Healthy Workplaces: The Case for Shared Clinical Decision Making and Increased Full-Time Employment

COMMENTARY

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ABSTRACT

Today, healthy work environments are recognized as essential to attain positive experiences and optimal clinical outcomes for patients, the well-being of healthcare providers and organizational effectiveness. Creating such environments is both a collective and an individual responsibility. It requires each of us to move away from the rhetoric, abandon our comfort zones and territorialities, adopt new evidence, and fully embrace the collective good. This commentary builds on the two excellent papers on this issue (Shamian and El-Jardali, and Clements, Dault and Priest), and adds two new necessary elements to build healthy workplaces and productive teamwork. The first is shared clinical decision making, the most substantive form of teamwork, and a necessary condition to build healthy work environments and deliver optimal patient care. The second is employment status: we cannot achieve healthy work environments and optimal teamwork with overreliance on part-

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time, casual or agency employment. The key premise for Ontario's 70% full-time employment policy is based on the fact that such a percentage is a necessary, minimal condition to ensure continuity of care and caregiver for patients, and continuity of relationships for our teams.

This special issue of *Healthcare Papers* focuses on policies, strategies and tools for ensuring healthy workplaces for healthcare workers. When asked to share my insights on the issues raised in the two lead papers, my first reaction was, "Of course, how can I not?" These are issues that have preoccupied us at the Registered Nurses' Association of Ontario (RNAO) for the past decade. They have moved us to advocate for specific policies that we believe are central to the "crisis in nursing human resources." And they have inspired us to create two important and internationally renowned programs of evidence-based guidelines: Healthy Work Environments (HWE), which began in 2003, and Clinical Best Practice Guidelines (BPGs) which began in 1999 (RNAO 2006a, 2006b).

The first paper, by Shamian and El-Jardali, presents some of the critical workplace factors that, over the past decade, have emerged as ones that positively affect patient care practices and clinical outcomes: higher registered nurse (RN) staffing and high nurse-patient ratios. The authors also highlight the key factors that negatively impact on nurses' health and well-being: job stress, fluctuating staff levels and excessive workloads. Additionally, they highlight the relationship between the health of workplaces and organizational health in outcome indicators such as work injuries, absenteeism, turnover rates and productivity. They provide a comprehensive review of provincial and territorial programs focused on advancing healthy work environments for nurses. Lastly, Shamian and El-Jardali offer an ambitious practice, research and policy agenda.

The second paper, by Clements, Dault and Priest and titled "Effective Teamwork in Canadian Healthcare: Research and Reality," focuses on research related to the advantages of teamwork. The authors discuss the current evidence about the characteristics of effective teams and what can be learned from successful interventions. They point out that teamwork is a concept that, so far, has not reached the 'tipping point' where workers or employers expect it." This observation is corroborated by the very fact that the concept does not appear as one of the critical factors highlighted by Shamian and El-Jardali.

I offer in this commentary two additional conditions to be considered as necessary when discussing, designing and evaluating healthy work environments and teamwork: shared clinical decision making and employment status.

Shared Clinical Decision Making: The Most Substantive Form of Teamwork

Clements, Dault and Priest reiterate that the Canadian Health Services Research Foundation (CHSRF) – funded research defines *team* as "something that exists any time two or more people are working together with a shared purpose." While healthcare teams will easily agree that their shared purpose is ensuring quality patient care and optimal clinical outcomes, other factors will often compromise this laudable principle. One such factor is occupational power and control, particularly evident in the often-troubled relationship between

physicians and nurses. The concept of "shared clinical decision making" can serve to advance the end goal of quality patient care and clinical outcomes, while also advancing healthy work environments and positive teamwork.

Shared clinical decision making necessitates that we acknowledge and respect the knowledge and expertise of all healthcare professionals, regardless of occupation and formal position. Moreover, it requires a tearing down of hierarchies and a redistribution of power allocation within organizations, and in society at large.

The notion of *teamwork*, presented in the paper by Clements et al. and in other papers on this topic, is both important and urgent. However, to move the concept from merely congenial relationships to strong working partnerships requires substantive and sustained efforts. Furthermore, if these efforts are to lead to optimal patients' outcomes, shared clinical decision making and power redistribution must be enacted. They must become clearly articulated expectations from the formal leaders in health service organizations, and they must be demonstrated by all health professionals through their actions. That clearly is not today's reality in most, if not all, health organizations. Clements and colleagues address this point shyly. In my view, it is the most important change we must effect in practices at all levels of healthcare organizations. Not only is shared clinical decision making paramount to enriching workplaces and those who work in them, more importantly, it is crucial to secure the very safety of our patients.

Power differentials and lack of joint clinical decision making between doctors and nurses have been identified as key contributors to negative patient outcomes. Moreover, there are serious risks associated with *not* integrating teamwork – in the form of shared clinical decision making – in the work nurses offer to healthcare organizations. These risks can represent a seemingly benign conceptual weakness in scholarly deliberations, but they can translate into failures in organizational performance. The latter became tragically clear when a pediatric cardiac surgery inquest investigated the deaths of 12 babies in a hospital in Manitoba. A key finding and recommendation from the report sums this up best:

> When problems arose, the concerns raised by nurses and others were not taken seriously. Even when a series of deaths occurred in rapid succession, there was not a timely and appropriate response within the surgical team, the Child Health program, the medical and administrative structures of the HSC, the death review processes of the OCME, and the complaints/investigation processes of the CPSM. To have all the components of the system fail in the case of the death of one child would be disturbing. To have the system fail repeatedly as the death toll mounted over a short period of several months is both shocking and difficult to understand. (Manitoba Health 2001: 127)

The report added:

> The inquest process revealed that nurses were not treated as full and equal members of the surgical team involved with the paediatric surgery program at HSC. Changes made to the hospital's organizational structure in 1994 were also seen to have reduced the status of nurses within the institution. More generally, the Sinclair Report portrays nurses as occupying a subordinate

> position within the health care system. (Manitoba Health 2001: 130)

This situation is not unique. We all witnessed the outrage expressed individually and collectively by nurses during the outbreak of severe acute respiratory syndrome (SARS). This was the expression of sheer frustration over the lack of integration of nurses' clinical expertise into organizational operations.

Fortunately, positive examples that we can build on as we continue to move forward in our quest to build shared clinical decision making – the most substantive form of teamwork – also exist. Such is the case of RNAO's partnership on clinical BPGs with expert physicians such as Dr. Gary Sibbald, a dermatologist internist who established the Canadian Association of Wound Care and the Wound Healing Clinic at Women's College Hospital in Toronto. Dr. Sibbald adopted RNAO's clinical BPGs on wound care to improve the care and clinical outcomes of his patients.

HWE and Employment Status

The link between healthy work environments and employment status can best be understood through patient and staff outcomes.

Full-Time Employment and Patient or Client Outcomes

SARS underscored the problem in relying on casual, part-time and agency nursing positions. As nurses were directed to work in one place only, staffing shortages and stress were heightened. The Walker Report recognized these challenges and recommended: "The Ministry should continue to establish sustainable employment strategies for nurses and other healthcare workers to increase the availability of full-time employment. Progress reports should be issued on an annual basis with a final goal of greater than 70% full-time employment across all healthcare sectors by April 1, 2005" (Expert Panel on SARS and Infectious Disease Control 2004: 47). Why did the report make this recommendation? Simply put, because it deemed it a necessary element to enable patient safety.

For RNAO, this was not a new recommendation. The association had been urging policy-makers in government and health organizations to adopt what we call the "70% Solution" (70% of all registered nurses working full time) since 2000 (Grinspun 2000a: 24; 2000b: 58; RNAO 2000, 2001, 2005). In 2003, that call was at last heeded by the newly elected government under the leadership of Premier Dalton McGuinty and Minister of Health and Long-Term Care George Smitherman (Ontario Liberal Party 2003: 13). The 70% Solution has since been adopted nationally by groups such as the Canadian Nursing Advisory Committee (CNAC), which recommended that "governments, employers and unions should collaborate to increase the proportion of nurses working full-time to at least 70% of the workforce in all health-care settings by April 2004, with an improvement of at least 10% to be completed by January 2003" (2002: 37).

The ability of nurses to know their patients is significantly compromised when nurses are assigned to different patients every day, which is mostly the case for agency, casual and part-time nurses and, in particular, for those who work for multiple employers. As I have stated elsewhere, "Care-giving requires the nurse to have a detailed understanding of the patient's condition, response, needs, and wishes" (Grinspun 2003: 64).

A study from the home care sector

found that reducing the number of nurses going into the home reduces the overall number of visits, and more so if the principal nurse makes the greatest proportion of visits (O'Brien-Pallas et al. 2001, 2002). This means that there are improved clinical and system utilization outcomes when the continuity of caregiver is maintained. Undoubtedly, continuity of caregiver can only be achieved with an adequate number of full-time nurses and stable staffing. The same study also showed greater effectiveness of BScN-prepared nurses as compared with diploma RNs or registered practical nurses (RPNs). The link between continuity of caregiver and improved clinical outcomes has also been demonstrated in hospital care (Aiken et al. 2002).

Failure to rescue has been linked to nurses' experience, expertise and continuity of care provision. For example, Clarke and Aiken (2003) made the link between the quality of surveillance and the number of experienced nurses relative to inexperienced nurses. Their study showed that units with more experienced nurses were more likely to detect problems or complications in a timely manner. The question, then, is this: Can nurses develop experience and expertise with patch-work employment?

Do nurses want to work full-time? Absolutely! RNAO's survey in 2003 showed that, in spite of the ongoing work environment challenges, if respondents had their preferred status, there would be an immediate net shift of 11% from non-full-time to full-time work. This would translate into almost 4,000 more RNs in full-time positions. And, if certain conditions changed, 42.7% would shift to full-time work. This would translate to a shift of well over 15,000 more full-time positions (or over 6,000 Full Time Equivalents – FTEs). This alone would put Ontario at 74% full time (which compares with the existing 71.6% in the United States). The answer is irrefutable: more nurses wish to work full time than positions are available.

Full-Time Employment in Ontario: Where Are We?

As Shamian and El-Jardali indicate, the Hospital Accountability Agreements between the hospitals and the Ontario Ministry of Health and Long-Term Care (MOHLTC) now include a target of at least 70% of front-line nursing by full-time nursing staff (RNs and RPNs) (Ontario Joint Policy and Planning Committee 2006: 45).

Today, about 60% of RNs in Ontario work full time, and this province is the fourth best in Canada in its full-time ratio (CIHI 2006). That number has not been reached for over a decade, but it is still below historic norms. The remaining 31.2%, or 27,799 RNs, work part time, and 8.9%, or 7,900, work in casual employment (College of Nurses of Ontario 2005: 54). Furthermore, Canadian Institute for Health Information (CIHI) reports show that 8,321 (9.3% of 89,429) Ontario RNs have multiple employers (CIHI 2006: 34). It is important to know that multiple employment, the least desirable of all work arrangements among nurses, is an employment status that has historically expanded or shrunk according to the availability of full-time work. We have made significant progress and, as our minister of health would agree, there is more progress yet to be made. What is clear, however, is that explicit government policies alongside earmarked funding and accountability mechanisms produce positive results (RNAO 2005). That must continue to lead the way forward.

One critical area to tackle is opportunities for newly graduated nurses for whom full-time employment remains an elusive

dream. A recent study found that an average 79.3% of students want to work full time, but it can take them up to two years to find a full-time job (Baumann et al. 2006). It is hard to believe that this generation of novice nurses will be inspired about nursing by working for multiple employers, or that they will be able to fully contribute to building a healthy work environment, shared clinical decision making and teamwork given their personal circumstances. The government has promised to deliver on full-time guaranteed employment for any new graduating nurse starting in 2007 (MOHLTC 2006). Nurses and their organizations will hold the government accountable for this promise in no uncertain terms.

Full-Time Employment, Healthy Work Environments and Teamwork

The move away from full-time employment for nurses in Canada during the past 15 years, and the slow return to it, has been well documented and discussed in detail elsewhere (Grinspun 2000b, 2002, 2003; RNAO 2001, 2003, 2005). While there is no empirical study that looks at the concept of *employment status* as it relates to the concept of *teamwork*, logic suggests that "teamwork" provides greater benefits when members of a team know how to work with one another and, more importantly, know their key team player, the patient, well. The key premise for 70% full-time employment derives from the fact that such a percentage is a necessary, minimal condition for ensuring continuity of care and of caregiver for patients. A report commissioned by the CNAC estimated that Canadian RNs worked a quarter million hours of overtime each week, the equivalent of 7,000 full-time jobs (Wortsman and Lockhead 2002). This, alongside turnover and the number of part-time, casual and agency employees, means that the average patient hospitalized for three days sees over 80 different people (CNAC 2002). Such a grim reality affects patient care, staff, teamwork and workplaces.

Much has been written about the urgent need to improve nurse-physician relationships. These relationships are of key importance as daily nurse-physician interactions have a direct influence on nurses' morale and patient care (Rosenstein 2002). A missing variable in studying these relationships has been employment status. Future research on workplace health and teamwork, as well as specifically on shared clinical decision making, should consider the different impacts that full time, part time, casual and agency work can effect. It is difficult to conceive how greater collaboration can be achieved with a large cadre of casual, part-time and agency nurses. If team players are constantly changing, which is the case in nursing when workplaces have an inadequate proportion of full-time staff, knowing colleagues and patients becomes a theoretical exercise that is difficult to translate into day-to-day practice. Healthy work environments and teamwork are concepts that we must urgently move from theory to reality through funding and employment policies, organizational practices and individual action.

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