is critical for the future of healthcare in Canada. We need a mechanism in Canada to engage information and people that goes beyond the existing pan-Canadian HHR framework of governments, mentioned by Shamian and El-Jardali. This framework does not engage stakeholders. Engagement with stakeholders is the only way to ensure appropriate, accountable action targets and time frames.

A strategy will help raise the profile of the health workforce agenda, improve the information base and strengthen health sector stewardship. A pan-Canadian strategy must coordinate multiple-stakeholder participation involving universities, ministries of health, professional associations and

unions. It must also coordinate information to strengthen strategic intelligence. We need national information, tools and measures, shared standards and technical frameworks. We need, for example, comparable indicators on workplace health to build on the initial work done by the Quality Worklife–Quality Healthcare Collaborative and the Health Council. We also need a practical evaluation tool to decide which micro-innovations should be replicated.

Lastly, we need investment from the macro level to replicate innovation through support for the stakeholders at the lower level: for employers, professional associations and unions to form partnerships for change. Financial and human resources and training are needed to ensure buy-in from employers and employees. These investments are necessary to sustain front-line change. A pan-Canadian HHR strategy must coordinate dialogue, evaluate information and innovation and fund replication of innovation.

New and Improved Accountability Architecture

The 2004 Ten-Year Plan to Strengthen Health Care committed the provinces to increase the supply of health professionals, to set targets for the training, recruitment and retention of professionals and to make those commitments public and regularly report on progress. The paper by Shamian and El-Jardali summarizes progress to date on provincial and territorial HHR action plans in Tables 1 and 2.

Saskatchewan’s health minister summarized the utility of the action plans as accountability mechanisms in this quotation about targets: “Even if we put a number on it [targets for more nurses], there’s no guarantee that we would be able to meet that number in any case” (Saskatchewan Union of Nurses 2006). However, the “no targets

because we might not meet them” strategy has produced HHR plans with no means to measure progress, and no accountability.

Shamian and El-Jardali make the recommendation that the Health Council ensure that recommendations and targets are implemented. The Health Council is mandated to report annually to Canadians on health status, health outcomes and progress on elements of the 2004 Ten-Year Plan to Strengthen Health Care and the 2003 Health Accord.

The Health Council is an important part of the accountability architecture in that it can arm the public with information on progress and can shame governments. We need more mechanisms. We need collective agreement language on healthy work environments, as noted by Shamian and El-Jardali. We need language on workload, ratios, full- and part-time work availabilities, continuing education, mentoring responsibilities and health and safety.

Nurses’ unions across Canada are battling the same issues: inadequate and unsafe staffing levels and an erosion of nurses’ professional authority. Nurses’ unions in nine provinces came together in 2003 to set long-term bargaining goals. Many of the long-term bargaining goals, if achieved, would set targets and ensure accountability for healthy work environments.

As one positive example of this, the British Columbia Nurses’ Union (BCNU) 2006 Collective Agreement states that employers will be required to take “all reasonable steps to eliminate, reduce and/or minimize threats to the safety of employees.” The new contract also gives community nurses the right to request backup “where there is reasonable cause to expect a violent situation and ... have access to appropriate communication equipment.” The contract also calls for a “respectful workplace,”

involving clear policies so that everyone who works at or uses the workplace will understand expectations and consequences of inappropriate behaviour. And, the ministry of health has committed \$1 million over the next four years to support initiatives around issues of violence in the workplace.

As a beginning, a new and improved accountability architecture for healthy workplaces and effective teamwork would include the following:

- A pan-Canadian HHR strategy that involves stakeholders in committing to targets with timelines
- Collective agreements with strong language on healthy work environments
- Government financial and non-financial incentives for change at the workplace
- Identification of front-line leaders to work in collaboration with employers on achieving workplace targets

Conclusions

The discussion on getting from promises to practices in regard to healthy work environments and effective teamwork is under way. It will take public will to generate the political will necessary to move from “Yes, we agree” to “I feel a difference in my everyday experiences as a worker and as a patient.”

Political action is needed at all levels of government, but public action can also make a difference. We must not take a fatalist approach in thinking that the issue at the heart of a healthy work environment and effective teamwork – workload – is too big. We must all do our part through advocacy and action to promote change. The New Brunswick Nurses Union, for example, has just launched a campaign to encourage people to go into nursing, working on the basis that nurses are the best recruiters for the profession. As the saying goes, “Those

who say it cannot be done should not interrupt the people doing it.”

The obstacles for change are great, but the reasons for change are greater – better patient outcomes, a more productive and efficient labour force and a greater quality of life for workers and patients. The evidence supporting change is well documented in these lead articles and their sources.

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