

Healthy Workplaces for Health Workers

Judith Shamian and Fadi El-Jardali

Effective Teamwork in Healthcare

David Clements, Mylène Dault and Alicia Priest

Commentary from Melissa Barton, Doris Grinspun, Linda Jones, Michael S. Kerr, Heather K. Spence Laschinger, Mélanie Lavoie-Tremblay, Michael P. Leiter, Sandra MacDonald-Rencz, Sue Matthews, Colin J. McMillan, Cam Mustard, Wendy Nicklin, Ivy Oandasan, Linda O'Brien-Pallas, Linda Silas, Marlene Smadu, Wayne Strelioff, Thomas F. Ward and Daniel Way

Best Practices.





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About the cover:

Doctors and nurses check all incoming patients as they show up for appointments. Often, patients are allowed in only after washing their hands and donning masks. Photo credit Ken Faught/Toronto Star.

Notes from the Editor-in-Chief

SEVERAL MONTHS AGO, Judith Shamian, who has long been recognized as one of Canada's most outspoken and dedicated proponents for healthcare workers, approached Longwoods with the idea of publishing a special issue of *Healthcare Papers* on healthy workplaces for healthcare workers. She and colleague Fadi El-Jardali had reviewed the existing and proposed policy related to healthy workplaces, and believed that there was an opportunity for this journal to help stimulate the debate on various issues and themes related to making the workplace

healthier. They
were soon joined
by the team of
Dave Clements,
Mylène Dault and
Janet Helmer, from
the Canadian Health
Services Research
Foundation, and Alicia

the most important topics in Canadian healthcare today.

... workplace health is one of

Priest, a freelance writer, who all agreed with the need to move the agenda forward, while also including teamwork as a technique for improving the standard of work life. We agreed that this would be a valuable issue for our readers.

Next, as with all issues of *Healthcare Papers*, we compiled a "wish list" of potential commentators who would be invited to respond to the issues raised, based on their unique perspectives. This list included researchers, practitioners, decision makers, policy makers, educators, representatives of unions, employers, professional associations and the national accreditation body – a who's who of Canadians with expertise in workplace health.

It's important to understand that with a typical issue of *Healthcare Papers*, we anticipate that approximately one third to one half of the commentators invited to respond to a specific issue will agree to write. However, to our surprise, when the invitations to respond to this issue were sent out, almost every single person or group accepted. In fact, we had to stop inviting people!

To us, this was clear evidence that workplace health is one of the most important topics in healthcare today. It was also obvious that people feel passionately about it.

I would suggest that it is a topic of interest worldwide. The lead essays and the 13 commentaries provide a thorough discussion of the issues and potential solutions – a must-read for every-

one involved in running, or working in, a healthcare facility.

As Shamian and El-Jardali summarize in their final response, "Changing the work environment for health workers enables us to attain the goals of our healthcare system, which are to provide access to quality, effective, patient-centred, team-based and safe health services."

Peggy Leatt, РнD Editor-in-Chief

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Healthcare Papers

Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice



INVITED ESSAY

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ABSTRACT

The World Health Report launched the Health Workforce Decade (2006–2015), with high priority given for countries to develop effective workforce strategies including healthy workplaces for health workers. Evidence shows that healthy workplaces improve recruitment and retention, workers' health and well-being, quality of care and patient safety, organizational performance and societal outcomes. Over the past few years, healthy workplace issues in Canada have been on the agenda of many governments and employers.

The purpose of this paper is to provide a progress update, using different datacollection approaches, on knowledge transfer and uptake of research evidence in policy and practice, including the next steps for the healthy workplace agenda in Canada. The objectives of this paper are (1) to summarize the current healthy workplace initiatives that are currently under way in Canada; (2) to synthesize what has been done in reality to determine how far the healthy workplace agenda has progressed from the perspectives of research, policy and practice; and (3) to outline the next steps for moving forward with the healthy workplace agenda to achieve its ultimate objectives. Some of the key questions discussed in this paper are as follows: Has the existing evidence on the benefits of healthy workplaces resulted in policy change? If so, how and to what extent? Have the existing policy initiatives resulted in healthier workplaces for healthcare workers? Are there indications that healthcare workers, particularly at the front line, are experiencing better working conditions?

While there has been significant progress in bringing policy changes as a result of research evidence, our synthesis suggests that more work is needed to ensure that existing policy initiatives bring effective changes to the workplace. In this paper, we outline the next steps for research, policy and practice that are required to help the healthy workplace agenda achieve its ultimate objectives.

The Early Decades of the 21st century belong to health human resources (HHR). The World Health Report (World Health Organization [WHO] 2006) launched the Health Workforce Decade (2006–2015), with high priority given for countries to develop effective workforce strategies that include three core elements: improving recruitment, helping the existing workforce to perform better and slowing the rate at which workers leave the health workforce. In this recent report, retaining high-quality healthcare workers is discussed as a major strategic issue for healthcare systems and employers, and improving workplaces as a key strategy for achieving this goal.

The workplace can act as either a push or pull factor for HHR. Heavy workloads, excessive overtime, inflexible scheduling, safety hazards, poor management and few opportunities for leadership and professional development are among the push factors that result in poor recruitment and retention of HHR. Evidence shows that healthy workplaces improve recruitment and retention, workers' health and well-being, quality of care and patient safety, organizational performance and societal outcomes.

What are healthy workplaces? Based on existing definitions, there is not yet a standardized and comprehensive definition of healthy workplaces. In this paper, we define healthy workplaces as mechanisms, programs, policies, initiatives, actions and practices that are in place to provide the health workforce with physical, mental, psychosocial and organizational conditions that, in return, contribute to improved workers' health and well-being, quality of care and patient safety, organizational performance and societal outcomes (Griffin et al. 2006).

Over the past few years, healthy work-place issues in Canada have been on the agenda of many governments and stake-holder organizations. Nationally and internationally, robust evidence has been accumulated on the impact of healthy work-places on workers' health and well-being, quality of care, patient safety, organizational performance and societal outcomes. This evidence has provided guidance for governments and employers in terms of what should be done to make the workplace healthier for healthcare workers. Across Canada, many initiatives to improve the working conditions for HHR are currently

under way, but the continuing concerns suggest that barriers remain. An assessment of the progress to date is necessary in order to inform the next steps for research, policy and practice.

Purpose

The purpose of this paper is to provide a progress update on knowledge transfer and uptake in policy and practice, including the next steps for the healthy workplace agenda in Canada. Specifically, the objectives of this paper are (1) to summarize the current healthy workplace initiatives that are currently under way in Canada; (2) to synthesize what has been done in reality to determine how far the healthy workplace agenda has progressed from the perspectives of research, policy and practice; and (3) to outline the next steps for moving forward with the healthy workplace agenda to achieve its ultimate objectives.

Approach

The data-collection method undertaken for this paper includes the following:

- A review and synthesis of major reports and research documents on HHR in Canada published between 2000 and 2006
- A search of federal, provincial and territorial governments and key stakeholders' websites to identify relevant healthy workplace initiatives and plans
- A review of HHR action plans (released on December 2005) for the federal, provincial and territorial governments; more emphasis is given on the extent to which those plans incorporate healthy workplace issues, initiatives and targets
- A literature search of MEDLINE and the Cumulative Index to Nursing and Allied Health Literature (CINAHL)

(1995–2006) on the terms healthy workplace, quality work environment and positive change in the workplace, including the terms healthcare professionals and nurses

This paper includes two main sections. In the first section, we review the progress that has been made on the healthy workplace issues in terms of research, policy and practice. Based on this review, we then outline (in the second section) the next steps for moving forward with the healthy workplace agenda.

Progress

Progress in Research

Over the past 20 years, the conceptual thinking about healthy workplaces has evolved at a progressive rate. From medical to ecological models, a better understanding has been provided of how a healthy workplace exerts its synergistic impacts on workers' health and well-being, patient outcomes, organizational performance and societal outcomes. Different conceptual models have blended a diverse range of perspectives and approaches by incorporating several factors addressed by different disciplines (Bachmann 2000; Dejoy and Southern 1993; Dejoy and Wilson 2003; Jones and Johnston 2000; Khoury et al. 1999; Laschinger and Kerr 2004; O'Brien-Pallas and Baumann 1992; Schaefer and Moos 1993; Shain 2000; Shain and Kramar 2004). Overall, the thinking behind the more comprehensive models is that multiple factors at all levels (extra-organizational, organizational and individual) are influential in creating healthy workplaces. Thus, no one level can be assessed without regard for the implications it may have on the others.

In terms of the progress at the empirical level, most of the research comes from

nursing. More opportunities exist now than previously to translate this evidence to other types of health professionals. Robust evidence has accumulated (both at the national and international levels) on the benefits of healthy workplaces. Evidence shows that the consequences of healthy workplaces are not only individual (i.e., psychological, physiological and behavioural) and organizational outcomes (e.g., absenteeism, turnover and performance), but are also patient (i.e., quality of care and patient safety) and societal outcomes (i.e., impact on government programs and national healthcare costs) (Kelloway and Day 2005).

Research on the impact of the workplace on workers' health and well-being shows that job stress increases the risk of musculoskeletal injuries, accidents, physical and mental illness, substance abuse and smoking. Hospitals with fluctuating staff levels were found to have a higher rate of needle-stick injuries than did magnet hospitals – institutions where staffing is stable. Excessive workloads were associated with negative physical and mental health outcomes among general nurses (Tyler and Cushway 1992).

The relationship between healthy workplaces and quality of care and patient safety has been demonstrated in numerous studies (Griffin et al. 2006). Evidence shows that an increased workload leads to an increased likelihood of errors involving patients (Sexton et al. 2000). Robust evidence exists on the inverse relationship between nurse staffing and adverse events among patients (Lee et al. 1999; van Servellen and Schultz 1999). Needleman et al. (2001) found strong evidence of an association between patient outcomes and the share of total staffing by registered nurses (RNs). Higher RN staffing was associated with a 3–12% reduction in the rates of patient outcomes potentially sensitive to nursing. Numerous

studies in Canada have found that high nurse-to-patient ratios lead to complications such as higher infection rates and poorer patient outcomes. Additionally, a study by Tourangeau et al. (2006) found that a 10% increase in the percentage of RNs in the staff mix is associated with six fewer deaths for every 1,000 discharged patients. The same study found that a 10% increase in nurse-reported adequacy of staffing and other resources is associated with 17 fewer deaths for every 1,000 discharged patients.

In terms of the impact of healthy workplaces on organizational performance, research shows that promoting healthier workplaces motivates health workers, enhances morale, reduces absenteeism, reduces personnel and welfare problems, leads to better outcomes and increased overall efficiency and improves organizational performance, competitiveness and public image (Chu et al. 2000; Kramer and Cole 2003; Price and Mueller 1981; Whitehead 2006). An increasing body of evidence suggests that poor workplaces result in a substantial health burden and cost that health service organizations bear as a result of ill health among their staff. The consequences for any organization that has an unhealthy workforce are many and include work-related accidents, high rates of absenteeism, a high turnover, high levels of stress, loss of productivity and a high incidence of health-related litigation (Addley et al. 2001; Verow and Hargreaves 2000; Whitehead 2006).

In relation to societal outcomes, evidence shows that consequences of healthy workplaces involve not only workers' health and well-being and organizational outcomes, but also societal outcomes (i.e., national healthcare costs and economy) (Kelloway and Day 2005; Lowe 2003). In the United States alone, the most accurate

estimates show that deaths from job-related injuries, nonfatal injuries, deaths from disease and illnesses amounted to US\$65 billion in direct costs and US\$106 billion in indirect costs in 1992 (Lowe 2003). In Australia, estimates of the direct costs of workers' compensation are 1.5% of the gross national product and about 20% of total healthcare costs (Chu et al. 2000). In Canada, it is estimated that work-life conflicts cost the healthcare system approximately \$425.8 million in physician visits in 1996-1997 (Duxbury et al. 1999). Ennals (2002) emphasized that organizations are obliged to consider the world beyond the workplace - the one where workers are engaged as citizens. Subsequently, and in line with the public health commitments of health service organizations, the healthy workplace potentially influences the health of immediate employees and their wider social circle (Whitehead 2006). While the impact of healthy workplaces on societal outcomes is less robust (and still awaits further systematic research), our review of the existing evidence shows that horrific economic and social costs are being incurred as a result of unhealthy workplaces in healthcare organizations.

Overall, as a result of more than 20 years of research, there is increasing evidence of the benefit of healthy workplaces on workers' health and well-being, patient outcomes, organizational performance and societal outcomes. Given this evidence, one would ask, has the existing evidence on the benefits of healthy workplaces resulted in policy change? If so, how and to what extent? Across Canada, many policy initiatives have been undertaken to create healthy workplaces for healthcare workers. Below, we provide a summary of those key healthy workplace initiatives.

Progress in Policy

Has the existing evidence on the benefits of healthy workplaces resulted in policy change? The answer to this question would help inform the debate about what can be done as next steps (i.e., to increase the chances that evidence will bring further changes to policy domains).

Despite the availability of a large body of knowledge on healthy workplaces for the past 20 years, it took the leadership of the Office of Nursing Policy at Health Canada in 2000 to engage policy-makers, researchers and service communities, including unions, executives and decision makers, to get the issue onto the policy agenda. This initiative led to much of the work that is described in this paper. Today, many policy initiatives to improve the workplace for healthcare workers are currently under way across Canada. Before summarizing and providing an update on those initiatives, it would be important to outline briefly the key national reports that contributed significantly to developing those policy initiatives on healthy workplaces. These reports are listed below:

- Canadian Health Services Research
 Foundation (CHSRF) (2001):
 "Commitment and Care: The Benefits
 of a Healthy Workplace for Nurses,
 Their Patients, and the System." This
 report provided a significant set of
 recommendations to improve working
 conditions and strengthen nursing across
 Canada.
- Canadian Nursing Advisory
 Committee (CNAC) (2002): Our
 Health, Our Future: Creating Healthy
 Workplaces for Canadian Nurses. Fifty one recommendations were provided by
 this report that offered governments,
 employers, unions and other stake-

- holders a broad menu of helpful suggestions to improving the working conditions of Canada's nurses.
- **Standing Senate Committee on Social** Affairs, Science and Technology (2002): The Health of Canadians – The Federal Role. In October 2002, this report, known as the Kirby Report, recommended that the federal government work with other concerned parties to create a permanent national coordinating body for HHR, composed of representatives from key stakeholder groups and the different levels of government. One of its mandates is to share and promote best practices with regard to strategies for retaining skilled healthcare professionals and coordinating efforts to repatriate Canadian healthcare professionals who have emigrated to other countries.
- Commission on the Future of Health Care in Canada (2002): Building on Values: The Future of Health Care in Canada. On November 28, 2002, the commission delivered its final report (known as the Romanow Report) to Canadians. The report was concerned about the quality of working life, especially for nurses, and the impact of poor working conditions on nurses' health and quality of patient care. In this report, it was recommended that the Health Council of Canada should collect, analyze and regularly report on relevant and necessary information about the Canadian health workforce, including critical issues related to recruitment, distribution and remuneration of healthcare providers.

The above reports contributed significantly to the federal, provincial and territorial policies and programs. For instance, the HHR component that was incorporated into the federal, provincial and territorial health accord of 2003 included a specific focus on recruitment and retention and healthy workplaces (Health Canada 2003). In a three-year period (2000–2003), researchers strived to bring the problem of low-quality work environments for nurses to the attention of governments. Efforts focused on providing new knowledge and raising awareness and dissemination.

As a result of tremendous efforts, the move toward healthy workplaces has been expanded to benefit not only Canada's nursing workforce but other healthcare workers as well. The 2003 and 2004 First Ministers' Accords on Health Care Renewal identify revitalization strategies for Canada's health system workforce. Coordinated actions to improve recruitment and retention are needed. The centrepiece of retention strategies is a healthy workplace initiative for healthcare workers. Workplace health issues now appear on public and government HHR policy agendas, on the Health Council of Canada agenda and in reviews conducted by provinces and territories. In addition, and in part of the commitments made to reform the health workforce, Canada's federal, provincial and territorial governments agreed to report to the public on their action plans by December 31, 2005, including targets for training, recruitment and retention and healthy workplaces for health professionals.

Key Initiatives and Progress Update

This section summarizes current policy initiatives undertaken (2001–2006) at the national and provincial levels by governments and stakeholder organizations. Table 1 provides a detailed description of those initiatives.

Table 1. Summary of key initiatives

Initiative	Accomplishments
Work-life quality indicators (Canadian Council on Health Services Accreditation)	New workplace quality indicators have been developed by the council and are now being tested.
Healthy Work Environments Best Practice Guidelines (Registered Nurses' Association of Ontario)	The project delivers six guidelines for the following topics: (1) developing and sustaining nursing leadership; (2) developing and sustaining effective staffing and workload practices; (3) embracing cultural diversity in healthcare: developing cultural competence; (4) professionalism of the nurse; (5) collaborative practice among nursing teams; and (6) workplace health, safety and well-being of the nurse.
3. Survey of the Work and Health of Nurses (Canadian Institute for Health Information)	The questionnaire content has been finalized, pilot tested and implemented. Survey results were released in December 2006.
4. Nursing Sector Study Corporation	Phase I has been completed.* Phase II will build on the findings and recommendations of the phase I report to help develop a pan-Canadian nursing human resources strategy.
5. Health Canada's Healthy Workplace Initiative (HWI)	Health Canada provided targeted funding to support innovative HWIs of individual organizations in many provinces and territories.
6. Toward 2020: a proposal to strengthen Canada's health human resources (Canadian Nurses Association)	The project has been completed, and the final report was published (Villeneuve and MacDonald 2006).
7. Understanding the costs and outcomes of nurses' turnover in Canadian hospitals (Nursing Health Services Research Unit, Faculty of Nursing, University of Toronto)	Work is in progress to study the effects of turnover on nurse and patient outcomes; simulations are being performed to estimate the effect of management interventions on system outcomes.
Quality Worklife–Quality Healthcare Collaborative: linking quality of work life, human resource practices and health system results (Canadian Council on Health Services Accreditation)	Work is in progress to develop a steering committee and working groups, and to create a virtual clearinghouse for innovative human resource practices.
9. Health human resource strategy – Yukon projects (2004–2005 to 2005–2006) (Department of Health and Social Services, Government of Yukon)	Project 1 is the Nursing Mentorship Feasibility Study. Project 2 is the Healthy Workplace Indicators Study.

^{*}Nursing Sector Study Corporation. 2005. Building the Future: An Integrated Strategy for Nursing Human Resources in Canada. Phase II Final Report Ottawa, Ontario: Author.

Federal, Provincial and Territorial HHR Action Plans

As part of the commitments made to reform the health workforce, Canada's federal, provincial and territorial governments agreed to report to the public on their action plans by December 31, 2005, including targets for training, recruitment and retention and healthy workplaces for health professionals.

To date, only Saskatchewan, Ontario, Quebec, Nova Scotia, New Brunswick,

Prince Edward Island, Newfoundland and Labrador, Nunavut and the Northwest Territories have released their action plans (Government of New Brunswick 2005; Northwest Territories Health and Social Services 2005; Ontario Ministry of Health and Long-Term Care [MOHLTC] and Ministry of Training, Colleges and Universities 2005; Santé et Services sociaux Québec 2004; Saskatchewan Health 2005). British Columbia, Alberta, Manitoba, the

Table 2. Summary of healthy workplace targets and initiatives listed in provincial and territorial health human resources plans

Jurisdiction	Healthy Workplace Targets and Initiatives
Ontario	No numerical targets for healthy workplaces are included. Key initiatives are as follows: • Nursing Mentorship/Preceptorship Initiative • New Graduate Initiative • Nursing Education Initiative • Late Career Initiative
Nova Scotia	No targets for healthy workplaces are included in the action plan. Key initiatives include a provincial nursing strategy for nurse education, recruitment, retention and workforce renewal. Since 2002, Nova Scotia has achieved its target of retaining at least 80% of its new graduates.
Saskatchewan	Saskatchewan's action plan includes initiatives to increase recruitment and retention by providing safe, supportive and quality workplaces that help to retain and recruit healthcare professionals. While Saskatchewan's plan includes healthy workplace objectives, it contains no specific numerical targets. Goals include the following:
	 To decrease the number and severity of Workers' Compensation Board lost-time claims To increase the percentage of staff reporting a positive score for their learning environment
Quebec	In the HHR section of Quebec's report, there are some important elements that attempt to address workforce shortages, including changes to scopes of practices, recruitment of internationally trained professionals and retention efforts for rural communities (Health Council of Canada 2006).
New Brunswick	Key initiatives are as follows: The Annual/Provincial Bursary Program Continuing education, which includes a Clinical Education Program Conversion of casual positions to permanent positions Nursing Mentorship Program Phased Retirement Program Financial incentives Nursing education and training
Prince Edward Island	The plan includes activities and future strategies to try to address the challenges that PEI experiences in recruiting and retaining healthcare professionals. No specific planned activities were outlined to address workplace issues.
Nunavut	Nunavut's plan centres on the key challenge of recruiting and retaining health professionals. The plan includes initiatives aimed at retention, increasing Aboriginal participation in the workforce and developing leaders in the sector to act as mentors and promote self-sufficiency (Health Council of Canada 2006).
Northwest Territories	The plan's primary focus is on getting people to work and remain in the territory. Future efforts in the NWT include promoting healthcare to their population, promoting the NWT as a place to live and work, improving succession planning and opportunities for continuing professional development for employees and management and promoting healthy workplaces. No numerical targets were identified in the plan.
Newfoundland and Labrador	The HHR action plan includes five goals. Goal four involves quality workplaces (to participate in and support the healthy workplace initiatives focused on creating an enhanced culture of safety and to continue to support the Quality Professional Practice Environments for Nurses Initiative). No numerical targets were identified in the plan.

HHR = health human resources.

Yukon and the Government of Canada are expected to release their plans in the near future (Health Council of Canada 2006a). In Table 2, we review the HHR plans that have been released to date to examine the extent to which those plans incorporate healthy workplace issues, initiatives and targets.

Our review of the policy progress demonstrates that federal, provincial and territorial governments and other stakeholder organizations are currently undertaking many healthy workplace initiatives across the nation. Our synthesis suggests that some are making significant commitments for healthy workplaces, particularly recruitment and retention initiatives. While many of those initiatives are focusing on financial incentives, such as tuition reimbursement, bursaries, loans, education opportunities and others, there is little evaluation of the impact of those incentives on improving the workplaces. Besides, literature argues that financial incentives are only one factor in creating healthier workplaces. For instance, the Health Council of Canada (2005) recommended that governments and other groups should develop non-financial recruitment and retention incentives. This recommendation was repeated in the recent council report (2006b) but with targets for employers to achieve by 2008.

Progress in Practice

Our review demonstrates that there have been significant policy-level improvements, particularly in bringing the healthy workplace issues into the policy agenda of governments. Despite such improvements, many questions remain unanswered. For instance, have the existing policy initiatives resulted in healthier workplaces for healthcare workers? Simply put, are there indications that healthcare workers, particularly at the front line, are experiencing better

working conditions? Examining those questions would help inform the debate about how to increase the chances that policy initiatives will bring effective changes to the workplaces and, hence, translate into a greater quality of patient care.

The CNAC's final report in 2002 was widely viewed as an essential document for those struggling with the complexity of nursing resource issues (CHSRF 2006). It gave stakeholders 51 ways to address the crisis. A subsequent study outlining which recommendations had been implemented revealed that progress has been slow and appears to be made in pockets (Canadian Policy Research Networks [CPRN] 2004). The findings of the progress report showed that there has been an increase in the number of education seats for RNs, licensed practical nurses (LPNs) and registered practical nurses (RPNs). However, progress has not been widespread around issues pertaining to workload, the number of full-time equivalents (FTEs), absenteeism, nurse mentors and scheduling, and the changes have been concentrated in acute care facilities rather than community, long-term care or other settings. The report states that there are some recommendations that have been implemented in every jurisdiction across Canada but that some barriers remain, such as accountability issues in terms of implementation, resources for employers for workplace improvements and collective bargaining. While the report found positive signs of improvement in quality of nursing work life as recommended in the CNAC report, such changes are not widespread.

Over the past two to three years, several Canadian studies (both academic and grey literature) documented the progress made at the practice level in terms of healthy workplaces (mostly nursing literature). The most recent one is the research project

Nursing Environments: Knowledge to Action (NEKTA), which identified positive changes in the nursing work environment (Leiter 2006). Below, we document evidence of the progress related to several thematic areas.

Public Reporting on Healthy Workplaces for the Health Workforce in Hospitals

The hospital report on acute care prepared by the Canadian Institute for Health Information (2005; Howe et al. 2005; Wagg et al. 2006) included healthy work environment as an indicator within the quadrant of system integration and change. The healthy work environment indicator was measured using four components: (1) health workplace plan or policy, (2) accountability, (3) assessment and improvement and (4) key dimensions that include a healthy and safe physical environment, a positive psychosocial environment and an environment that promotes a healthy lifestyle (Howe et al. 2005).

According to the 2005 report, the provincial average performance of Ontario hospitals on the healthy work environment was 61.5%, and there were significant variations between hospitals. Teaching hospitals had the highest average score at 67.9%, community hospitals averaged 66% and small hospitals had an average score of 46.1%. These scores represent data collected from 98 of the 108 hospitals that completed the system integration and change survey (Canadian Institute for Health Information 2005).

Hospital Accountability Agreements

The MOHLTC in Ontario has recently included healthy work environment as a measure in the Hospital Accountability Agreement. The target set by the ministry is the provision of at least 70% of front-line nursing by full-time nursing staff (RNs and RPNs) (Ontario Joint Policy and Planning Committee 2005).

Strategic Plans of Health Authorities

The NEKTA research project found evidence of healthy workplace objectives in the strategic plans of several district health authorities in the Atlantic region. For example, Leiter (2006) found that healthy workplace objectives are included in Strategic Plan 2002–2006 Annapolis Valley Health (Nova Scotia), Strategic Plan 2002–2006 Capital Health (Nova Scotia), Strategic Plan 2001–2005 IWK Health Centre (Nova Scotia), Strategic Plan 2003–2006 Atlantic Health Sciences Corporation (New Brunswick), Strategic Plan 2001–2005 Department of Health and Community Services (Prince Edward Island) and Strategic Plan 2004–2006 Eastern Health District (Newfoundland and Labrador).

Physician Health and Well-Being

The impact of a healthy workplace extends to physicians as well as nurses and other health workers. Physicians are just as vulnerable to the influence of stress in the workplace and challenges of balancing life and work. This was recognized by the Canadian Medical Association (CMA) in the policy passed in 1998 regarding physician health and well-being, which consequently led to the passing of three resolutions to support physician health in 2002 (CMA 2006). In 2003, the CMA launched the CMA Centre for Physician Health and Well-Being to be an information resource for physicians, medical students and their families, to help them maintain health and prevent illness and to provide national leadership and advocacy. In 2003, the centre also announced \$100,000 for research into doctors' health (Puddester 2004).

Accreditation

The framework of the Canadian Council on Health Services Accreditation (CCHSA) includes work life as one of its four quality dimensions. The work-life descriptors include open communication, role clarity, participation in decision making, learning environment and well-being. In addition, there are new healthy workplace indicators that have been developed by the CCHSA and are now being tested. These indicators will become part of the standards used to assess accreditation of healthcare settings across Canada. This will motivate employers to address working conditions and their impacts on employees and patients.

Occupational Health and Safety

The most common policy and regulation changes across provinces were related to the need for safer equipment (e.g., lifts and electric beds), musculoskeletal injury-prevention programs, return-to-work programs and violence-prevention programs. With the implementation of these programs, many provinces reported an initial drop in injury rates (Occupational Health and Safety Agency for Healthcare in BC [OHSAH] 2004). According to a report prepared by OHSAH and published by Health Canada (2004–2005), the national rates for time-lost injuries (all provinces combined) actually decreased from approximately 4.1 injuries per 100 FTEs in 1996 to 3.7 injuries per 100 FTEs in 2002. The report suggests that the many interventions and policy changes implemented throughout Canada have been at least partially effective in reducing the national injury rates in healthcare (OHSAH) 2004).

In an effort to limit the incidence of needle-stick injuries and exposure to blood and body fluids, British Columbia, Alberta and Manitoba have amended their regulations to incorporate requirements for the use of safety-engineered devices (Visser 2006). British Columbia and Ontario have purchased new hospital beds and patient lifts designed to prevent back injuries among hospital and nursing home staff. For instance, Ontario has so far provided funding for more than 13,000 bed lifts in hospitals, long-term care homes and rehabilitation centres to help prevent injuries (Ontario MOHLTC and Ministry of Training, Colleges and Universities 2005). In 2004–2005, Ontario provided funding to help hospitals convert to safer medical equipment, including safety-engineered sharps devices. The OHSAH report found that Ontario's low frequency of time-lost injury claims in comparison to its large workforce is positive, and may indicate that health-related policies and programs implemented in this province have been successful. It appears that the injury rate in British Columbia had an important effect on the national rate as well, given that the dramatic decrease in its injury rate from 1999 to 2002 was also reflected in the decrease in the national injury rate. The positive results in British Columbia may be attributed to several reasons, ranging from the introduction of regulations for musculoskeletal injuries in 1997, to the formation of OHSAH, a provincial health and safety agency, in 1998, to the amalgamations of authorities in 2001 (OHSAH 2004).

Health, Safety and Violence

Site-specific safety programs are common (CHSRF 2006). For example, St. Michael's Hospital in Toronto is creating a healthy workplace scorecard that includes both mental and physical exposures to workplace hazards. Zero-tolerance and harassment policies are common in acute care settings (CHSRF 2006).

Education

There has been an increase in the number of nursing seats (CPRN 2004). In 2001, education seats for RNs, LPNs and registered psychiatric nurses increased by 43% compared with 1998 levels. British Columbia, Saskatchewan and Nova Scotia recently reported an even greater increase in seats. Many nursing schools are offering distance education programs; for example, in Newfoundland and Labrador, distance technology is used for the bachelor, graduate and postgraduate programs, as well as for continuing education. Also, British Columbia, Alberta, New Brunswick, Prince Edward Island and Newfoundland and Labrador have established paid co-operative placement programs for upper-year RN students, which provide students with income and work experience (CHSRF 2006). The Reimbursement of Tuition for Refresher Program issued in New Brunswick in 2001 encouraged RNs and LPNs to re-enter the nursing profession, and provided the province with a pool of skilled health professionals who had been out of the workforce. Ontario has provided funding for all schools of nursing to purchase clinical simulation equipment in order to ensure that nursing students are confident in their knowledge and skills, making them more practice ready upon graduation.

Professional Development, Continuing Education and Training

Many jurisdictions have instituted supportive education programs. For example, they fund education and professional development programs for RNs, LPNs and registered psychiatric nurses (Health Council of Canada 2005). New Brunswick, for instance, developed a continuing education initiative that includes Clinical Education

Program funding to promote continuing education events for health professionals. Another example is the Skills Enhancement for Health Surveillance Program, which is a continuing education initiative of the Public Health Agency of Canada for frontline public health professionals (Health Council of Canada 2005). In addition, healthcare organizations have started to institute continuing education programs. For example, the Hospital for Sick Children pays for nurses to attend conferences and provides a nursing scholarship program and a research training competition to support graduate education (CHSRF 2006). In its HHR action plan, Ontario outlined that it will provide funding to support professional development activities for practising nurses. In Nova Scotia, the nursing strategy offers programs to support employers in their recruitment and retention efforts, including funding for orientation, continuing education, bursaries, co-operative education programs, re-entry, relocation, recruitment websites and job fairs, nursing grants and leadership development (Nova Scotia Health 2005). Beginning in 2003, Nova Scotia committed funding to train 60 additional nurses each year for a four-year period.

Staffing

Some jurisdictions, such as Ontario, created new full-time positions for new nurse graduates; others, such as New Brunswick, have converted casual positions to permanent, aiming to improve staffing levels and mix and to decrease the workload. In 2004–2005, Ontario provided 1,000 temporary full-time positions for new nursing graduates to help them make a successful transition to the workforce. In New Brunswick, from 1999 to 2004, the number of permanent RNs increased to 6,726 from 6,014, or by 11.8%,

while the number of permanent LPNs increased to 1,934 from 1,634, an increase of more than 18%. By 2004, only 6.7% of nurses employed in New Brunswick were working as casuals (Government of New Brunswick 2005). In Nova Scotia, 238 more LPNs and RNs were employed in 2004 than in 2002 (Nova Scotia Health 2005).

Workload

In their HHR action plans, reported jurisdictions did not include any numerical targets for workload. Based on a review of several documents, a recent report stated that workload measurement systems are in place in the acute care sector across the country (CHSRF 2006). However, there is no evidence yet on whether the actual workload for healthcare workers has eased. In this recent report, it was noted that nursing unions in at least five provinces are bringing workload issues into contract negotiations. A similar observation was noted in the recent NEKTA report, which found that nurses' workload has not been eased in the Atlantic provinces (Leiter 2006).

Retention of Older Workers

The most notable accomplishment in retention of older workers is New Brunswick's phased-in retirement program. In New Brunswick, union contracts allow for phased-in retirement and also give full benefits for part-time and casual nurses. At age 55 years, nurses can opt for part-time work, keep their benefits and begin to collect a pension. This has the double benefit of opening up places for new graduates while retaining the skills and mentorship of experienced nurses (Health Council of Canada 2005). Three other provinces plan to introduce similar measures during collective bargaining (CHSRF 2006).

Flexible Scheduling

According to a recent report (CHSRF 2006), it was stated that some collective agreements contain arrangements for selfscheduling, flexible scheduling, job sharing or other work options. For instance, New Brunswick negotiated a new four-year collective agreement for RNs, nurse managers and nurse supervisors offering salaries and working conditions that are competitive with the other Atlantic provinces. Also, the phased retirement program in New Brunswick offers nurses the opportunity to work part time rather than leave their jobs completely. The NEKTA report found evidence of progress in the area of selfscheduling in Atlantic Canada (Leiter 2006).

Best Practice Guidelines for Workplace Health

The Healthy Work Environments Best Practice Guidelines project was designed to support healthcare organizations in creating and sustaining positive environments for nurses. Led by the Registered Nurses' Association of Ontario (RNAO) and funded by the Ontario MOHLTC working in partnership with Health Canada, Office of Nursing Policy, this project will deliver six guidelines and systematic literature reviews related to healthy work environments. The first, "Developing and Sustaining Nursing Leadership," was released in June 2006 after extensive consultation and review by panels and an advisory board containing Canadian and international experts (RNAO 2006).

Innovative Opportunities for Healthcare Workers to Take on New Roles

When experienced healthcare providers move from full-time practice into mentoring new graduates, a significant investment in time is required (Health Council of Canada 2005). Innovations have been introduced

to address these issues. For example, in Alberta's Capital Health region, hiring a new nursing graduate creates an additional position for the first year, over and above the current staffing allocation. The program is designed to improve job satisfaction for older nurses and increase retention of new nurses (Health Council of Canada 2005). The Montreal Regional Health Authority has undertaken a similar program to support newly qualified nurses.

Another innovative initiative is the 80-20 model, where front-line nurses have 20% of their clinical time freed from their regular working day to focus on teaching, research or on-the-job mentoring. In Ontario, the 80-20 model is being introduced provincewide as an option for nurses aged 55 years and older, as part of efforts to reduce early retirement (Health Council of Canada 2005). In 2004–2005, Ontario established nurse mentorship programs in 45 healthcare organizations across the province and provided funds to support late-career nurses in less physically demanding roles (Ontario MOHLTC and Ministry of Training, Colleges and Universities 2005).

Despite all the initiatives that are currently under way to improve workplaces, there still are few indications that healthcare workers, particularly at the front line, are experiencing better working conditions. This does not mean that the initiatives are not effective – progress at the practice level takes time. More evaluation research is needed to document the effects of those initiatives on the front-line workers. A recent review prepared by CHSRF showed that there are few indications that frontline nurses are experiencing better working conditions (CHSRF 2006). In hospital wards and units, in long-term care facilities and in the community, front-line nurses continue to work overtime, are injured

or ill, lack leadership and support and become discouraged, stressed and burnt out. Another recent study found that the nursing practice environment for Ontario acute care hospitals continues to be rated poorly by medical nurses (Tourangeau et al. 2006).

Next Steps for Research, Policy and Practice

While there has been significant progress in bringing policy changes as a result of research evidence, our synthesis suggests that more work is needed to ensure that existing policy initiatives bring effective changes to the workplace. After all, the ultimate objectives of the healthy workplace agenda are to ascertain that healthcare workers, particularly at the front line, are experiencing better working conditions. This will translate into better quality of care, organizational performance and system outcomes.

While we recognize that progress at the practice level takes time, there are still few indications that healthcare workers are working in good practice environments. In 2003, over 13,000 Ontario nurses were surveyed to explore how they evaluated their hospital work environments and their responses to these practice environments. Nurses reported weak professional practice environments, weak job satisfaction and moderate levels of burnout (Tourangeau et al. 2005). Although it should be kept in mind that most policy initiatives started in 2005, we believe that important next steps are required to bring effective and much faster and sustainable changes to the practice environments. Below we outline the next steps for research, policy and practice that are required to help the healthy workplace agenda achieve its ultimate objectives.

Next Steps for Research

Next steps to be taken in research to achieve

healthy workplace objectives are as follows:

- Evaluation research is needed to provide indications that the front-line healthcare workers are experiencing better working conditions. If healthcare organizations are to track whether healthy workplace initiatives are achieving their desired effects, some evaluation of the implementation is needed in research. Yet, there have been few evaluations done of the impact of such initiatives (El-Jardali and Fooks 2005).
- More research is needed to provide an update on the state of implementation of CNAC recommendations and to facilitate further implementation (CPRN 2004).
- Learning is required from micro-level innovations at the practice environment level. Monitoring, evaluation, documentation and effective dissemination and exchange mechanisms are essential.
- Greater sharing of knowledge is needed about what works with respect to workplace practice issues where, not surprisingly, most of the research and innovation comes from nursing. Research is needed to translate innovations from one profession to others, particularly to translate innovations in nursing workplace practices to other types of healthcare (Health Council of Canada 2005).
- More knowledge is needed regarding the ease of implementing healthy workplace interventions, the costs involved and time frames for the effects to take place.
- Working conditions have been researched in acute care settings, but for long-term care and home care settings, almost nothing is known. With the increasing shift to community-based care, research is needed to increase the

- knowledge on how to best recruit and retain healthcare workers in home and community care settings (Victorian Order of Nurses 2005).
- Implementation and evaluation of outcomes and impacts of RNAO healthy work environment guidelines are needed, particularly their impact on patient, nurse and system outcomes. And more systematic research is needed on the impact of healthy workplaces on societal outcomes.
- Research should continue to change the way of thinking about healthy workplaces, particularly to improve the understanding of the benefits of healthy workplaces that matter to the policy-makers and employers. In order to promote and keep healthy workplace issues in political agendas, researchers need to use innovative and effective dissemination strategies to make better instrumental and strategic use of their research evidence.
- More public reporting of measurable results from healthy workplace initiatives is encouraged – both to increase transparency and accountability and to share information on successes and barriers.
- Continued examination of work-life indicators within the accreditation processes is required to determine whether the health of the workplace and its link to patient outcomes is adequately measured. The CCHSA should further develop indicators for healthy workplaces to be integrated in accreditation standards and balanced scorecard reports.
- Comparable indicators on workplace health are required in order to make comprehensive assessments in areas such as retention, satisfaction and other aspects of healthy workplaces.

Next Steps for Policy

Next steps to be taken in policy to achieve healthy workplaces include the following:

- There needs to be a better integration of healthy workplace indicators and numerical targets within the HHR strategies and action plans of federal, provincial and territorial governments.
- Accountability frameworks that include healthy workplace indicators should be introduced. For example, healthy workplace indicators should be integrated within the performance agreements between governments and employers.
- Governments and stakeholders should support employers in implementing action plans to meet the healthy workplace targets for 2008 developed by the Health Council of Canada.
- The Health Council of Canada should ensure that recommendations and targets for healthy workplaces are implemented. The council plans to report publicly on interim progress toward achieving healthy workplace targets for 2008 (Health Council of Canada 2005).
- Governments need to evaluate the implementation of their healthy workplace initiatives to ensure good outcomes and sustain the momentum for positive change.
- Sustainability of funding healthy workplace initiatives that are targeted at the organizational level (i.e., front line) needs to be ensured.
- New collective agreements should contain arrangements for self-scheduling, flexible scheduling, overtime, job sharing and other setups.
- Policy consensus is needed on strategies and incentives (i.e., non-financial) to improve practice environments for healthcare workers.

• The Quality Worklife–Quality
Healthcare Collaborative (CCHSA)
must act both as a knowledge-transfer
laboratory and a best practice clearinghouse for healthy workplace information. There should be a call for a greater
sharing of knowledge about what works
in healthy workplace practices, where
most of the research and innovation
comes from nursing (Health Council
of Canada 2005). The collaborative can
create more opportunities to translate
innovations in nursing workplace practices to other types of care providers.

Next Steps for Practice

Finally, next steps to be taken in practice to achieve healthy workplace objectives are as follows:

- The healthy workplace targets for 2008 developed by the Health Council of Canada (Health Council of Canada 2005) need to be implemented.
- The notion of "professional development to lifelong learning" should be broadened in an effort to make it more inclusive (WHO 2006). Employers need to make professional development a regular part of budget planning and provide time for staff to enhance their training.
- Whether current collective agreements might be a barrier or facilitator to creating quality practice environments for healthcare professionals should be explored.
- There needs to be an improvement in management and leadership, such as more on-the-job leadership training. The goal is to help supervisors and middle managers do a better job of managing the tension between productivity and workers' health and safety.
- Employers must practise ethics-based

leadership (Morrison 2006) – people expect healthcare organizations to act with social responsibility and serve as good stewards of resources to make every effort to provide good working conditions for health workers, which translates into greater quality of care.

- Different styles of management and leadership are recommended for implementing healthy workplace initiatives. Johnson et al. (2003) stress that the current workplace health situation is still managed through conventional management practices and is shaped according to the practices of employment law.
- We must act now to cut waste and improve incentives. This can be achieved by reducing absenteeism and turnover and improving performance through compensation adjustment, work incentives and safe working conditions (WHO 2006).
- Healthcare organizations should develop a statement of clear vision and values that reflects the importance of supporting healthy workplaces. Employers should demonstrate that employee health and well-being are an integral part of their strategic plans (i.e., the way they do business). Healthy workplace indicators and numerical targets should be included in their strategic plans.
- Employers need to monitor and evaluate the implementation and impact of healthy workplace initiatives on the front-line healthcare workers.
- Healthy Work Environments Best Practice Guidelines established by the RNAO should be used as tools for the development and sustainability of a healthy work environment. The extensive work and consultation undertaken in this project allowed for the development of a comprehensive and valuable

set of guidelines to which workplaces should adhere.

Summary

The progress in the healthy workplaces for health workers agenda in Canada is a classic example of how knowledge can be used for policy and practice. It further evidences the need for collaboration between researchers, policy-makers, decision makers, stakeholders and practitioners. There have been major accomplishments to date, but change takes time and it is important to continue the efforts at all levels until we attain healthy workplaces by all measures.

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Effective Teamwork in Healthcare: Research and Reality



INVITED ESSAY

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ABSTRACT

Issues affecting health workplaces range from serious concerns that could affect the immediate physical safety of workers to those that would improve productivity and efficiency, or make an organization a preferred employer. Employers and workers might consider effective teamwork an asset, but for patients it is a prerequisite. This paper reviews the evidence for effective teamwork, primarily that gathered by a research team funded by the Canadian Health Services Research Foundation (CHSRF). We also review the expert opinion provided by a group of 25 researchers and decision makers convened by CHSRF in late 2005 at a forum for discussion about issues related to effective teamwork. Included in the retreat were representatives from professional organizations and occupations as well as areas such as legal liability.

Taken together, the research and expert opinion provide a comprehensive overview of the benefits of effective teamwork and the conditions needed for its implementation. In addition, we review policy and management perspectives on the most significant challenges to the implementation of effective teamwork in the Canadian context, and potential opportunities to overcome these obstacles.

In the companion paper, Shamian and El-Jardali provide an exhaustive summary of the issues affecting health workplaces in Canada, and areas of potential and actual improvement in the Canadian context. The issues raised range from minimum requirements for any workplace, such as protection from violence on the job, to initiatives that would make some workplaces preferred employers, such as flexible scheduling.

This paper addresses the issue of effective teamwork, a critical element of a healthy workplace but so far not at the "tipping point" where workers or employers expect it. However, for people receiving health services, effective teamwork is already more than just highly desirable. It is a basic prerequisite they often assume to be in place. The task of health system managers, policy makers and clinicians is to find ways of implementing the desired conditions for workers while meeting the expectations of patients.

Fortunately, significant work is happening on the research, management and policy fronts. Researchers have worked hard to bring together data on effective teamwork in healthcare and to extract key messages for management and policy. This includes teams here in Canada (Lemieux-Charles and McGuire 2006) and abroad (Baker et al. 2005a). System managers and policy makers are also making significant attempts to transform healthcare workplaces into effective team-based environments. This includes efforts on the national level, such as the great strides made by the 2004 Health Canada Initiative on Interprofessional

Education for Collaborative Patient-Centred Practice (IECPCP), which developed an evolving framework to help accomplish the task; as well as the Enhancing Interdisciplinary Collaboration in Primary Healthcare Initiative, funded by Health Canada's Primary Healthcare Transition Fund. In addition, a major contribution has come from the health human resource sector studies funded by the federal government.

The Canadian Health Services Research Foundation (CHSRF) has engaged in a number of efforts on both the research and decision-making fronts, in keeping with its role of supporting the evidence-informed management of Canada's healthcare system by facilitating knowledge exchange between research and healthcare management and policy. The CHSRF has made the management of the healthcare workplace one of its key research themes, and effective teamwork and inter-professional collaboration - with a focus on the role of occupational hierarchies, organizational structures and management practices and approaches and their effects on workplace productivity, stress and absenteeism – are areas for which the foundation encourages both research and knowledge exchange.

In 2005, the CHSRF commissioned a team of researchers to synthesize the existing evidence regarding effective teams in healthcare and what is being done to promote effective teamwork in Canada and abroad. Funding for this work was also provided by Health Canada (Oandasan et

al. 2006). With a draft report in hand, the CHSRF also brought together a number of policy and management decision makers, clinicians and researchers for two days of frank and open discussion about priorities and concerns, with the goal of developing recommendations that tackle the issue of how to implement effective teamwork at the different levels of Canada's healthcare systems.

This paper references some of the key evidence gathered by the researchers funded by the CHSRF, as well as other key research. It is not a summary of their synthesis work (which is available in complete form on the CHSRF website) but, rather, a perspective on the report, as well as other relevant research. Similarly, the discussions with managers and policy makers referenced in this paper are not verbatim transcriptions but, rather, a presentation of what the CHSRF sees as some of the most pertinent discussions regarding the challenge at hand: the evidence-informed implementation of effective teamwork in healthy workplaces across Canada.

Teams, Work and Teamwork

The CHSRF-funded researchers found that, in the literature, the concept of a team is indeed broad – it is something that exists any time two or more people are working together with a shared purpose. According to the literature, the way teams are designed depends greatly on the task that needs to be performed and when and where it is being performed. However, despite the broad definition of a team, there are some common ideas. For instance, when people are working in a team, they have particular responsibilities that relate to their own specific skills and knowledge. One individual is always the leader, and this is agreed upon by the team or those who created it.

In healthcare, teamwork is the ongoing process of interaction between team members as they work together to provide care to patients. The researchers found that while teamwork and collaboration are often used as synonyms in casual discussion, they are not synonymous. Critically, the researchers identified inter-professional collaboration as both a process affecting teamwork (and, in turn, patient care and health provider satisfaction) and an outcome in and of itself. In fact, collaboration can take place whether or not health professionals consider themselves to be part of a team. The researchers cite the example of primary healthcare, where professionals including a family physician, a physiotherapist and a dentist may all provide care to the same patient, yet in most cases do not see themselves as a functioning team. On the other hand, effective teamwork rarely happens where there is no collaboration (Oandasan et al. 2006).

Teamwork requires an explicit decision by the team members to co-operate in meeting the shared objective. This requires that team members sacrifice their autonomy, allowing their activity to be coordinated by the team, either through decisions by the team leader or through shared decision making. As a result, the responsibilities of professionals working as a team include not only activities they deliver because of their specialized skills or knowledge, but also those resulting from their commitment to monitor the activities performed by their teammates, including managing the conflicts that may result (Oandasan et al. 2006).

When Is Teamwork Effective?

The CHSRF-funded team pulled together a strong evidence base for the characteristics of effective teams, and the evidence tells us that these teams adapt and respond to changing conditions. Members of effective teams have faith in their ability to solve problems, are positive about their activities and trust each other. They can determine areas for improvement and reallocate resources to do so. And, of course, effective teams are often self-evident because they produce high-quality results. In healthcare, these include improved patient outcomes and cohesion, and competency or stability for the team itself.

Outside of healthcare, research tells us that teams working together in high-risk and high-intensity work environments make fewer mistakes than do individuals. This includes empirical evidence from commercial aviation, the military, firefighting and rapid-response police activities. These studies show a strong relationship between qualities such as flexibility, adaptability, resistance to stress, cohesion, retention and morale with effective team performance (Baker et al. 2005a; Gully et al. 1995, 2002).

In healthcare, studies have suggested that teamwork, when enhanced by interprofessional collaboration, could have a range of benefits. Although the link is far from definitive, it appears that teamwork and team composition could have positive effects, particularly in quality and safety (Oandasan et al. 2006). These include reducing medical errors, improving quality of patient care, addressing workload issues, building cohesion and reducing burnout of healthcare professionals. For example, a trial of team training for emergency room staff in US hospitals resulted in a reduction in clinical error rates from 30.9 to 4.4% over a 12-month period (Morey et al. 2002).

The CHSRF synthesis references a range of potential benefits from effective teamwork gleaned from selected teamwork initiatives:

- Improved communication and partnership among health providers and patients (Kates and Ackerman 2002; Nolte 2005)
- Clarity on the role of all health providers (Nolte 2005)
- Better response processes in addressing the determinants of health (Nolte 2005)
- Improved coordination of healthcare services (Kates and Ackerman 2002)
- High levels of satisfaction on the delivery of services (Kates and Ackerman 2002; Marriott and Mable 2002)
- Effective use of health resources (Task Force Two 2005)

What Can Managers and Policy Makers Do?

Practical and well-evaluated plans for implementing teamwork are fairly rare, although Oandasan et al. (2006) note that in health services research, there have been a number of recent attempts to capture and evaluate individual training programs to enhance teamwork, with some evidence of effectiveness. For example, they note that patient safety studies have found that team training and decision aids such as checklists and communication protocols can be used to improve team processes and reduce adverse events (Hoff et al. 2004; Lingard et al. 2004; Pronovost et al. 2003).

In the United States, researchers looked recently at more than 20 years of research on specific techniques for building and training teams, which focuses on building appropriate knowledge, skills, and attitudes among potential team members in medical environments. This review produced an extensive collection of guidelines relating to the content and style of team training programs (Baker et al. 2005b; Volpe et al. 1996). In addition, a recent review of six medical team training programs concluded that crew

resource management (CRM), a team training model from the aviation field, has many important lessons to offer healthcare professionals, a point also noted by the CHSRF-funded team (Baker et al. 2006; Oandasan et al. 2006). So far, a few jurisdictions have developed customized healthcare CRM programs for teams in operating rooms, obstetrics, intensive care and emergency care. However, the delivery of medical team training across the healthcare community is "generally haphazard" (Baker 2005b).

Is Effective Teamwork a Priority in Canada?

Broadly speaking, health human resources have been a preoccupation for managers and policy makers in Canada's healthcare systems. Back in 2001, those who were consulted as part of the first Listening for Direction national priority-setting exercise on health services and policy issues said clearly that health human resources would be the number one priority in the next two to five years (Gagnon et al. 2001).

With the exception of clinical organizations, which in 2001 were concerned about how new healthcare teams should be composed in order to meet the changing needs of patients, decision makers were preoccupied not with healthy workplaces or effective teamwork but with the supply of health human resources. In particular, federal and provincial policy makers wanted to find mechanisms to help them to avoid cycles of surplus and shortage, while managers wanted to know about forecasting models that might help them plan for these cycles and employ retention and recruitment strategies. In 2001, teamwork came across as a major concern, primarily in clinical organizations.

However, when the CHSRF and its partners repeated the Listening for

Direction process in 2004, a clear separation appeared between the *workforce* and *work-place* aspects of the issue, and concerns about teamwork were pervasive and prominent within both themes. Within the workforce aspect were concerns about the best ways to facilitate inter-professional teamwork and approaches, as well as the regulation of scope of practice and entry to practice. Within the workplace aspect was an interest in the role of occupational hierarchies, organizational structures and management practices and approaches and their effects on workplace productivity, stress, absenteeism and so on (Dault et al. 2004).

In other words, for Canadian decision makers, effective teamwork is a means to achieve improved quality and productivity for patients. For decision makers, it is a way to achieve a better balanced and more productive workforce but also one that is able to better serve the needs of patients. Teamwork is seen as a way to improve quality of care for the patient, not only through improved efficiency but also through a happier and healthier workforce. Since the 2004 process, the Health Council of Canada has identified improving teamwork as a critical component to both accelerating system change (Health Council of Canada 2005a) and improving human resource management (Health Council of Canada 2005b).

Challenges and Opportunities for Management and Policy

It is difficult to imagine who could oppose implementing effective teamwork as a way to improve healthcare. Even casual observers would likely equate the healthcare sector with teams and teamwork, and cite the history of nursing as an example. However, in healthcare delivery, teams rarely exist that incorporate different professions and occupations, as well as patients and families.

The greatest obstacle to change is arguably the hierarchical culture of healthcare. Entrenched attitudes about scopes of practice, professional "turf" and historical power structures can sabotage the essence of what teamwork is. Providers need to address their personal power issues, adopt common goals, break down hierarchies and then educate patients about how each team member contributes to their care.

Formidable barriers that arise out of this culture include the self-regulation of professions, current malpractice and liability laws and funding and remuneration models. All these discourage and deter the establishment of teams. For instance, current malpractice legislation places responsibility solely on individuals. Regulations that support teamwork, on the other hand, would refocus this "culture of blame" to a culture of patient safety and risk management. Much work needs to be done to clarify the accountability for non-physician team members in performing shared tasks. As for remuneration models, traditional fee-for-service payment systems for physicians impede movement toward collaborative care. What is more, no financial incentives exist that tie funding to collaboration and teamwork efforts, unlike initiatives in other countries such as England (Oandasan et al. 2006).

In addition, significant and persisting supply issues continue to preoccupy both health workers and system managers and policy makers, and confound dedicated efforts to implement effective teamwork. The current shortage of some health professionals creates a pressure-cooker workplace environment where few people have the time, energy or will to experiment with new models of healthcare delivery.

To get a better picture of not only the challenges to implementing effective teamwork but also ways to overcome the challenges, the CHSRF convened a group of 25 researchers and decision makers in late 2005 to provide a forum for discussion about issues related to effective teamwork. Included in the retreat were representatives from professional organizations and occupations as well as areas such as legal liability. The idea was to bring together experts from various perspectives with the goal of working toward tackling the issue and developing recommendations of how to implement teamwork at the differing levels of the healthcare system. While a consensus was not expected, the aim was to secure a foundation based on current knowledge and evidence that would serve as a basis for evolving discussions and decisions in the future.

One major focus of the discussions was to identify why previous or existing efforts to implement collaborative practice in healthcare organizations had succeeded or failed to meet expectations. In particular, the experts around the table were asked the question, "Based on our knowledge and experience, what factors have underpinned success in implementing collaborative practice?"

The key factors underpinning success identified by the experts at the retreat were as follows:

- Leadership, and having champions who can drive change management processes
- Clarity regarding roles on the part of all team members
- Trust, respect, value, and being valued within the teamwork setting
- Cultural readiness within the workplace, or significant efforts to try to create a culture of acceptance

Conversely, the factors that would signal likely failure in implementing collaborative practice for the experts included the following:

- A lack of time to bring people together to reflect and to change
- Insufficient inter-professional education, including continuing education, and the persistence of professional silos
- Systems of payment that do not reward collaboration
- Few links between collaborative practice and individual goals
- The absence of efforts to capture evidence for success and communicate this to key stakeholders, including the public

The participants at the retreat identified particular challenges and opportunities for furthering the implementation of effective teamwork in the areas of management and policy.

Management Challenges and Opportunities

At the level of health system management, the participants at the CHSRF retreat felt the most serious challenges to interprofessional collaboration include a lack of designated responsibility for ensuring collaboration takes place. History and tradition can serve as barriers as people often want to perpetuate the status quo, either to stay within their comfort zones or to protect vested interests. Ineffective communication can also be a critical barrier, unless multiple strategies are put in place to ensure effective communication within and between professions, as well as vertically within the institution. Finally, while project-based funding for collaboration can stimulate change at the project level, it does nothing at a systemic level, often making it difficult, or impossible, for change to become permanent and sustained.

To overcome the challenges at the organizational level, the experts recom-

mended accreditation systems that outline clear requirements for inter-professional collaboration within organizations. In addition, they felt that dedicated funding for inter-professional collaboration would support a transition to, and ongoing review of, collaborative practice. Also, more could be done in the area of intra-organizational knowledge transfer to help organizations share what they know about the results of research, demonstration site activities and learning projects.

In the immediate future, the participants saw opportunities for organizational change in the areas of information and education. On the information front, common measures of performance to monitor, evaluate or measure collaborative practice need to be developed. In addition, systems need to be implemented that capture, share, and link patient data, in order to facilitate collaborative practice. While they were sympathetic to concerns about privacy and confidentiality, the participants saw expanded access to patient information through electronic health records as a major facilitator of collaborative practice.

In education, it is vital to bring educators together to determine core competencies and curricula, while building on the existing initiatives such as the IECPCP, and to support learning initiatives throughout the country where lessons learned vis-à-vis collaborative practice could be shared – this could include ways to institute mentorship and other ways of learning by example. In addition, structures and a culture to value collaborative practice through organizational learning mechanisms should be adopted, particularly through continuing education. Finally, leadership training opportunities that include a collaborative practice component should be promoted within and across organizations.

Policy Challenges and Opportunities

At the policy level, the primary challenges identified related to the difficulty of planning change across multiple jurisdictions and among many stakeholders. Barriers to change include the territoriality of professions, as well as cross-sectoral professional issues such as liability and education. Within the policy context, the division between health and education programs at the provincial level was also seen as an obstacle, and one that governments are unlikely to address. In general, participants felt that there is not a high degree of sustainability for any one issue or long-term planning, given that healthcare is highly dependent upon the priorities of current provincial governments. Issues such as waiting lists and patient safety are currently dominating the policy agenda. While there may be some potential to reframe these issues as symptoms of systems that lack collaboration, this is a difficult task to undertake.

Nonetheless, participants were optimistic about developments such as the pan-Canadian Health Human Resources planning framework, as well as two 2005 reports from the Health Council of Canada, which reference teamwork and collaboration (Health Council of Canada 2005a, 2005b). The work of the IECPCP was often cited and seen as a hopeful example of longer-term funding commitments that could assist policy change. In the immediate future, the participants called for a national policy forum on collaborative practice to be convened, including discussion on topics such as research and evaluation dimensions to best practices, lessons learned, return on investment, impacts of these projects, change in policy and policy buy-in.

Most ambitiously, the experts convened by the CHSRF called for the creation of a pan-Canadian strategy that would develop a vision, strategic objectives, tasks, and responsibilities for implementing effective teamwork across Canada. The strategy would be led by an independent coordinating body that could identify stakeholders, help facilitate dialogue, and assist in determining which stakeholders could best help in addressing some of the gaps and issues not only in planning and implementation but also regarding policy, measurement, outcomes, and evaluations of the various projects already in place. This would include an inventory or clearinghouse of the various programs and initiatives throughout the country to capture best practices, identify gaps, and issue calls for papers on deficits in knowledge. The formation of the Canadian Interprofessional Health Collaborative (www.cihc.ca) in August 2006 is an extremely positive step in this regard.

Conclusions

The empirical evidence from high-risk work environments tells us that collaboration and teamwork is a way to produce high-quality results. In the health workplace, the evidence for inter-professional coordination and effective teamwork continues to grow. One of the most critical tasks facing researchers, managers, policy makers and clinicians will be to work together to create, share and use all forms of evidence, including methods and techniques for effective and ineffective implementation. The path toward effective teamwork in Canadian healthcare will probably be bumpy and windy, but it is one that all stakeholders, particularly patients, are likely to demand both more frequently and vocally.

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Healthcare Papers

Collaborating to Embrace Evidence-Informed Management Practices within Canada's Health System



COMMENTARY

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ABSTRACT

In late 2005, 11 major national health organizations decided to work together to build healthier workplaces for healthcare providers. To do so, they created a pan-Canadian collaborative of 45 experts and asked them to develop an action strategy to improve healthcare workplaces. One of the first steps taken by members of the collaborative was to adopt the following shared belief statements to guide their thinking: "We believe it is unacceptable to fund, govern, manage, work in or

receive care in an unhealthy health workplace," and, "A fundamental way to better healthcare is through healthier healthcare workplaces."

This commentary provides an overview of the Quality Worklife–Quality Healthcare Collaborative action strategy. This strategy embraces the thinking set out by the lead papers (by Shamian and El-Jardali and by Clements, Dault and Priest) and brings to life evidence-informed management practices.

Our healthcare leaders know that the number one question Canadians continue to ask is, "Will I be able to get the care I need when I need it?" At the same time, healthcare leaders are asking, "Will we have the workforce to provide the care?" Our leaders also know that our health system is a key competitive advantage with our main trading partner, the United States. Our system costs nearly 40% less as a percentage of our gross domestic product and yet has better health outcomes and is available to all citizens.

An effective and sustainable health system is an important part of Canada's current and future successes. However, many healthcare organizations are not healthy places to work. We know that healthcare providers face more violence in their workplace than do law enforcement officers (Canadian Nurses Association 2002), and healthcare professionals have the lowest levels of trust, of commitment to their employer and of decision-making influence of any occupation in Canada (Lowe 2002).

We also know that healthcare providers are absent from work due to illness or disability at least 1.5 times greater than the average of all workers (Canadian Institute for Health Information [CIHI] 2005). The cost of absenteeism is growing and is now 10% of the annual total cost of government-funded healthcare (Office of the Auditor General of British Columbia 2004). Another startling statistic is that 46% of

physicians are in advanced stages of burnout (Canadian Medical Association 2003). To ensure patient care is delivered in a safe and effective manner, the health of healthcare providers and the health of their work environments must be improved.

In addition to this evidence of an unhealthy (and, thus, poorly managed) healthcare workplace, 20–30% of Canadian healthcare providers are eligible to retire in the next decade (CIHI 2005). This retirement will take place at a time of increasing demand for labour-intensive care by an aging population who will be coping with varying degrees of chronic disease.

Our elected leaders seem to have decided the road to better healthcare can be found by monitoring three healthcare indicators: waiting times, access and patient safety. They also seem to be ready to fund proposals that might lead to positive change to any of these indicators. Much less attention is given to more effectively managing the health system's main asset, our estimated one million healthcare providers. Reducing waiting times, increasing access to care and ensuring patient safety will not happen unless healthcare organizations become healthy workplaces.

Evidence shows healthy healthcare workplaces lead to better patient care. Our health system needs to embrace evidenced-informed management and accountability practices. In order to ensure more effective and focused activity to improve the quality

of work life (QWL) in healthcare, we need to monitor key QWL indicators.

In their paper, Judith Shamian and Fadi El-Jardali set out valuable examples of evidence-informed management practices related to healthy workplaces. They point out that healthy workplaces benefit individual and organizational performances, as well as patient and societal outcomes. They also provide advice on what needs to be done in terms of policies and practice to encourage the health system to put in place and nurture sound management and accountability practices.

Dave Clements, Mylène Dault and Alicia Priest explain in their paper the critical role that effective teamwork has on the quality of the healthcare workplace and the quality of patient care. They note that teamwork leads to improved performance and is an essential ingredient to effective patient care. They also set out issues that need to be addressed to make healthcare teams more effective. For example, they argue that the health system needs to put in place collaborative practice training within its education programs to help the many health professionals realize the benefits of working together.

In late 2005, 11 major national health organizations decided to work together to build healthier workplaces for healthcare providers (Table 1). To do so, they created a pan-Canadian collaborative of 45 experts and asked them to develop an action strategy to improve healthcare workplaces. They named it the Quality Worklife-Quality Healthcare Collaborative (QWQHC). Leaders of those organizations recognized that a pan-Canadian approach was needed that would galvanize the health system to improve healthcare workplaces. They seek action-oriented strategies that embrace evidence-informed management and accountability practices.

Table 1. QWQHC national health partners

Canadian Council on Health Services Accreditation (coordinating secretariat)

Health Canada Office of Nursing Policy (main funder)

Canadian College of Health Service Executives

Canadian Nurses Association

Canadian Healthcare Association

Canadian Federation of Nurses Unions

Canadian Medical Association

Canadian Health Services Research Foundation

Association of Canadian Academic Healthcare Organizations

Academy of Canadian Executive Nurses

National Quality Institute

One of the first steps taken by members of the collaborative was to adopt the following shared belief statements to guide their thinking: "We believe it is unacceptable to fund, govern, manage, work in or receive care in an unhealthy health workplace," and, "A fundamental way to better healthcare is through healthier healthcare workplaces."

The 45 members of the collaborative know from hard and often-frustrating experience that enormous opportunity exists to use healthcare resources more effectively and that a key ingredient is a healthy workplace for healthcare providers. They also know that there are innovative healthy workplace initiatives currently implemented within organizations and that we need to build on these experiences, share them and work together to raise the overall standards of health human resource management practices across Canada.

Through the work of the QWQHC, which will be completed in March 2007, we have developed three action strategies that embrace evidence-informed management and accountability practices. These strategies are intended to help the Canadian

healthcare community work together to build healthy workplaces and link improvement to patient care outcomes.

First, we have identified a standard set of healthy workplace indicators that we think all healthcare organizations should build into their management information systems, performance agreements and accountability reports. The standard QWL indicators with standard definitions include the following:

- Two system-level indicators provincial healthy workplace targeted funding and organizational healthy workplace program spending

Second, we have identified priority actions that are known to improve the workplace and that can be put in place without delay. The actions focus on organizational and system-wide performance improvements. A self-assessment checklist is provided for organizational leaders to determine their strengths, areas for opportunities and potential leading practices for each priority action area. For each of these action areas, "menus" of leading practices as well as the overall recommended change process for implementing these QWL initiatives are also proposed.

Ten organizational-level action areas include putting the following in place:

A strategic foundation for a QWL initiative

- Organizational data systems to track and analyze QWL
- Organizational structures and processes that facilitate collaborative working practices
- Healthy leadership support and development programs
- Strategic training and development programs
- Fatigue-management policy and programs
- Innovative approaches to workload and staffing systems
- An integrated disability prevention and management system
- A comprehensive support system for employee wellness
- A healing environment

Four system-level priority action areas include putting in place the following:

- A national QWL database and support for reporting of standard QWL indicators
- Enhanced performance and accountability agreements, and accreditation standards
- A pan-Canadian QWQHC knowledge network to recognize and share leading practices
- A national workplace health program for healthcare

Third, the QWQHC members have set out a framework to exchange and apply knowledge, leading practices and research on healthy workplace strategies among all healthcare organizations across Canada. In order to know where to begin and then how to succeed in implementing positive change, healthcare organizations need easy access to research, advice and leading practices. The proposed knowledge network would actively

connect explicit knowledge (i.e., research findings) and tacit knowledge (i.e., front-line experiences) and would provide a "one-stop shopping" approach for individual change agents, organizations, policy-makers and researchers to connect on QWL issues in healthcare. The knowledge network would also identify existing knowledge exchange vehicles and initiatives wherever possible, and provide a clearinghouse for key target knowledge users. The knowledge would be presented in a format that allows users to find explicit and tacit knowledge for key areas that they have prioritized for action.

From the National Survey on the Work and Health of Nurses

Over a **quarter** (29%) of nurses who provided direct care reported that they had been physically assaulted by a patient in the previous year. Emotional abuse from a patient was reported by 44% of all nurses.

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

To expand on this further, key activities of the proposed knowledge exchange network include the following:

- Developing an actively updated central clearinghouse or website that provides links to relevant existing knowledge exchange initiatives
- Supporting communities of practice

 bringing together and supporting the development of QWL champions in health organizations, and supporting knowledge exchange relating to priority areas for improvement

- Providing a "go-to person" for providing active relational engagement between stakeholders
- Keeping the inventory of the research for QWL up to date by building on the current database on published literature and "grey literature" documents that was used to generate the environmental scan for the QWQHC initiative; this aim is to ensure easy access to current and relevant information for all health leaders
- Developing an easy-to-access database of leading and promising practices in quality work life and quality healthcare
- Developing the capacity to respond to organizational requests for "just in time" customized knowledge products such as briefing notes, background documents, research syntheses, multimedia presentations, overviews of specific leading practices and organizational QWL options
- Providing skilled "scribes" who codify tacit knowledge into explicit knowledge by seeking out and sharing leading practices on how organizations create success and share knowledge and skills internally between components of large healthcare organizations

The work of the QWQHC has been shared with broadly represented groups of stakeholders at a series of conferences as well as at the pan-Canadian QWQHC Stakeholder Summit held in December 2006. The feedback elicited from each of these opportunities will be incorporated into our final action strategy, to be released in March 2007. This report will be broadly disseminated by each of the QWQHC partner organizations. Committed engagement of key stakeholders is an ongoing key activity of QWQHC members as we are actively

identifying sustainable ways to bring the pan-Canadian QWQHC action strategy to life before the end of our mandate.

There is currently great momentum across the country regarding a pan-Canadian approach to addressing our health human resources (HHR) issues, as described in the Advisory Committee on Health Delivery and Human Resources' Framework for Collaborative Pan-Canadian HHR Planning (Federal, Provincial, Territorial Advisory Committee 2005). We feel that it is important to support the sustainability of the work of the QWQHC through the integration of the proposed QWQHC action strategy into this broader HHR planning framework. The QWQHC has essentially built an evidence-informed solution to achieve one of its major HHR goals. However, until this new pan-Canadian HHR planning mechanism is decided upon, it is important that we not lose any momentum on the work of the QWQHC. Ongoing collaboration between key stakeholders will be facilitated and supported by the QWQHC's national health partners.

Improved patient care depends on a healthier work environment for healthcare workers. Waiting times, access and patient safety will get worse, not better, if we continue to tolerate unhealthy healthcare workplaces. Surely, building a healthy workplace is a more effective use of public money than paying for the costs of unhealthy healthcare workplaces.

All Canadians need to know that it is unacceptable to fund, govern, manage, work

in or receive care in an unhealthy health workplace. Policy-makers, managers, health professionals, educators, researchers and unions need to work together effectively to build and sustain healthy workplaces through the uptake of evidence-informed management practices. The sustainability of our Canadian health system depends on it.

Acknowledgements

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Building Healthy Workplaces: Time to Act on the Evidence



COMMENTARY

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ABSTRACT

Numerous initiatives have been developed to create healthy workplaces in healthcare settings. However, despite these efforts nurses continue to experience negative conditions in their work settings and report challenges to maintaining physical and mental health. Stronger incentives must be put in place to ensure that current healthcare settings meet evidence-based standards for healthy work environments.

The authors of these two papers provide us with a good overview of healthy workplace issues and describe various initiatives that have been implemented in Canadian healthcare settings in recent years. They focus on two priorities established by the Office of Nursing Policy in Health Canada and championed by Dr. Judith Shamian and Dr. Sandra MacDonald-Rencz – healthy nursing workplaces and effective interdisci-

plinary teamwork. Shamian and El-Jardali provide a convincing array of research findings to support the need for these initiatives. It is helpful to see a collation of these various programs in a single article, and it clearly demonstrates that healthy workplaces are on the current policy agenda. The authors outline a number of recommendations for research, policy, practice and education to take this work to the next

level. In their paper, Clements et al. focus on the importance of teamwork among health providers as a strategy for fostering and sustaining healthy work environments.

It is encouraging to know that these initiatives are under way across the country, but, as the authors point out, it is not clear whether these initiatives have had an impact on direct care providers. Leiter (2006) found that few nurses at the patient care level were familiar with the recommendations of various national reports on the quality of work life in nursing work settings. My own research in the past year has shown that an alarming proportion of nurses (54-66%) are experiencing severe emotional exhaustion in current hospital settings (Cho et al. 2006; Greco et al. 2006). Three different studies with representative samples of nurse managers, new graduates and nurses in acute care settings revealed that the primary predictor of emotional exhaustion and burnout was excessive workload, followed by a perceived lack of fairness of organizational procedures, poor interpersonal relationships in the work setting, a perceived lack of recognition for their contribution to organizational goals, a lack of congruence between their own and organizational values, and a disempowering work environment. In another 2005 study (Laschinger 2004; Laschinger and Finegan 2005b), fewer than 50% of nurses surveyed reported that they received the respect they deserved for their contribution to the healthcare in their organization. This result was replicated in the National Survey of Work and Health of Nurses (NSWHN) conducted by Statistics Canada and Canadian Institute for Health Information (CIHI) (2006) in which perceived lack of respect and work overload were significant predictors of nurses' mental and physical health.

Clearly, we have a long way to go in creating healthy work environments in nursing as these results show that basic human factors that foster individual health and well-being are still lacking in current nursing work environments. It is important to pay attention to these basic psychosocial aspects of healthy work environments as well as the physical health aspects of nursing work settings. In all of the above-mentioned studies, the extent to which nurses felt they had access to empowering work structures, such as information, support, resources and opportunities to learn and grow, was strongly predictive of nurses' feelings of being respected in their workplace, their burnout levels and their perceived fit with their work environment. Creating empowering work environments is the mandate of management. It must be supported at higher levels of the organization and monitored to ensure that these conditions are in place. While empowerment is only one of the many important components of a healthy work environment, it has been shown to be fundamental to nurses' health and wellbeing and an important determinant of job satisfaction, organizational commitment and turnover (Nedd 2006).

We know that the nursing profession is currently experiencing a severe nursing shortage, with many nurses approaching retirement and fewer people entering the profession. Many are leaving the profession altogether. Furthermore, Boychuk Duchscher (2001) and a Canadian Nurses Association report (2000) showed that many new graduates are leaving their jobs within two years of graduation. All these factors will intensify the nursing shortage and add to the stressful nature of nursing working conditions. Burnout, the inevitable result of long-term exposure to stressful working conditions, is a precursor of job dissatisfac-

tion and turnover, something we can ill afford with the current nursing shortage. We have considerable evidence and theory that articulate factors in the workplace that contribute to this syndrome; this knowledge can guide efforts to change things for the better. We also know that burnout has negative health effects for both nurses and the patients they serve (Laschinger and Finegan 2005a; Leiter et al. 1998). Therefore, workplace initiatives that address this issue are urgently needed if we are to sustain a healthy nursing workforce that will ensure that patients will continue to receive the high-quality care they deserve.

Shamian and El-Jardali note a need for the evaluation of current healthy workplace initiatives and for employers to be made accountable for ensuring that their organizations meet standards for healthy workplaces. Since 1999, Canadian Council on Health Services Accreditation (CCHSA) standards have included work-life quality indicators that increase the likelihood that organizations will pay more attention to these issues. However, since the accreditation process is voluntary and funding and approval are not tied to meeting these criteria, it is difficult to ensure that these conditions are met consistently across healthcare settings. There is a need for a mechanism that requires organizations to demonstrate that these standards are in place and that they are effective in promoting employee health.

The Quality Worklife–Quality
Healthcare Collaborative (QWQHC) is a
promising initiative that brings together a
coalition of 11 national health partners to
develop a pan–Canadian strategy for translating evidence-based approaches to building
and sustaining healthy work environments
into practice at the direct care level. An
important component of this initiative will
be to put in place a mechanism for moni-

toring the quality of work life across the country over time, using a common measure or set of indicators. This will provide a basis for monitoring the effects of healthy work environment programs over time using a common metric and provide direction for any necessary improvements that may be required. This approach will permit national comparisons of work-life quality and could serve as a national report card on healthy work environments in Canada. This will be a major improvement on current practice, where there is little consistency in measures across settings - making it difficult for organizations to benchmark their progress in this area. This common measure could even be used by all healthcare organizations on an annual basis as part of their quality-improvement programs to enable them to track their own progress and to compare their results with those of similar organizations across the country. Ultimately, these results could be collected in a national database and used in research to study the impact of these work-life conditions on provider, client and system outcomes.

Ideally, such a measure is based on an evidence-based explicit theoretical framework that articulates the relevant components of a healthy workplace and their interrelationships. The Pulse measure to be used by the QWQHC is grounded in the CCHSA healthy workplace framework. The national nurses' health survey conducted by Statistics Canada and CIHI is another source of data on the health effects of worklife interventions that could be used over time to monitor nurses' health. Indeed, this survey could be extended to include all health providers in the system, which would provide a comprehensive assessment of working conditions in our healthcare sector. The QWQHC is the first national initiative involving a powerful mix of stakeholders at a variety of levels committed to putting knowledge into action. It will be crucial to ensure that this effort receives sustainable funding to enable them to continue their work.

Clements et al. describe the importance of effective teamwork in ensuring high-quality work life and positive patient outcomes. Interdisciplinary silos and disciplinary turf wars have contributed to workplace stress and affected patient care quality in the past, and efforts are being made to promote effective interdisciplinary education and practice. These efforts are strongly supported by policy groups, such as Health Canada, that have launched a number of initiatives intended to improve teamwork among the health professions. Evidence to support this work was established in the NSWHN study where poor nurse/physician collaboration was found to be a significant predictor of nurses' mental and physical health (Statistics Canada and CIHI 2006).

Interestingly, the proposed solutions for improving teamwork mirror those for ensuring healthy work environments are in place. This is logical since effective collaboration in teams is an important component of healthy workplaces. There is evidence that effective collaboration among health professionals has positive effects on provider, client and system outcomes. However, it is important that all team members retain their professional identity and are clear about what they bring to the healthcare process. Effective interdisciplinary collaboration requires mutual respect for all team members' skills and expertise and a willingness to listen to other points of view in the process of planning and providing optimal patient care. The authors suggest several strategies that will lay the foundation for mutually respectful, effective healthcare teams. These relationships must be supported and, indeed, demanded in all healthcare settings if patients are

to benefit from the expertise of all health professionals and continue to receive highquality patient care.

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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 McCraken 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 work-place 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 microinnovations, 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 (Wortsman 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-thetrainer 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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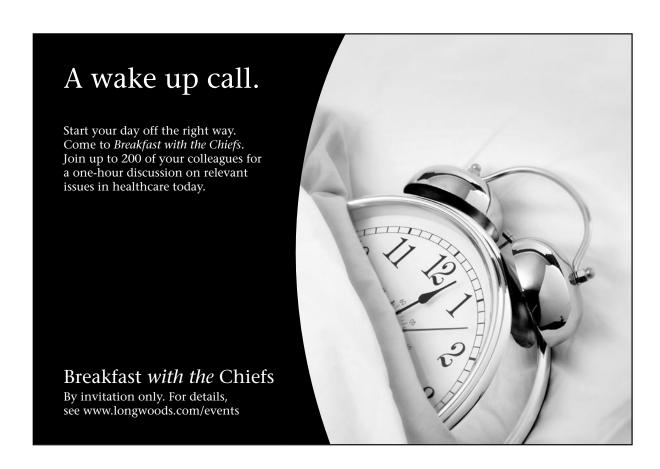
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Healthy Workplaces and Teamwork for Healthcare Workers Need Public Engagement



COMMENTARY

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ABSTRACT

This response challenges the healthcare system to take full responsibility for the work environments created for health human resources. While the need for healthy work environments and teamwork in healthcare are inarguable, the fact is they are not a reality in today's health system. The authors suggest strategies to address this issue and identify the person or groups that should take responsibility, including governments, organizations, individuals and the public. Strategies include ensuring that policies do not contradict one another and holding each level responsible for the outcomes of a healthy work environment – retention and recruitment of health human resources, better patient/client outcomes and healthcare costs. The need for strong and appropriate leadership for health human resources with "content knowledge" is discussed, along with recommendations for measuring the performance and success of healthy work environments and teamwork. The authors conclude that collaboration at the micro, meso and macro levels is required to facilitate the true change that is needed to improve the work environments of health human resources.

THE PAPERS BY Shamian and El-Jardali and by Clements, Dault and Priest provide an excellent review of knowledge transfer of the research focusing on healthy working environments and teamwork in Canada. While recognizing that there has been significant progress in the past decade, both papers underline the importance of continued efforts to ensure that this work is firmly embedded in the healthcare system.

An effectively functioning health system is one of the many factors that determine the health of a population. Research has shown that a healthy workforce is a prerequisite for a quality health system. At the heart of any healthcare system are the people who deliver care – health human resources. Promoting healthy working conditions for all healthcare providers is, consequently, an important strategy for improving the health of Canadians. Many governments and organizations have acknowledged the need for healthy workplaces, including teamwork, in order to retain and recruit healthcare workers. However, as both sets of authors discuss, the responsibility for healthy workplaces and teamwork extends beyond the organization and the government. Individual healthcare professionals also need to take responsibility for creating and sustaining healthy workplaces. For example, governments and organizations cannot design policies to mandate respect, a necessary component of a healthy workplace. The decision about how you treat others is not a policy. It is a philosophy that cannot be directed by others. Some of the strategies outlined by Shamian and El-Jardali such as zero-tolerance policies are a step in the right direction, but individuals must take personal responsibility.

In addition to governments, organizations and individuals, the public also needs to take responsibility for, and get engaged in,

ensuring a healthy workplace for healthcare professionals. Clements et al. describe the fact that the public expects teamwork as a prerequisite for their healthcare. It is logical to assume that an informed public would assume this as a mode of operating and therefore show limited demand in a public way. This said, recent research has shown that while the public may be interested in and review public report cards, they do not make decisions about their healthcare based on these report cards (Canadian Health Services Research Foundation 2006a). Change will continue to be slow if the public does not react to evidence suggesting, first, that team practice is not necessarily present in the delivery of healthcare and, second, that practice environments are unhealthy and unsafe for both practitioners and the patients they serve. The public must hold organizations and governments accountable for the state of healthcare environments, and must make demands for immediate and ongoing improvement.

Clements et al. speak of the traditional hierarchies as a barrier to both teamwork and healthy work environments. Healthcare organizations are often seen as classic examples of hierarchical, authoritarian structures, with "chain of command" organization, rules and regulations called policies and procedures, departments and disciplines with rigid boundaries, and a "command" mentality complete with "tours of duty" (Gelinas and Manthey 1995). This rigidity can affect outcomes for both staff and patients in these environments. Cumbey and Alexander (1998) showed that organizational structure is a critical variable predicting job satisfaction.

The organizational structure, in turn, influences the organizational climate (Langfield-Smith 1995). *Organizational climate* is defined as the way it "feels" to

work in a particular environment (Snow 2002). Several studies have examined the relationship between organizational climate and job satisfaction. Keuter et al. (2000) identified a significant positive correlation between an aggregate measure of organizational climate and job satisfaction. Kangas et al. (1999) found that a supportive climate led to higher levels of job satisfaction. Tzeng et al. (2002) also demonstrated a positive correlation between nursing job satisfaction and organizational climate. Governments and healthcare organizations have been working to design new organizational structures. In the 1990s, we saw the shift to program management, which was an attempt to design a system that is more patient or client centred. However, this has resulted in varying degrees of success. We still see bureaucratic systems that make it difficult for teams to collaborate effectively.

From the National Survey on the Work and Health of Nurses

One in three nurses (35%) report occasional or frequent nosocomial infections (infections that originate in hospitals or other health facilities) in patients under their care.

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

Contradicting Policies

In addition to hierarchical structures, policies often conflict. As a government or organization focuses on one aspect of its priorities, another often suffers. For example, healthcare-funding models have not kept up with the need to create and sustain healthy work environments. Funding models such as managed competition and

hospital funding formulas that are efficiency driven can cause organizations to focus only on the direct costs of providing care, without considering the indirect measures such as support for team training, professional development and so on, which research has shown have an impact on the quality of care. The 1990s saw healthcare workers turned into variable costs and "downsized" in large numbers, along with the elimination of many of the support systems (such as staff development) to meet the immediate costreduction needs. However, the long-term costs of these changes (driven by efficiency and cost-reduction policy decisions) are only now being fully understood. Measures that retain staff can be more cost effective in the long term. In an international study of turnover, Shamian et al. (2003) found that the cost of turnover of one nurse is approximately US\$22,000 and that the average turnover rate per unit is 9.5%. Governments and organizations are just now beginning to see healthcare workers as a fixed rather than variable cost, thus increasing their tolerance for considering the long term in their decision making. In addition, fee-for-service models may impact teamwork. Current physician funding models that act as barriers to physicians engaging in team practice should be reconsidered. Providing incentives to the team rather than the individual may be a more effective model to break down the hierarchies and support healthy work environments for the whole team.

Leadership

Governments and organizations with human resource—specific leadership in place have shown great strides in healthy workplace initiatives. Only some provinces have provincial chief nursing officers at the senior level of government, and not all organizations have chief nursing officers or chiefs of professional practice at their most senior levels. Ontario has a regulatory requirement for all hospitals to have a chief nurse executive reporting to the chief executive officer. In addition, Ontario has added an assistant deputy minister for health human resources to bring the health human resource agenda to the forefront of decision making. The addition of this content expertise to the most senior levels of government and organizations ensures that policy decisions take into account the health human resource perspective. Individuals in these roles can translate the research and information into a language that others can understand, identifying the impact that all decisions can have on healthcare providers, organizations and the system.

Accountability

It is also important to ensure that when new policies are being implemented, corresponding performance measures are also developed and implemented. A government or an organization that invests in healthy work environment strategies will want to demonstrate a return on its investment. These performance measures need to be clear and measurable, and then governments, organizations and individuals need to set a reasonable time frame to track this effect – change does not happen quickly.

Who should be accountable, and how do we hold them accountable for facilitating team-based and healthy work environments? This accountability needs to be shared between governments, organizations and health professionals. Governments should be accountable through their policies and funding formulas for the health system. Organizations should be accountable through performance contracts, accountability agreements and retention rates – held accountable by the govern-

ment, communities and their current and prospective employees. Finally, individuals should be held accountable by their peers and colleagues and formally noted through performance appraisals.

Further Research

Success will be measured through continuing support for research and evaluation of the existing initiatives. That said, there are significant gaps in the research. Little research has been focused on the needs of a multi-generational, multicultural workforce that has mixed values, beliefs, needs and preferences. Further research is needed to determine how to create a work environment that meets this diverse workforce. Research on teams needs to focus on those with multi-generational and multicultural variables to determine the mix of strategies to support a broad range of individuals.

Collaboration

Clements, Dault, Priest, Shamian and El-Jardali have reminded us that the factors that create healthy workplaces are well known. However, making change a reality will take the involvement of multiple stakeholders, including provincial, territorial and federal governments, healthcare organizations, professional associations and individual healthcare providers. Fortunately, this collaboration is beginning to take place.

At the heart of any healthcare system are the people who deliver care – healthcare professionals. This workforce is the healthcare system's greatest asset. Canada's ability to provide access to quality, effective, patient-centred, team-based and safe health services depends on the right mix of healthcare providers with the right skills in the right place at the right time. As Clements et al. suggest, historically, decision makers have focused more on the supply

or quantity of health human resources than on qualitative retention strategies such as healthy workplaces or effective teamwork. Increasingly, decision makers are recognizing that supply issues will be resolved, in part, through these retention strategies, which keep healthcare professionals through supportive, positive work environments.

Clements et al. note the role that collaborative, team-based work environments play for improvements in quality of care and overall job satisfaction and performance of the organization. Increasingly evidence suggests that collaborative, team-based practice results in improved job satisfaction - a critical element of a healthy work environment. The research also suggests that these two concepts are fundamentally linked. Collaborative team practice is a vehicle for healthy working environments (Canadian Health Services Research Foundation 2006b; D'Amour and Oandason 2005), while team practice most effectively occurs in an environment that is positive and progressive. The federal government's investment in the Interprofessional Education for Collaborative Patient-Centred Practice is contributing to a growing evidence base promoting positive working relationships and working environments in which tomorrow's healthcare providers will practise (Health Canada 2006).

A Framework for Collaboration

Finally, one of the most exciting policy levers on the horizon appears to be the recently developed Framework for Collaborative Pan-Canadian Health Human Resources Planning. The framework was developed through the Advisory Committee on Health Delivery and Human Resources (a federal, provincial and territorial committee reporting to the Conference of Deputy Ministers of Health) (Federal/Provincial/

Territorial Advisory Committee on Health Delivery and Human Resources 2006). The vision for the framework includes more supportive satisfying work environments for healthcare providers through collaborative strategic health human resource planning. It underlines the importance between collaborative team practice and healthy working environments, which is consistent with the reflections of Clements et al. The framework will provide a powerful tool in further facilitating change in the working environments of healthcare providers.

Clements, Dault, Priest, Shamian and El-Jardali are right in saying that change is occurring. However, we need to stay the course. Indeed, the work has just begun. Collaborative team practice is good for patients and contributes to a healthy working environment. Further changes and continuing investments need to occur for this progress to be sustained. Collaboration, at multiple levels, will facilitate the required system level change. The Framework for Collaborative Pan-Canadian Health Human Resources Planning offers a positive policy lever for such change.

Canada's healthcare providers are a part of a constantly evolving healthcare landscape in which factors such as an aging population and workforce, new technologies and healthcare reforms, including policy movements such as patient wait-time reductions, are constantly being challenged. However they, our healthcare providers, remain our healthcare system's greatest assets. Their health and well-being predict the quality of care that will be delivered within our health system. Healthy working environments translate into healthy healthcare providers. They, in turn, will assist all levels of government, healthcare organizations, health professional associations and other healthcare providers to

attain our common goal of health for all. The power is in collaboration.

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CCHSA Accreditation: A Change Catalyst toward Healthier Work Environments



COMMENTARY

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ABSTRACT

Canada has made significant progress in research and policy development regarding work environment issues that contribute to the quality of the work environment in health organizations. In order to successfully achieve the outcomes that healthier work environments can have on providers, patients and the system, more definitive action is required now. The Canadian Council on Health Services Accreditation (CCHSA) is a recognized catalyst of change in health organizations and systems in Canada and internationally. This paper reviews CCHSA's role in contributing to the improvement of the health of work environments in order to improve both the well-being of those working in healthcare and the quality of care being provided to their patients or clients.

THE NEED FOR a strong focus on a healthy work environment is increasingly acknowledged and respected as fundamental to the provision of safe, effective healthcare. The evidence of the negative impacts of an unhealthy work environment is escalating and making this issue a priority. While some initiatives to improve the work environment have been implemented, it is evident that considerable work remains to be done.

The Canadian Council on Health Services Accreditation (CCHSA) believes in both the fundamental contribution that the quality of the work environment makes toward the health of employees (both the impact of the job on their health and in supporting their personal health promotion) and in the relationship between a healthy workplace and the quality of patient care. A safe and healthy environment for staff is a safe and healthy environment for patients and clients. For example, if staff members have the appropriate lifts required to do the job, the lifting risk is minimized for both staff and clients. Also, if staff members are active participants in planning and decision making, their satisfaction is positively affected, potentially having an impact on staff retention and the quality of care provided.

All staff within the healthcare industry (community through to rehabilitation) require a quality work environment. The combined focus and efforts of healthcare leaders and stakeholders are essential to effectively address this issue.

It is recognized that the health services environment is one of the most difficult within which to work. It is physically and emotionally demanding and poses a high risk of injury. Health service providers have limited control over workload and work schedules. They may also be subject to potential violence. Employment instability

due to provincial, regional or organizational restructuring has contributed to increased stress and less effective communication, with obvious impacts on team cohesiveness. Absenteeism and human resource shortages add to the challenge of delivering quality healthcare. The retention and recruitment challenges for all professions within healthcare are a reality requiring strengthened attention and effectiveness. Clearly, the quality of work life and the health of the work environment are critical factors to be respected and effectively addressed.

The Evidence

In the past decade, there has been an explosion of literature providing evidence that action must be taken now. The lead paper by Shamian and El-Jardali effectively summarizes the challenges in the healthcare workplace environment and outlines recommendations on the directions to be taken. The paper by Clements, Dault and Priest outlines the critical importance of effective teamwork. The Registered Nurses' Association of Ontario (RNAO) has undertaken commendable synthesis work within the Best Practice Guidelines. Specifically, the Healthy Work Environments Best Practices Guidelines Project (led by the RNAO and funded by the Ontario Ministry of Health and Long-Term Care working in partnership with Health Canada and the Office of Nursing Policy) will result in six guidelines including systematic literature reviews.

Strategies to improve healthcare working conditions have been identified. Accountability must now take over – accountability of all key stakeholders to move forward and implement the necessary improvements.

CCHSA and Quality of Work Life

This paper outlines the commitment of the

CCHSA and the strategies being used in order to improve quality in health services and to raise the bar for the improved health of healthcare work environments. The vision and mission of CCHSA reflect this commitment to quality. CCHSA's corporate values include reference to quality of work life, for CCHSA staff and the surveyors, as well as within the broader healthcare environment.

CCHSA Vision: The leader in raising the bar for health quality CCHSA Mission:

Driving quality in health services through accreditation

All of CCHSA's work is national in scale and is developed to be applicable to most healthcare organizations throughout the continuum of care, including both public and private. The CCHSA standards are standards of excellence, not basic standards. The goal is to enable and encourage organizations to improve, to "raise the bar."

CCHSA is a world leader in identifying work life as a key component of *quality* for healthcare organizations. In 1999, work life was incorporated into the accreditation program. At that time, work life was identified as one of the four quality dimensions within the definition of quality, resulting in the introduction of work-life standards. CCHSA accreditation standards are continuously improved through a comprehensive consultative process that includes literature reviews, expert advisory committees and key individual interviews in the healthcare field.

The CCHSA Work-Life Strategy

Several years after the 1999 introduction of work-life standards, CCHSA undertook a review of all recommendations from the 2002 accreditation surveys. Two of the top 10 compliance issues noted by the survey-

ors were related to work life. Nearly 200 recommendations were made about human resources planning, specifically addressing the need to plan, anticipate and respond to current and future human resources needs. In response to this review, six work-life seminars (supported by the Office of Nursing Policy at Health Canada) were held across Canada, with 370 attendees. The information from the seminars provided valuable direction to the CCHSA and led to the next phase of the work-life strategy. This was approved by the CCHSA board in 2004.

The CCHSA Worklife Advisory Committee was convened, and under its guidance the work-life model was developed and the working definition of work life revised. CCHSA based the further development of work-life standards on the following definition: "The organization provides a work environment that enables optimal individual, client and organizational health and outcomes." The CCHSA work-life model takes a comprehensive and strategic approach to work life as it includes organizational factors, care and service processes, staff characteristics and patient characteristics, and their impact on staff, organization and patient outcomes. Some key areas that the accreditation program addresses in relation to this expanded model include culture, open communication, decision-making participation, learning environment, work and job design (which includes issues such as span of control and staffing effectiveness) and supportive physical work environment.

CCHSA has further strengthened the work-life standards. These were released in January 2006 and will apply to 2007 accreditation surveys. The number of criteria that measure work life have more than doubled and are distributed across the standards sections.

Quality of Work Life and Patient Safety

In 2004, under the guidance of the CCHSA Patient Safety Advisory Committee, five patient safety goals were identified, one of which specifically references work life. Introducing work life as a patient safety goal further contributed toward raising the profile of the fundamental and strategic importance of addressing work life.

Does Accreditation Make a Difference?

Canadian and international research evidence supports the fact that accreditation is a valuable tool to increase organizational uptake of continuous quality improvement initiatives (Baker 1997; LeBrasseur et al. 2002). Accreditation leads to the enhanced use of indicators, promotes effective change management, improves organizational learning practices, improves communication among teams and facilitates organizational and regional restructuring (Duckett 1983; Lemieux-Charles et al. 2000). In addition, most organizations implement the recommendations arising from their accreditation visit and report (Beaumont 2002). Accreditation contributes to positive change. The next phase of accreditation-related research will include examining its impact on patient and client outcomes.

CCHSA Patient Safety Goal # 5 Create a worklife and physical environment that supports the safe delivery of care/service.

Most policy reports on quality of work life in healthcare recommend working with CCHSA, supporting accreditation activities to monitor and improve the quality of work life for nurses and other health providers. Accreditation is a significant lever and catalyst to propel this agenda forward, to move healthcare organizations toward healthier work environments. Unquestionably, the CCHSA board, staff and surveyors are committed to the importance of this issue and its relationship to quality of care.

Next Steps for the CCHSA and Work Life

The Pulse Survey Tool

In 2005, CCHSA began the development of a "work-life pulse" employee survey tool to complement the work-life standards. While most health organizations conduct a staff satisfaction survey every one to two years, a simpler complementary tool, focusing on key work-life measures, was identified as necessary. CCHSA, in partnership with the Ontario Hospital Association, contracted Brock University Workplace Health Research Laboratory and the Graham Lowe Group to develop the tool. Pilot tested in 17 organizations across Canada, the Pulse Survey provides a snapshot of employee perceptions of key work environment factors as outlined in the CCHSA work-life model. The tool consists of 21 survey measures. It is designed (1) to assist organizations to track and identify issues for further investigation and to identify specific work units that are exemplary or deficient in their quality of work life, and (2) to allow for benchmarking and identification of national leading practices in this area. The Pulse Survey tool is currently undergoing further testing and will be available nationally as part of the accreditation program in the near future.

Accreditation Leading Practices Database

During each accreditation survey, surveyors identify practices that are noteworthy and that should be shared across the country. These are called leading practices. To date, these leading practices relating to the accreditation standards have been summarized in the CCHSA *Canadian Health Accreditation Report*, the most recent of which was released in June 2006. CCHSA now offers a fully accessible online searchable database of these leading practices on the website. This section of the website will continuously grow and strengthen, improving on our knowledge exchange responsibility and strategy.

From the National Survey on the Work and Health of Nurses

Nearly **half** of all nurses (48%) who provided direct care reported having ever had a needlestick or other injury from a sharp object (for example, scissors, scalpels, razors) that had been contaminated by use on a patient. One in ten reported having had such an injury in the past year alone.

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

The Quality Worklife–Quality Healthcare Collaborative

Partnerships are key to effectively addressing pivotal issues such as quality of work life. The Quality Worklife–Quality Healthcare Collaborative (QWQHC) is an excellent example of effective partnerships. During 2004, a meeting of national health organizations was convened by the Canadian College of Health Services Executives. Consensus was achieved on two major points: (1) there is sufficient research evidence to support the need to improve the health of the healthcare environment as well as the quality of work life, and (2) there is insufficient effective action being taken. It was

agreed that by working together and involving key experts, an integrated and coordinated pan-Canadian action strategy could be developed. In response to this, in late 2005, 11 national healthcare organizations created a pan-Canadian collaborative that is guided by the work of over 45 experts. CCHSA provides the secretariat support for the QWQHC. It is funded by Health Canada as part of the 2004 Health Accord Recruitment and Retention Fund.

The collaborative is working to develop a pan-Canadian action strategy focusing on improving healthcare workplaces to improve patient care. The QWQHC pan-Canadian action strategy, the topic of a companion paper in this journal, focuses on activities that embrace evidence-informed management practices (including standard indicators, priority action strategies and ongoing knowledge exchange). CCHSA with the QWQHC partners will play a key role in providing leadership and engaging all stakeholders on the sustainable implementation of these activities in an integrated and coordinated way.

Conclusions

The lead articles by Shamian and El-Jardali and by Clements, Dault and Priest set the stage for discussion of this critical healthcare issue. CCHSA is strongly committed to contributing to improving the quality of work life and to improving the health of the work environment for all members of the healthcare team. CCHSA standards and the entire accreditation program are a catalyst supporting and enabling the necessary change.

It is important to emphasize that while the healthcare organizations, national associations and key policy-makers have a significant role to play in addressing the issue, the professions and the individual providers

Accreditation Leading Practice at Capital Health, Alberta

The Creating Respectful Workplaces Program has been developed to provide information and strategies to help the region interact positively with colleagues, clients, and the public. Six modules have been developed that cover guiding principles and expectations of respectful behaviour; workplace communication; dealing with disrespectful behaviour, abuse, and harassment; strategies for reducing interpersonal conflict; respect for patients and clients; and respecting cultural diversity in the workplace. This strategy enables the organization to educate and "walk the talk" with respect to creating a culture of patient safety and a quality workplace.

have key roles to play as well. Collectively and individually, all professions and providers are accountable. The respective responsibilities attributable to each group must be assumed in a integrated manner to successfully address this important issue. With the integrated and timely implementation of initiatives, an increasingly healthy healthcare work environment will result in improved quality of work life. The positive measurable impacts of the successes will benefit our patients and clients, providers and the healthcare system as a whole.

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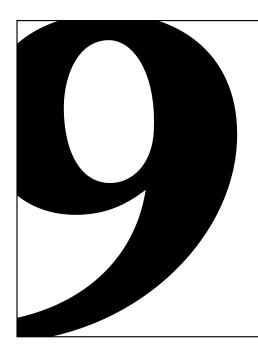
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Time to Move from Paper to Practice



COMMENTARY

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ABSTRACT

The paper by Shamian and El-Jardali provides a timely and important overview of research on healthy work environments and its translation into policy and practice. Although the research is abundant, progress is slow, with most of the efforts focused on nursing. The paper unfortunately does not give justice to key research and policy documents generated by the national nursing and physician sector studies. The elements of healthy work environments common to these two studies speak to the need to approach healthy work environments in a multi-professional manner. They also speak to the need for work environments to address career life cycles in order to foster effective recruitment and retention of health providers. While the authors are subtle in their suggestion of this, this commentary is more explicit in proposing such action. The need to create healthy work environments is urgent, as providers, patients and the system suffer with continued inertia.

THE PAPER BY Shamian and El-Jardali illustrates that, despite an abundance of evidence on the impact of healthy work environments, the health system has been slow to uptake and apply such knowledge. The authors begin by acknowledging that it has taken 20 years to bring this large body of knowledge into the health policy arena. In their article, they present a range of federal, provincial, territorial and regional reports that include recommendations for creating healthy working conditions for health workers, albeit limited to nurses. Their review of the literature reveals that progress of these policy directions across various sectors and levels of the health system has been fractional and slow, with little sign of relief for health workers. Acceleration and expansion of current action on healthy work environments are needed to bring about meaningful change.

The research on healthy workplaces illustrates the relationship between workplace environments and three outcomes: provider, patient and system. This is consistent with the Health System and Health Human Resources Conceptual Model by O'Brien-Pallas, Tomblin Murphy, Birch and Baumann (Advisory Committee on Health Delivery and Human Resources 2005) in the Framework for Collaborative Pan-Canadian Health Human Resources Planning released by governments in 2005. While Shamian and El-Jardali comment to varying degrees on outcomes, they fail to acknowledge the results of relevant research undertaken through the national Nursing Sector Study and its counterpart in the physician community, Task Force Two: A Physician Human Resource Strategy for Canada. Both of these sector studies provide evidence on the impact of work environments on the health of nurses and physicians. For physicians, "heavy workload is a factor in fatigue, burnout and low morale" (Canadian Labour

and Business Centre and Canadian Policy Research Networks 2005: 6). Similarly for nurses, "work environments affected nurses' physical and mental health" (O'Brien-Pallas et al. 2005: 32).

Based on extensive research, the final reports of both of these studies show that creating and sustaining healthy work environments are critical to attracting and retaining health providers, which, in turn, affect the performance and responsiveness of the health system. Elements of healthy work environments common to both studies include the need for continuing education, flexibility in scheduling, manageable workloads, effective teamwork and communication, autonomy and appropriate technology. These two studies were landmark studies that contributed greatly to both research and policy, providing the empirical evidence for what had been suspected for many years.

Shamian and El-Jardali note two important national initiatives in the area of provider outcomes. The Canadian Medical Association (CMA) has created the CMA Centre for Physician Health and Well-Being, which has four priorities: health promotion and disease prevention, awareness and education, research and data collection, and advocacy and leadership. In the spring of 2007, the CMA centre will conduct the first comprehensive national survey of physician health, in partnership with the Canadian Physician Health Network and with support from Health Canada.

The second initiative is the National Survey of the Work and Health of Nurses, which is a partnership of Health Canada, Statistics Canada, the Canadian Institute for Health Information and the nursing community, including the Canadian Nurses Association (CNA). Initial results will be released December 11, 2006, by Statistics Canada and will offer concrete direction

with regard to creating healthy work environments that promote positive nursing outcomes. The survey will also measure the effect of various healthy workplace policies and initiatives implemented over the past few years on the health of nurses.

From the National Survey on the Work and Health of Nurses

The proportion of nurses reporting a high level of work stress was higher than for employed people in general. Nearly **one in three** female nurses were classified as having high job strain, compared to one in four employed women overall.

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

The CMA, CNA and others have repeatedly advocated for a pan-Canadian inter-professional approach to human resources planning, including recruiting and retaining health providers. At a recent meeting, CMA and CNA executives acknowledged their collaborative work over the years, which provides a basis for the pursuit of a coordinated, inter-professional approach to healthy work environments. This includes the development of frameworks to examine the impacts on other health professions of policies or strategies aimed at one profession. Similarly, the coordinated framework development will need to identify how best to measure the outcomes for patients and the system of policies that direct the establishment of teams of health professionals. Findings from the two national sector studies offer common elements and directions forward.

Perhaps in the future, research such as surveys on the health of health provid-

ers should be multidisciplinary in nature, offering comparable findings across professions and offering effective policies for all. Shamian and El-Jardali, in the section on next steps, do not take the opportunity to suggest a multidisciplinary approach to healthy workplace research, policy and practice. Instead, they offer more subtle suggestions of translating innovations related to one profession to another. While this is valuable in terms of sharing lessons learned, a more aggressive, concerted approach is needed to create and sustain healthy work environments. As we move to an interprofessional or teamwork approach to providing healthcare across the country, it is only fitting that we take a similar approach to the environments in which those teams practise. Each day in which health professionals are subjected to unsafe, unhealthy and even intolerable working conditions, providers, patients and the health system are at risk. One promising initiative in this area is the Quality Worklife-Quality Healthcare Collaborative, in which the CNA and CMA and nine other national health partners and some 45 experts have come together in an effort to coordinate, integrate and share learning about improving the quality of work life in healthcare.

The article by Shamian and El-Jardali includes a number of mechanisms by which select governments and organizations have incorporated healthy workplace indicators, including the hospital report on acute care, hospital accountability agreements, accreditation by the Canadian Council on Health Services Accreditation (CCHSA) and others. With the exception of the hospital report on acute care published by the Canadian Institute for Health Information (2005), the performance of healthcare organizations on these indicators is relatively unknown to the public or healthcare work-

ers in general. Many of them are also limited to the hospital sector, with little information on how this is playing out in the community. Empirically and anecdotally, we know that the new generation of health professionals is looking for a better work-life balance than the generations before them. This includes healthy work environments composed of the elements noted above. Health professionals are interested in such information to inform their employment and practice decisions. Employers and recruiters should be prepared to respond to questions from providers regarding the organization's performance on indicators of healthy work environments. This will become increasingly important as critical health professional shortages persist.

Moreover, public reporting of performance of healthcare organizations could serve an important benchmarking function. Benchmarking has been used in other aspects of the health system as a means to promote quality improvement. The hospital report on acute care could serve as a benchmarking tool to allow healthcare organizations to compare themselves with others. Of course, it would need to be expanded to other sectors of the health system such as home care, long-term care and public health to be inclusive of all types of health organizations. It would also be important for health professionals themselves to be involved in the development of the organizations' healthy workplace plan or policy and reporting function. Organizations may indicate that they have a certain policy or program supporting a healthy work environment, but the ability of providers to access that policy or program may limit the effectiveness of the effort.

The article by Shamian and El-Jardali provides evidence of progress on a number of elements of healthy workplace environments, including health and safety programs for health workers, professional development and continuing education and training, mentorship, workload, scheduling and staffing levels. It provides several examples of initiatives focused on retaining older nurses, as well as the creation of full-time employment opportunities for new graduates. These issues lend themselves to a broader discussion of what the CNA and CMA term *career life cycle*. In June 2005, the CNA and CMA jointly released *Toward* a Pan-Canadian Planning Framework for Health Human Resources, A Green Paper. This document sets out 10 core principles and associated strategic directions that should underpin a strategic health human resources planning approach in Canada under the themes of patient-centred care, planning and career life cycle. Within the career life cycle theme, the CMA and CNA identify four principles: competitive human resource policies, healthy workplaces, a balance between personal and professional life and lifelong learning. Each of the principles shares a common platform of the need for a diverse set of strategies that are expandable across the career lifespan of the provider. The needs of health providers often vary according to their career stage. For example, young health professionals are looking for full-time employment, while older pre-retirement health professionals may be looking to reduce hours and the physical demands of the job. Strategies employed by government and employers need to respond to the profile and needs of their particular set of health professionals.

Overall, the paper by Shamian and El-Jardali is to be commended as it captures many of the essential elements of this complex issue. The research is explicit and abundant on the benefits of healthy work environments. Canada seems to be struggling with how to translate the evidence into action. Nurses, doctors and other health professionals faced with inaction in this area are fast reaching a frustration level that poses a threat to the sustainability of the health system unless immediate action is taken. Governments, employers and others need to create and sustain healthy work environments for the well-being of health professionals, patients and the health system. Those environments need to be informed by evidence and healthcare providers themselves, be multi-professional in their design and address the career life cycle. Maintaining the status quo is no longer acceptable. The time for action is now.

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The Challenge of Effective Workplace Change in the Health Sector



COMMENTARY

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ABSTRACT

There is significant personal injury risk associated with the provision of high-quality healthcare. The magnitude of this risk, combined with the possibility that it can often go underappreciated by caregivers and the organizations they work for, might help explain why the health sector has largely missed out on the benefits of an overall declining trend in injury rates. Despite covering two very different topics in their lead papers, Shamian and El-Jardali and Clements, Dault and Priest present a surprising degree of overlap in relation to what might help enable effective workplace change. Leadership, role clarity, trust, respect, values and workplace culture are all viewed as key enablers of effective teamwork by Clements, Dault and Priest. They could also be considered required ingredients of successful workplace health initia-

tives, as discussed by Shamian and El-Jardali. A lot of background and positional work regarding teamwork and healthy workplaces exists, but this has not necessarily translated into front-line change. These authors have done an excellent job of pointing out the potential benefits of workplace changes. What is needed now is for someone to take the lead in developing, implementing and evaluating these changes.

The adult human form is an awkward burden to lift or carry. Weighing up to 200 pounds or more, it has no handles, it is not rigid, and it is susceptible to severe damage if mishandled or dropped. When lying in bed, a patient is placed inconveniently for lifting and the weight and placement of such a load would be tolerated by few industrial workers.

-T.C. Tsolakas, J.P. Davies and S. Oram, "The Nurse's Load" (1965)

THE RATHER DETACHED and industrial tone of the above quote from an editorial in *The* Lancet certainly does not highlight the level of caring and respect for human dignity that forms the foundation for modern healthcare; however, it could be argued that it remains as insightful today as when it was written over 40 years ago. Its message, combined with those in the two companion papers in this journal issue by Shamian and El-Jardali and by Clements, Dault and Priest, demonstrates that we have come a long way over the past few decades in how we view work organization in the healthcare sector, even though we still have a lot to contend with in terms of developing and sustaining "healthy" healthcare workplaces.

Perhaps the greatest relevance of the quote for this journal issue is that it rather creatively highlights an important but often overlooked aspect of health and safety within the health sector – that there are significant personal injury risks associated with the provision of high-quality healthcare. The magnitude of these and other risks, combined with the possibility that they can often go underappreciated by

caregivers and the organizations they work for, might help explain why the health sector injury rates have noticeably lagged behind those in other sectors, where steady declines have been observed throughout most jurisdictions over the past decade (Workplace Safety and Insurance Board 2005). The health sector has largely missed out on the benefits of an overall trend in injury reduction, both in the form of a healthier workforce and reduced workers' compensation insurance premiums.

Given the severe staff shortages already being experienced in most segments of the health sector, and in particular with nursing staff, translating work-related absence into "missing" full-time equivalents makes for an even more dramatic story. In Canada, it has been estimated that more than 16 million nursing hours are lost to injury and illness yearly, roughly the equivalent of almost 9,000 full-time nursing positions lost across the country each year (Canadian Labour and Business Centre 2002). It is reasonable to assume that much of this burden of disability is preventable and, indeed, needs to be prevented if the healthcare system is to

successfully cope with the already-chronic shortage of nurses and other staff.

Although efforts to improve teamwork and to create healthy workplaces may seem only loosely connected at first glance, the two lead papers present a surprising degree of overlap in relation to what might help enable effective workplace change, the ultimate aim in both papers. Leadership, role clarity, trust, respect, values and workplace [safety] culture are all viewed as key enablers of effective teamwork by Clements, Dault and Priest, but they could also be considered required ingredients of successful workplace health initiatives, as discussed in the paper by Shamian and El-Jardali. Thus, there is clear overlap between teamwork and healthy workplace initiatives - common elements that these two approaches share and, thus, can be used to help support initiatives in each area. The notions of workplace support, empowerment, burnout or stress, job satisfaction, participatory approaches to interventions and workload also come to mind as factors relevant to both, underscoring the pervasiveness that quality work environments can have – not just on health, but on productivity and quality of care as well. The information found in these two papers would support contentions drawn elsewhere that organizations that take an active role in enabling staff in the delivery of high-quality care are also leaders in the provision of a healthy workplace. While both papers make a call for better integration at the clinician [worker or caregiver], management and policymaker levels to facilitate change in workplaces, there is also the suggestion that managers and policymakers have been so overwhelmed by the current healthcare context – in particular, the hot button issues of staff shortages, wait times and patient safety – that they have been unable to deal with workplace change.

The paper by Clements, Dault and Priest sums this situation up nicely: "The current shortage of some health professionals creates a pressure-cooker workplace environment where few people have the time, energy or will to experiment...."

To be fair, it is not just the day-today survival in an incredibly complex and demanding healthcare work environment that people must contend with. The myriad of reports and recommendations that have been released in the past few years, especially in relation to healthy workplace initiatives for nurses, must at some level be overwhelming for administrators and policymakers. We live in an age of evidence-based practice in the healthcare sector; yet, as pointed out by Shamian and El-Jardali, despite the sheer volume of these reports, there has been very little high-quality research evidence available upon which to base effective interventions. But the scope of the challenges faced when conducting rigorous workplace intervention research should not be underestimated (Cole et al. 2003).

Clements, Dault and Priest also point to the "hierarchical culture of healthcare" as being one of the key barriers to implementing teamwork interventions. Work in other sectors suggests that this problem should not always be dismissed as "creeping credentialism" or some other "turf" issue. When groups or key individuals do not feel that they have been a legitimate part of the change process in a workplace, the effectiveness of the process can be jeopardized. Evidence accumulating from research in other sectors regarding the effectiveness of different approaches to workplace change suggests that the participatory action model could be potentially useful for interventions related to either teamwork or a healthy workplace. The success of the participatory action model is built upon on the direct involvement, at all

levels in the change process, of those potentially affected by the changes under consideration (Cole et al. 2005a).

From the National Survey on the Work and Health of Nurses

Job dissatisfaction was more prevalent (12%) among nurses than among employees in general (8%) – but only 4% intended to leave the profession.

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

It is important to note that both papers also make a call for integrating researchers, clinicians [workers and caregivers], managers and policy-makers to further the agenda in workplace change. Researchers perhaps need to focus their efforts on addressing some of the key deficiencies present in prior research. For example, developing a set of valid indicators for measuring workplace health would permit the monitoring of workplaces in a prospective manner and thereby provide a stronger basis for evaluating change (Cole et al. 2005b). There are other gaps to be addressed as well, including how healthcare workers from outside the regulated health professions can participate in and benefit from healthy workplace and teamwork activities, and how certain segments of the healthcare sector, such as long-term care and home care, have been relatively neglected in comparison with the rest of the sector. We might also need to start considering the impact of generational differences when devising workplace interventions: Are younger workers, from Generations X and Y, going to be interested in the same things as older workers? Are we going to have to start thinking about the

flexibility of workplaces as never before to ward off the impending shortages that could overwhelm the potential benefits of even the best intervention efforts?

It is worth noting that, for several reasons, nursing could be best situated to take a lead in these activities: nurses typically make up the majority of the healthcare workforce; their demographic profile portends continued high turnover in the near future; they work in a wide variety of settings; and they routinely interface with patients and all other members of the healthcare workforce. These factors, combined with the extent of recent teamwork and healthy workplace activity directed solely or primarily at nursing (such as the new National Survey of the Work and Health of Nurses mentioned in Table 1 of the paper by Shamian and El-Jardali), give them both a head start and a potentially stronger imperative to initiate action. As a potential champion for the health sector, they could lead the way to effective change, as the new slate of Healthy Work Environments Best Practice Guidelines, developed by the Registered Nurses' Association of Ontario (2006), might suggest.

Clearly, a lot of background and positional work regarding teamwork and healthy workplaces exists, but for whatever reason, this has not necessarily translated into frontline changes in workplaces. The authors of these two papers have done an excellent job of pointing out the potential benefits of workplace changes. What needs to be done now is for someone to take the lead in developing, implementing and evaluating these changes.

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Mapping Out the Territory



COMMENTARY

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ABSTRACT

This commentary is a response to the paper "Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice," in which Shamian and El-Jardali describe completed research and policy directions to improve work-life practices and create healthy workplaces in the environments where health workers are employed. Two issues that are raised in the discussion are focused on, the first one being health of the workforce and the second concerning workload measurement and work overload. Evidence from two recently completed studies is provided to demonstrate the importance of monitoring the health of caregivers and the need for development of new workload measurement systems. Such progress requires large-scale studies to help us understand the correlates of staff satisfaction, staffing outcomes and workplace demands. Most importantly, evaluation of policy intervention in Canada has been limited; therefore, once fiscal and human resources are directed to policy initiatives, these actions need to be formally evaluated.

In recent years, issues relating to healthy workplaces have become a priority on the agenda of decision makers in government and employment institutions. In "Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice," Shamian and El-Jardali astutely identify the major theme areas of research completed in Canada. The authors provide an account of how major reports have built on the research and led to policy directions to improve work-life practices and work environments for health workers. They have outlined the federal, provincial and territorial practices, policy uptake and implementation of strategies across the different levels of policy-makers. However, Canada-wide evaluation of policy intervention has been limited, and the authors are correct in indicating that once fiscal and human resources are directed to policy initiatives, these need to be formally evaluated. The paper by Shamian and El-Jardali highlights the advantage of engaging all the players (researchers; senior and junior government policy-makers from federal, provincial and territorial bodies; managers of health systems; front-line caregivers and unions) at the policy table. Involving the key players in the research review and the development of policy strategies is a necessary process to ensure successful action because the resulting policies will have been given the formal "sniff test" through representation of all the players in the health system. The Canadian Health Services Research Foundation (CHSRF) has fostered this approach for several years now, and Shamian and El-Jardali have demonstrated its utility in their paper.

The establishment of an Office of Nursing Policy within the federal government under Dr. Shamian's leadership was a necessary catalyst to directly inform senior decision makers, generate an understanding of the role of the federal government, spark enthusiasm for the health workforce issues and build a network to support funding for the Canadian Nurses Advisory Committee and other initiatives over time. The vision of the CHSRF added to the success of this committee.

In this commentary, I want to build upon the themes articulated by Shamian and El-Jardali by speaking to two important issues raised. The first issue is health of the workforce, and the second concerns workload measurement and work overload. While the examples I use are based on research with samples from the nursing population, the findings undoubtedly apply to other disciplines, given that similar issues exist.

In addition to the studies cited in Shamian and El-Jardali's paper and a special survey on the health of nurses that Statistics Canada released in mid-December (Statistics Canada 2006), two other recent unpublished studies also address the health of nurses using the SF-12 (Ware et al. 2002). In the first study of cardiac and cardiovascular nurses in five Ontario and one New Brunswick hospital, 35% of the nurses fell below the SF-12 US norm for females for physical health and 49% fell below the same norm for mental health. The predictors of poor physical and mental health relative to the workplace differed. The likelihood of being physically healthy increased by 58% when nurses were satisfied with their job and decreased by 28% for every 10% increase in registered nurse worked hours, probably because the increase in worked hours represented increased overtime rather than additional staff allocated to the unit. The likelihood of being mentally healthy increased by 74% when nurses were satisfied with their current job and decreased by 79% when nurses were at risk of emotional

exhaustion. About one-third of the nurses in the study sample reported emotional burnout (O'Brien-Pallas et al. 2004).

From the National Survey on the Work and Health of Nurses

31% said patients in their care had been injured in a fall.

Nearly **one in five** (18%) reported occasional or frequent medication errors among patients in their care.

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

The second national study, which surveyed all three nursing occupational groups, was part of the research arm to inform the National Nursing Sector Study (O'Brien-Pallas et al. 2005). In this study, work environments were associated with nurses' physical and mental health. Nurses were less likely to be physically or mentally healthy when they worked involuntary overtime or preferred to reduce their work hours (from full time to part time or casual). Nurses were also less likely to be in good physical and mental health when there was violence at the workplace. Nurses who worked in direct care or anticipated job instability were less likely to be physically healthy than those in non-direct care or in stable working environments. Dimensions of practice and anticipation of job instability, however, had no effects on nurses' mental health. In contrast, frequent shift changes affected their mental, but not physical, health. Nurses who changed work shifts more than twice within two weeks were less healthy mentally than those who changed only once or did not change at all. The importance of rest breaks was supported in

that nurses who were able to take coffee and meal breaks reported better mental health than did nurses who missed breaks during their shifts (O'Brien-Pallas et al. 2005). The findings of both of these studies suggest that the predictors of physical and mental health or non-health encompass issues of workload and staffing and the work environment.

Secondly, I wish to speak to concerns about workload measurement and work overload. At national and provincial policy tables, there is continued debate about the inclusion of nursing workload in reporting and data-collection systems as recommended by the Canadian Nursing Advisory Committee report (2002). Some who question the validity of workload-measurement systems have suggested a return to nursing hours per patient-day or nurse-patient ratios as the measure of choice. Others propose that, although the old workload systems are no longer adequate, nursing hours per patient-day is an inappropriate measure of nursing resources because each patient is assumed to have standard requirements for nursing care despite significant research evidence (and clinician experience) to the contrary. Instead, the priority should be the development of next-generation workloadmeasurement systems that can be used in all settings by different care providers and that address (1) patient medical severity and complexity from a nursing perspective, (2) the characteristics of nurses, the work environment and the organization and (3) how these relate to outcomes for patients, nurses and the system. Currently, the inclusion of workload measurement as part of the new work environment standards developed by the Canadian Council of Health Care Accreditation remains unclear.

In the study of cardiac and cardiovascular nurses, patient, nurse and system outcomes declined as nursing units became understaffed. Nurse staffing level was measured at the unit level as patient workload divided by nurse worked hours. Although this formula is the traditional definition of productivity for the Canadian Institute

be achieved by moderating productivity or utilization levels within a range of 85%, plus or minus 5% (O'Brien-Pallas et al. 2004). As we develop the next-generation workload systems, these types of parameters can

Table 1. Utilization and outcomes

Productivity or Utilization Level (%)	Outcomes
>91	Longer length of stay
>90	Higher costs per resource intensity weight
>88	Less improvement in patient health behaviour scores at discharge
>85	Higher nurse autonomy
	Deteriorated nurse relationships with physicians
>83	Higher intention to leave among nurses
>80	More nurse absenteeism
	Less improvement in patient physical health scores at discharge
	Less nurse job satisfaction

Adapted from O'Brien-Pallas et al. 2004.

of Health Information (CIHI), it is more accurately termed a measure of utilization. The utilization level is an index of how well a unit is staffed relative to patients' care needs. Consistent with the Management Information System (MIS) guidelines (CIHI 1999), the maximum work capacity (i.e., utilization) of any employee is 93% because 7% is allocated to paid breaks during which time no work is contractually expected. At 93%, nurses are working flat out with no flexibility to meet unanticipated demands or rapidly changing patient acuity. Specific utilization cut points were determined based on patient workload and nurse worked hours (Table 1; O'Brien-Pallas et al. 2004). This study demonstrated that significant benefits, both fiscal and human, can

be validated across a variety of settings and could serve as the mathematical estimates to be used when evaluating the workload.

Essentially, this study found that sustained utilization levels above 80% result in higher costs, poorer quality of care and deteriorated staff outcomes. Depending on performance goals, organizations may wish to target a specific unit utilization level shown in Table 1. These values

are cumulative in nature, such that, if a unit works at a 92% utilization level, not only will lengths of stay be longer, all the other negative outcomes that occur with utilization values below 92% will apply (O'Brien-Pallas et al. 2004).

Considering the iterative and unpredictable nature of the policy cycle and the influence and uptake of research, we need to realize that nothing stays forever on the radars and agendas of busy decision makers. We need to share our practical and empirical successes and to identify the areas in need of improvement to guide each dollar that policy-makers spend on managing the health workforce. We also need continued research to understand and improve the workplace, especially

well-designed and controlled intervention studies. Development and testing of new workload-measurement systems and also validation of other appropriate measures, if that is the desired future, should be undertaken. Ongoing monitoring of the health of nurses and other healthcare workers is necessary because research to date suggests that the health of nurses suffers as a result of workload, staffing and workplace issues. Large-scale studies will continue to help us understand the correlates of staff satisfaction, and positive outcomes from staffing, workload and workplace demands. Given our rapidly aging workforce, we need to understand and address generational differences in perceived and actual physical and mental health to ensure that we retain our health workforce in healthy and productive work environments.

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Deepening the Impact of Initiatives to Promote Teamwork and Workplace Health: A Perspective from the NEKTA Study



COMMENTARY

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ABSTRACT

Evaluations of major policy initiatives on workplace health and teamwork have found significant progress on some issues and inertia on others. This article explores the applicability of a model describing employees' psychological relationships with work as a framework for considering workplace health initiatives. The Mediation Model contributes a way of focusing on experiences that are integral to staff nurses' day-to-day work life. As such, the model provides direction for developing and evaluating strategies for enhancing the quality of work life, especially pertaining to workplace health. The commentary considers a few key findings from the Nursing Environments: Knowledge to Action (NETKA) study that reviewed the applicability of national policy documents on the healthcare systems of Atlantic Canada. The discussion considers implications of staff nurses' participation in sharing and using new knowledge about workplace health.

THE ARTICLES BY Shamian and El-Jardali and by Clements, Dault and Priest in this issue provide valuable, thorough and insightful overviews of the issues at the forefront of defining the quality of work life in Canadian healthcare systems. They consider the current state of healthy workplace initiatives in Canadian healthcare systems, and a mechanism – teamwork – that can play a defining role in further progress. They present evidence of widespread concern about workplace health from the perspectives of providers, managers, professional organizations and government policymakers. The authors acknowledge a wealth of information - research based and anecdotal – elucidating the dynamics underlying unhealthy workplaces, the impact on providers' well-being and the ultimate consequences for service recipients. And they identify ways of addressing the challenges, including teamwork, as a method of ensuring the best service delivery while sharing the demands of care among members of diverse professional groups.

The articles note areas of progress, critique shortcomings in approaches and suggest directions for further development. Regarding healthy workplace initiatives, the authors note that there are few indications that healthcare workers, particularly at the front line, are experiencing better working conditions. This perspective is consistent with the findings of the Nursing Environments: Knowledge to Action (NETKA) survey (Leiter 2006), in which nurses gave more positive progress ratings on issues distant from their work (information systems, leadership and scope of practice) than on more immediate issues (workload, hours of work and workplace health). An optimistic perspective is that the impacts of broader policy developments are trickling down to staff nurses and will eventually be

evident in their relationships with work. An alternative explanation is that change is stopping at the level of broad policy. The system lacks the capacity (understanding, resources or know-how) to translate policy into the mechanics of job descriptions, staffing plans or accountability frameworks.

This commentary considers the second, gloomier perspective. It proposes that more robust theoretical frameworks guiding initiatives in healthy workplaces and teamwork would support more vigorous progress. Although descriptive research is a necessary and appropriate phase along the way to comprehending a complex challenge, the contribution of that research format diminishes over time. Research guided by theoretical constructs about people, organizations and their interaction makes a more enduring contribution.

Lasting progress on a widespread basis requires a deep rationale for action. Canada and other post-industrialized nations deliver healthcare through large, diverse, geographically dispersed systems. Despite centralization of pivotal issues of policy and funding, local healthcare facilities exercise considerable latitude in managing a workforce with varying degrees of autonomy in their dayto-day practice. They also vary greatly in their capacity to translate policy into action. Settings vary in the priority they assign to specific policy initiatives. They vary in the resources, talent and thoroughness they can devote to an initiative, even when they agree upon its importance.

In this context, initiatives that fit readily with the way people work have a greater potential for success. The system does not have the means to impose awkward practices or procedures. Instead, enduring change requires harnessing positive momentum inherent in positive psychological relationships with work.

A good fit of people with their work environment has been a guiding principle in the Mediation Model (Maslach and Leiter 1997), also known as the Areas of Worklife Model. The model proposes that a congruence of a workplace with employees' aspirations and expectations promotes work engagement; a poor match aggravates burnout. Second, *flexibility* on the part of individuals and their organizations makes congruence more likely by permitting a wider range of possible ways in which people can connect with their work environments. The third principle is *responsiveness*. Congruence is more likely when individuals and organizations have access to the information and resources necessary to react to challenges and opportunities that are integral to the complex environments of healthcare institutions. The model identifies six areas of work life, outlined below, that are relevant to the thoughts and feelings that people have about their work. A basic proposal from the model is that initiatives that enhance the potential for congruence in these key areas of work life have a greater potential for enduring success.

NEKTA Survey

This conceptual framework guided the NEKTA study (Leiter 2006), which examined the impact of major healthcare policy documents on Atlantic Canada healthcare systems. This project differed from parallel projects by its emphasis on knowledge transfer and use among staff nurses as distinct from these activities among decision makers and policy-makers.

One finding was that staff nurses were familiar with the core issues addressed in these reports and recognized the importance of these issues in their work life. But they were not familiar with the reports, their proposed solutions, their recommendations for change or activities arising from these recommendations. As one participant said, "We weren't in a position to receive those; we are staff nurses. I'm not clear on who would be responsible for circulating them to us. I don't know if others in the organization are reading them. I don't know anyone that does. I would assume that some are, depending on their positions."

The problem evident in this pattern is that respondents who were familiar with the reports had a more positive perception of progress. They did not simply know that there were problematic issues; they knew that there were proposed solutions. Knowing that someone at their facility was working on implementing solutions brightened their perception even more.

A second relevant finding was that active participation in sharing and using knowledge on improving workplace health was associated with greater professional efficacy. One potential element of this relationship is that research knowledge on professional issues is high-status information. Being up to date on these issues conveyed a deeper sense of belonging to the profession. It also provided nurses with knowledge that helped them to be more effective in their work. This is a powerful finding as changing perceptions of self-efficacy in any domain of life requires convincing evidence.

A fundamental question arising from these findings is whether successful change in healthcare workplaces requires the active participation of staff nurses. Although there are commendable efforts to bring information to their attention, systems are proceeding as if staff nurses' active participation in the process would be a good thing but not necessarily an essential thing. With good leadership and solid organizational policy, institutions can implement new procedures, structures and policies that are so sufficiently

compelling that all will be drawn along in their wake to a healthier, more fulfilling workplace. There are signs that this approach encounters serious limits in practice.

Healthy Workplace Initiatives

A pattern evident in the lead paper by Shamian and El-Jardali is that successful interventions occur at a broad system level. There are more seats in nursing programs and more participation in continuing education. Accreditation and accountability procedures attend more closely to issues of quality of work life. Quality of work life is more thoroughly considered in strategic plans of healthcare organizations. These important developments are within the domain of healthcare systems, a few steps removed from the day-to-day challenges of nurses.

From the National Survey on the Work and Health of Nurses

More than **one in four** (27%) said the quality of care delivered in their workplace had deteriorated in the previous 12 months, compared to 16% reporting improvements.

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

Closer, but still a step or two away, are initiatives to improve the general parameters of healthcare jobs: flexible staffing, phased retirement and an increased proportion of full-time permanent positions. The initiatives that are closest to point-of-care nurses' work life define an 80-20 balance between direct care and professional development in staff nurses' job structures. These initiatives go directly to day-to-day work life, having a direct impact on each of the six areas of

work life in the model: workload, control, reward, community, fairness and values.

Workload

The 80-20 balance provides nurses with opportunities to shape the pace, content and variety of their job demands. Responding to patients' needs is demanding from a quantitative perspective (the amount of work to be done), a pacing perspective (when, how promptly and for what duration) and a qualitative perspective (the complexity or difficulty of response). Many aspects of professional development activities are more within the nurses' discretion. An 80-20 initiative allows for more successful resolutions on workload.

Control

Participation in professional development activities provides opportunities for nurses to make decisions about their approach to these activities. By developing new skills, abilities and perspectives through professional development, nurses also enhance the control they can exercise over treatment provision.

Reward

Increased professional development activity produces more opportunities to engage in enjoyable work and receive recognition from others. In the long run, it could enhance nurses' potential for career advancement, providing rewards from position and remuneration.

Community

Changes in the fundamental structure of work affect nurses' relationships with others at work. These activities generally enhance networks among nurses and of nurses with members of other healthcare professions who are concerned with professional issues. Learning, developing and implementing

new ideas usually involves teamwork that enriches nurses' social context at work.

Fairness

Increased opportunities for professional development convey a strong vote of confidence from the employer. It is an investment in nurses' long-term potential, conveying recognition that they have the talent and dedication to support a more substantial contribution to the mission of their hospital or clinic. The respect experienced by nurses in this position is in sharp contrast to the sense of injustice communicated by many Canadian nurses in surveys.

Values

The 80-20 balance provides a means for nurses to deepen their dedication to professional values. With the active support of their employer through job redesign, the initiative emphasizes congruence between organizational and personal values. This meeting of the minds on core values is fundamental to nurses developing work engagement rather than gravitating toward burnout.

Anecdotal reports of 80-20 initiatives suggest that they are associated with reduced sick leave for the participants, permitting at least a partial recovery of the costs of providing coverage for the 20% reduction in direct patient care activities. This experience is in sharp contrast to the situation reported by nurses experiencing burnout.

This example is not meant to indicate that an 80-20 job design is a panacea. It may be feasible, desirable or appropriate only in certain circumstances, which research is still in the process of identifying. The point of the example is that it demonstrates the relevance of a specific model of work life. This sort of analysis suggests that the initiative's benefits make sense within a perspective on employees' psychological relationships with

their work. The 80-20 structure appeals to the thoughts and feelings that nurses have about themselves, their service recipients, their employers and healthcare in general. It demonstrates ways in which the initiative can enhance their perspectives on aspects of work life that are closely tied to their basic energy level, potential for meaningful involvement and sense of professional efficacy. These are the core dimensions on which job burnout differs from work engagement.

Conclusions

The central point of this commentary is a reiteration of the idea that there is "nothing more practical than a good theory" (Lewin 1951: 169). The discussion applies a framework developed to explain the organizational context of psychological relationships with work that range from burnout to work engagement. It proposes that theoretical frameworks are useful. They have the potential to bring policy changes closer to the work of point-of-care healthcare providers and to sustain the hard-won gains of those leading improvements in teamwork and workplace health. The model is not the only relevant theory, and it may not provide an exhaustive framework for every situation. But its conceptual framework and translation into a short questionnaire, the Areas of Worklife Survey (Leiter and Maslach 2004, 2006), argue for its use to evaluate workplace initiatives. It is a framework on which to build additional constructs, such as personal knowledge transfer involvement (Leiter 2006; Leiter et al. in press) and empowerment (Laschinger and Wong 2006).

Regardless of the framework, policy initiatives benefit from good theory. They deepen one's appreciation of organizations as environments that shape behaviour and respond to actions and feelings of their members. The understanding derived from these concepts will help researchers, decision makers and policy-makers develop initiatives with lasting, positive impact on the work lives of healthcare providers.

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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-

This article is based on a component of the author's PhD dissertation work.

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 employ-

ment. 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 fulltime 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 dayto-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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Healthy Workplaces and Effective Teamwork: Viewed through the Lens of Primary Healthcare Renewal



COMMENTARY

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ABSTRACT

This commentary reviews the content of the lead papers through the lens of primary healthcare renewal (PHCR). Although PHCR has been on the national agenda for decades, only since the turn of the century has real progress been made with emerging new practice models based on inter-professional team care. While much is expected, relatively little is known of the function and effectiveness of such teams in Canada. As well, information regarding healthy workplaces has focused on individual professional groups rather than an inter-professional workforce. Much of the knowledge currently available regarding team effectiveness and healthy workplaces comes from the hospital sector and may not be completely transferable. The work of the Interprofessional Education for Collaborative Patient-Centred Practice initiative and the results of the Health Transition Fund and Primary Health Care

Transition Fund are additional key sources of research and knowledge transfer to guide the education, function and evaluation of inter-professional teamwork in these new primary healthcare practice models.

Thank you for the opportunity to review and comment on the lead article by Shamian and El-Jardali, which focuses directly on the issues pertaining to healthy workplaces, and the companion article by Clements, Dault and Priest, which views healthy workplaces through the lens of effective teamwork. As nurse practitioner and family physician partners, we have worked together since 1988 as clinicians in a community health centre, as researchers and facilitators for Health Transition Fund (HTF) and Primary Health Care Transition Fund (PHCTF) projects and as co-authors on collaborative practice in primary healthcare (PHC) settings (Bailey et al. 2006; Way and Jones 1994; Way et al. 2000). Therefore, it will come as no surprise that we have viewed both articles through the lens of primary healthcare renewal (PHCR).

The Call for PHCR

The last decade of the 20th century in Canada, as in other industrialized countries, witnessed an overwhelming focus on healthcare reform. Most countries undertook significant changes in both the organization of PHC and the hospital sector. However, although making significant changes in hospital care through consolidation and restructuring, Canada made little progress in PHCR in the 1990s (Decter 2004; Hughes Tuohy 2004; Hutchison 2004).

In comparison, the first six years of this century have seen marked progress. Innovations are under way in all jurisdictions with the introduction of new practice models (Canadian Institute for Health Information 2003; Wilson et al. 2004).

Action has resulted from the realizations that (1) the gains of the 1990s with hospital sector restructuring would be lost without a more robust and comprehensive package of PHC services, (2) there are increasing needs of Canadians for assistance with chronic illness and disease prevention requiring PHC services and (3) there is a growing concern regarding inadequate health human resources, especially of physicians and nurses (Decter 2004; Maiona 2004).

The Importance of Inter-professional Teamwork to PHCR

Care delivery through inter-professional teams has been recognized consistently as a key component of PHCR (Canadian Nurses Association 2002; College of Family Physicians of Canada 2000; Standing Senate Committee on Social Affairs, Science and Technology 2002b). Health policy reports from Hastings and LaLonde through to Fyke, Clair, Mazankowski, Kirby and Romanow have called for the implementation of teams (Commission on the Future of Health Care in Canada [Romanow Report 2002; Saskatchewan Commission on Medicare [Fyke Commission] 2001; Hastings 1970; Health Canada 2003, 2004a; LaLonde 1975; Premier's Advisory Council on Health 2001; Standing Senate Committee on Social Affairs, Science and Technology [Kirby Report] 2002a; Study Commission on Medicare [Clair Commission 2000). There is now substantial commitment on the part of federal, provincial and territorial governments to move toward inter-professional team care. It is postulated that collaborating teams will

accomplish the following:

- 1. Be better able to deal with the increasing complexity of care
- 2. Increase focus on health promotion and disease prevention
- 3. Coordinate and meet the needs of the population being served
- 4. Keep abreast of new developments (including technological advances and best practices)
- 5. Better integrate care with community and institutional services
- 6. Make the best use of health human resources

While much is expected of this transition to teamwork, current health providers have little experience in working in PHC teams. Community health centres especially in Ontario and Centre Locale Service Communautaire in Quebec have been in existence since the 1970s. However, solo or small-group physician practices are the models that predominate in primary care delivery.

Traditionally, health providers have been prepared for their roles in "educational silos." The need to now prepare providers at both the pre-licensure and post-licensure levels for teamwork is recognized and politically supported. In the 2002 report Building on Values: The Future of Health Care in Canada, Roy Romanow recommended a review of "current education and training programs for health care providers to focus more on integrated provider education approaches for preparing health care teams" (Commission on the Future of Health Care in Canada 2002). The 2003 Health Accord resulted in the formation of Health Canada's Pan-Canadian Health Human Resource Strategy (Health Canada 2003). One of the three key initiatives under this

strategy is the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) initiative (Health Canada 2006b).

Clements, Dault and Priest refer to the great strides made by the IECPCP. To date, this initiative has accomplished the following:

- 1. Established a National Expert Committee to guide its work
- 2. Commissioned a major literature review and environmental scan (Health Canada 2004b), with a resulting IECPCP model (D'Amour and Oandasan 2005)
- 3. Commissioned a series of nine research papers to fill gaps identified in the literature review
- 4. Funded 20 inter-professional learning projects across Canada
- 5. Supported the development of the Canadian Interprofessional Health Coalition
- 6. Commissioned complementary projects to help address major barriers to the transition to inter-professional care

These complementary projects include addressing accreditation, legislation and regulation and liability issues. Eight of the 20 learning projects involve PHC settings (Health Canada 2006b).

Team Effectiveness in PHC Delivery

While the transition to team care has been embedded into PHCR initiatives, relatively little is known of the function and effectiveness of such teams. In their systematic review for the IECPCP of the existing valid international empirical research, Zwarenstein et al. (2005) determined that the majority of rigorously evaluated studies occurred in the in-patient hospital setting and that "the impact of teams in primary

care is essentially untested."

The Canadian Health Services Research Foundation (CHSRF) teamwork synthesis paper, reviewed by Clements, Dault and Priest, refers to important differences between team function across healthcare settings that may not allow for the direct transfer of knowledge from the hospital to the PHC sector. Systemic comparisons of healthcare teams across settings have yet to be done. It is also unclear whether instruments used to measure team structures and processes in one setting will be valid and reliable in another. To illustrate, qualitative interviews conducted for the synthesis paper identified differences in the "boundedness" of teams. A "bounded" team, descriptive of the hospital sector, is often co-located, is supported by resources and management or administrative hierarchies and views itself as a social entity. Providers working in the new PHC practice models as core members may form a bounded team. However, they will also collaborate in "virtual" teams that are fluid in order to respond to patient needs and the availability of health resources. Traditionally, primary care practices have required few structures (policies and procedures) or resources to support team function (Oandasan et al. 2006).

As we discussed in our working paper written for the CHSRF teamwork synthesis paper, the Canadian research literature regarding the effectiveness of PHC teamwork is particularly limited. The synthesis results of pilot projects associated with the HTF and the anticipated results of the PHCTF projects are the principal resources.

The HTF was created to encourage and support evidence-based decision making in healthcare reform as a joint federal, provincial and territorial effort. The HTF synthesis paper on PHC summarizes the key learning from 65 projects. The section on collabora-

tive practice refers specifically to four studies that focused on team building, education and training (Mable and Marriott 2002).

The PHCTF supported transitional costs of implementing large-scale PHCR initiatives to bring about fundamental and sustainable change in PHC organization and delivery. The vast majority of national, multi-jurisdictional and provincial or territorial projects include collaborative practice objectives and activities with the potential for greatly increasing our understanding of the effectiveness of teamwork. The final project reports were received at the end of September 2006. Efforts now focus on synthesis and dissemination. Synthesis products will include summaries and fact sheets for each initiative; a series of analytical reports, one of which will report on collaborative care; and a national conference in February 2007 (Health Canada 2006c). Knowledge transfer from the PHCTF projects to assist the development and evaluation of inter-professional teamwork in the emerging PHC practice models is essential.

Healthy Workplaces and PCHR

Clements, Dault and Priest identify the link between teamwork and a healthier and happier workforce. As Shamian and El-Jardali point out, the healthy workplace agenda has been embedded in the Health Human Resource Strategy as part of recruitment and retention initiatives (Health Canada 2006a). However, it is unclear that healthy workplace strategies have been embedded into PHCR.

Shamian and El-Jardali indicate that robust evidence has been accumulated on the impact of healthy workplaces on workers' health and well-being, quality of care and patient safety, organizational performance and societal outcomes. With their suggestions regarding next steps for

research, the authors point out that much of what is known regarding healthy workplaces comes from nursing. Yet, the research for nursing is incomplete, lacking information not only regarding long-term care, public health and home care but also primary care settings. Research has focused on individual professions and not on the inter-professional workforce as an entity. As with teamwork effectiveness, the direct transference of knowledge and impact measures to other health professionals and teams and from the hospital to the PHC sector may not be fully appropriate.

From the National Survey on the Work and Health of Nurses

Nurses were much more likely to work overtime than employees overall. **Three in ten** nurses said they regularly worked paid overtime, while an even greater number of nurses (1 in 2) said they regularly worked unpaid overtime – about twice the national average for female employees.

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

Summary and Conclusion

Our review and comments are based on viewing team effectiveness and health workplaces through the lens of PHCR. Although much of the findings can be extrapolated to community and primary care settings, there is a clear need for increased understanding of PHC practices regarding teamwork and workplace issues. The emerging practice models across Canada especially need to include processes and measures that ensure team effectiveness is understood, encour-

aged, measured and rewarded and that PHC practices are "healthy workplaces."

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Teamwork and Healthy Workplaces: Strengthening the Links for Deliberation and Action through Research and Policy



COMMENTARY

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ABSTRACT

The two lead articles for this issue by Shamian and El-Jardali and by Clements, Dault and Priest provide an opportunity to consider how two agendas – teamwork in healthcare and the healthy workplace – can be strengthened to gain mutual advancement. Both agendas are in the pan-Canadian Health Human Resource (HHR) strategic plan in Canada and were also identified within the Health Council of Canada's 2005 Annual Report. Strong links have yet to be made related to the teamwork in healthcare agenda and its relationship with the workplace environment. Significant research has been conducted, and advocates are pushing for policy change. It is recommended that those engaged in the research in these two domains dialogue with each other and collectively consider ways in which they could advance the policy directions required to enhance both patient and provider satisfaction in our healthcare system. The teamwork and healthy workplace agendas require thoughtful deliberation between researchers and policy-makers to inform action.

This commentary provides an example of how the Ontario government has been able to engage within an evidence-informed process to develop inter-professional care that may ultimately positively impact the teamwork in healthcare agenda and the healthy workplace agenda in the future.

In this era of healthcare renewal, collaborative healthcare delivery and teamwork are top of mind for many Canadians and policy decision makers. Research has shown that in certain healthcare settings, healthcare professionals who practise in "teams" in their workplace results in improved provider and patient care outcomes (Canadian Health Services Research Foundation [CHSRF] 2006). Yet, we have not seen teamwork practised in all healthcare settings, nor is it a priority at the system, practice or institutional levels in providing the tools and resources for healthcare professionals to provide collaborative healthcare delivery.

Engaging in teamwork requires that health professionals possess the competencies and skills to practise as collaborators within healthcare teams through education, whether at the pre-licensure, post-licensure or continuing education level. Further, most health professionals need to understand the complexity to engage in teamwork and to know when to collaborate, with whom, how and why. This can be challenging for healthcare professionals who practise in different healthcare settings to define their teams or engage in teamwork.

Romanow noted, "If health care professionals are expected to work in teams ... their education must prepare them to do so or else they will continue to work in status quo health care environments" (Commission on the Future of Health Care in Canada 2002). The challenge is how to translate the education of teamwork to healthcare professionals in the health workplace setting through research and policy.

In the past three years, initiatives have been under way across the country to facilitate teamwork in healthcare environments. Specifically, the implementation of teamwork or inter-professional care is one strategy considered for effective health human resources planning in making the healthcare system more sustainable and cost effective. Progress has been made, but at a gradual pace. It is well known that current professional practices foster a system of separate silos of professional practice and impose major constraints on the development of team-based care. At the government level, legislative and regulatory reforms need to keep up with changes and trends in the practice environment. At the organizational level, the focus has been on the perceived lack of responsiveness and willingness of healthcare groups to change or work together. This, despite the fact that professional groups acknowledge the urgent need for health system renewal and are willing to co-operate. Within institutions, support and funding for inter-professional care is fairly minimal due to the inherent incremental operating and administrative costs involved. At the individual level, there is a need to change prevailing mindsets on how healthcare professions can work together, given the entrenched attitudes and views of health professions' respective roles. The resistance to change must be overcome in order to create a sustainable healthcare workforce.

Building a stable health workforce requires innovative, flexible ways to educate healthcare providers. More importantly, it requires better integration between the education system that prepares healthcare providers and the health system that employs and deploys them (Government of Ontario 2005). It is widely recognized that planning for health human resources must be a truly collaborative process because it affects every facet of the healthcare system. The change in the healthcare system must be linked with how health professionals are educated and how they apply what has been learned in the workplace setting.

Health Canada's Interprofessional Education for Collaborative Patient-Centred Practice initiative has been one strategy of the pan-Canadian Health Human Resource Strategy as the means to address the challenges with health human resource and workplace issues (i.e., shortages). Funding of over \$20 million has been awarded to educational leaders across the country to develop ways to enhance health professionals to learn with, from and about each other in providing quality and collaborative patient care delivery. Much has been done to help move this strategy agenda forward through an evidence-informed approach that is influencing public policy. Ultimately, the goal is to improve patient care – but what about the goal for healthcare providers and their workplace environment?

In their article on the healthy workplace agenda, Shamian and El-Jardali describe key drivers that lie at the heart of both the teamwork and healthy workplace agendas. Of significance is that effective teamwork practices will improve the well-being of healthcare providers. Their article summarizes that there is evidence to support that healthy workplaces improve recruitment and retention, workers' health and well-being, quality of care and patient safety, organizational performance and societal outcomes. They note that several studies have shown an inverse relationship between nurse staff-

ing and adverse events. Poor workplaces have resulted in a substantial health burden and cost to health service organizations as a result of ill health among their staff, impacting loss time from work, errors and litigation.

Similarly, the literature review of teamwork in healthcare synthesis that was conducted by Oandasan et al. found evidence to support that health professionals working in collaborative teams have increased provider satisfaction in the workplace, resulting in reduced staff shortages and decreasing stress and burnout levels among healthcare professionals (CHSRF 2006). Key factors that led to teamwork lie in leadership, availability of resources and the provision of innovative organizational supports and structures to achieve healthy workplaces. In a recent study conducted by West et al. (2006), the authors emphasize that investing in health human resource systems in hospital settings that develop policies and practices focusing on training, performance management, participation, decentralized decision making, involvement, teams and employment security contributes to high-quality care, including improved patient mortality statistics. The findings suggest that managers and policy-makers should focus on improving the functioning of relevant human resource management systems in healthcare organizations.

The teamwork in healthcare synthesis (CHSRF 2006) and the article by Shamian and El-Jardali support the need to focus on organizational leadership to develop clear organizational philosophies that support teamwork and healthy workplace environments to improve patient care and provider satisfaction. The teamwork synthesis revealed, however, that an investment in resources and organizational structures alone will not foster effective teamwork. Individual willingness and capacity to

Interprofessional Education For Collaborative Patient - Centred Practice: An Evolving Framework

Interprofessional Education to Enhance Learner Outcomes

Interdependent Care Outcomes

Collaborative Practice to Enhance Patient Care Outcomes

Educational System
(eg. Accreditation, institutional structures)

Systemic Factors
(Eg. Regulatory bodies, liability)

Foressional System
Outcomes

Faculty

Foressional System
(eg. Regulatory bodies, liability)

Foressional System
Outcomes

Foressional System
Outcomes

Faculty

Foressional System

Complete Statistication

Foressional System

F

Government Policies: Federal/Provincial/Regional/Territorial (eg. education, health and social services) Social & Cultural Values

Figure 1. Inter-professional education for collaborative patient-centred practice. Reproduced with permission from D'Amour and Oandasan (2005).

engage in teamwork are needed for success. Attitudinal willingness and capacity or competence to engage in teamwork imply the need for health professionals to be educated through professional development or inter-professional education curricula for those still in their formative years. The teamwork synthesis builds upon the evolving framework that was developed by D'Amour and Oandasan (2005), which concludes that inter-professional education is interdependent with collaborative practice. The framework shown in Figure 1 suggests that one must learn how to be a collaborator in order to practise collaboration within healthcare teams. According to D'Amour and Oandasan, it is therefore the responsibility of educators to teach the competencies of collaboration to learners so that they can enter the workforce when they graduate applying principles and competencies related

Research to Inform

to collaboration in their workplaces.

However, many healthcare organizations are not structured in a way that supports teamwork in the workplace. This has led to unhealthy work environments. For policymakers, the ultimate goal of teamwork is the improvement of patient care outcomes, the enhancement of provider satisfaction and the advancement of organizational and system efficiencies. Further research is needed to support the argument that healthy workplaces through teamwork will enhance recruitment and retention and patient care. Yet, an opportunity exists to study this area if we believe that teamwork and healthy workplaces are important for health system reform. We need a better understanding of if, how and why teamwork and healthy workplaces can positively impact the delivery of care. This evidence can inform the development of public policies. But, is

Table 1. Priorities arising from the Ontario summit to advance inter-professional care

Education and Research

- 1. Incorporate required inter-professional care curricula by establishing appropriate learning strategies and timelines.
- 2. Agree upon shared competencies and education models, based on evidence (i.e., demonstration projects) and incorporate them into curricula, faculty development, clinical education and accreditation.
- 3. Use innovative technologies to educate and engage health professionals and consumers in inter-professional care.
- 4. Evaluate educational models developed to ensure sustainability use demonstration models and share learnings.
- 5. Implement mechanisms to educate and engage health professionals and consumers alike about inter-professional care.

Regulation and Liability

- 1. Define inter-professional care practices in healthcare settings that currently do not require regulatory changes.
- 2. Develop definitions and standards for scope of practice and core competencies for all healthcare professions that can be applied to all healthcare settings.
- 3. Implement mandatory adequate liability protection for collaborative care practices and settings.
- 4. Encourage regulators to develop collaborative regulations, first establishing a baseline from which to proceed.
- 5. Address risk management issues that will facilitate inter-professional care.

Organizational Structure

- 1. Address structural issues that reinforce power hierarchies across healthcare professions.
- 2. Create champions to facilitate inter-professional communication and leadership development in teamwork.
- 3. Create incentives for all health professionals to practise collaboratively (within and across sectors).
- 4. Clarify roles of all players in the healthcare system, including patients.
- 5. Increase profile, recognition, systemic support and coordination of inter-professional care at all levels to the degree necessary to affect change in the long term.

Cultural Shift

- 1. Organizational structures, systems and processes (i.e., rewards, incentives, performance appraisals, standards and accreditation) must change to support inter-professional care.
- 2. Evaluation and continuous improvement are necessary to ensure successful implementation of inter-professional care.
- 3. Continuous and sustainable funding must be made available for inter-professional care.
- 4. Information should be broadly shared, and role models (leaders and mentors) should be seen as champions of change toward inter-professional care.
- 5. Evaluation and creation of standardized indicators will be needed to ascertain when the culture has shifted and to track quality improvement.

there enough evidence to move it forward? Shamian and El-Jardali and Oandasan et al. (CHSRF 2006) believe that there is; however, there is a need to move forward with caution and rigour through evaluation to inform policy decisions.

In June 2006, by invitation, 110 decision makers, healthcare providers, community leaders, researchers and educators gathered in Toronto for the Summit on Advancing Interprofessional Education and Practice. Sponsored by the Ontario government, it sought the input and guidance of summit participants in developing and implementing practical, timely ways to remove the barriers that prevent effective use of health human resources and inter-professional care based upon the evidence for inter-profes-

sional care collected to date. There was a high level of interest and commitment generated among participants to advance inter-professional care in Ontario. Summit participants identified priorities on action steps for policy development to achieve inter-professional care. These are outlined in Table 1.

As a result of the recommendations that were forwarded by stakeholders at the summit, the Ontario government has provided resources and support to carry out the development of a policy blueprint for advancing inter-professional care in Ontario by spring 2007. The Interprofessional Care Project, which is being carried out by a steering committee and three working groups, intends to build upon the research evidence to inform the policy direction. The steps following the June summit in Ontario provide a living example of how evidence-informed policy development can be enacted.

Drawing upon the literature review and work that has been done to date, Lomas et al. (2005) have suggested that research evidence can assist in informing policy decisions through a process of deliberation with key stakeholders. Lomas et al. describe three types of evidence: context-specific evidence, context-free evidence (e.g., from randomized control trials) and colloquial evidence. Each has its merits, but collectively the opportunity to make evidencebased informed decisions can be made real by facilitating dialogue among stakeholders - colloquial evidence meets context-specific and context-free evidence from the literature and brings rigour to the development of policy decisions.

Those engaged in enhancing teamwork in practice could learn about the policy interventions that have been implemented over the years on the healthy workplace agenda according to Shamian and ElJardali. Policy interventions include public reporting measures, hospital accountability agreements, healthy workplace objectives embedded within strategic plans, the development of accreditation and workplace indicators, more educational seats, new staffing protocols and workload targets. Yet, the authors note that more work is needed to ensure that these policy initiatives bring effective changes to the workplace for better working conditions for healthcare workers. Similar to the recommendations by the teamwork synthesis (CHSRF 2006), the need for collaboration among researchers, policy-makers, decision makers, stakeholders and practitioners is required to attain healthy workplaces.

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Boundaries of the "Healthcare Workplace" Must Be Expanded



COMMENTARY

Thomas F. Ward



ABSTRACT

There is merit in considering the lead papers within a context of the current social and political landscape, the status of our healthcare system and the role of public policy to drive change. In doing so, it becomes clear that the notion of workplace must extend beyond what has been traditionally confined to physician offices and healthcare facilities, and the traditional workforces within. Until the concept of health workforce include patients, unpaid care providers and new healthcare roles, and the concept of workplace includes communities and homes, we miss the identification of problems and the possible solutions to them.

As part of preparing to write this commentary, I was interested to re-read the essays in a 2002 edition of *Healthcare Papers* on the topic of supply, demand and management of health human resources. Then, the evolution of the *healthcare team* concept was a central theme in the invited essay by Canadian Institute for Health Information authors, and the intersection of work-

force data and research evidence with policy-making was central to another. The editor-in-chief noted then that many of the issues raised "are not new. They have been raised at almost every forum or review of Canada's healthcare system" (Leatt 2002). The message was repeated in most of the commentaries that followed.

In this edition, the invited essays by

Judith Shamian and Fadi El-Jardali and by Dave Clements, Mylène Dault and Alicia Priest are appreciated because they provide a knowledge update on the themes of workplace health and the healthcare team, and suggest directions for research and policy initiatives. In doing so, they remind us that the issues remain, more knowledge is required and much of what is known remains to be translated into practices and policy. Progress continues to be slow, and we should not be surprised. As Carolyn Tuohy (1999) pointed out in her seminal work, Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States. Great Britain, and Canada, the evolution of healthcare is a path-dependent process. Policy shifts can be instituted at certain times and not others, and are as much dictated by factors in the broader political landscape as the healthcare arena.

Our essayists' recommendations may well define much of the future direction of the Canadian healthcare system. My contribution is to cast them in the light of the current status of our healthcare system and the social and political landscapes that surround it; this serves as the base for my argument that the healthcare workplace is much more than acute care or other institutional settings, and the healthcare workforce is composed of many more than the paid care providers we have identified for decades. Although Shamian and El-Jardali define the workplace as "mechanisms, programs, policies, initiatives, actions and practices that are in place," there is a need to underscore the variations in where healthcare is now provided and by whom. By not doing so, we are avoiding the identification of research and policy initiatives and directions.

As a brief reminder, there has been evolution of the system since the Canada Health Act of 1984, when hospital and physician offices were implicitly understood to be the workplace, health professionals its workforce and acute care the business at hand. The reduction of acute beds in Canada was accomplished in the late 1980s and 1990s by using new technologies combined with early discharge programs. Work done previously by paid care providers was now moved to the home and community, with expectations that most care would be assumed by family and friends. There was a marked shift from acute to chronic disease and, so, marked increases in longevity and morbidity of patients.

Take cancer. As the population ages, more cancer is detected and treated with success. It is now estimated that 16% of cancer care funds are directed to followup of patients who have been treated, and the growth of this percentage is likely to continue. Take cardiac disease. Although cardiac disease is no longer the leading cause of death in our country, associated morbidities remain a significant problem. Uncontrolled congestive heart failure (CHF) is still the leading cause of the admission of seniors to emergency departments. Estimates suggest that 12% of health dollars are directed to management of the disease. Take neurodegenerative disorders such as Alzheimer's disease. They extract an increasing demand on the healthcare expenditures and a devastating toll on families and unpaid support networks.

Interesting questions surface. Cancer care has the best organized diagnostic and treatment processes in Canada, but the industry continues to be prodded by the growing cancer population. This was highlighted in a recent series in *The Globe and Mail*. In the articles on December 9, 2006 (Anderssen 2006), patients reaffirmed their right to be intimately involved in the management of their disease – in other

words, their right to be a member of the healthcare workforce. The patient navigator was mentioned, a new health worker with the task of guiding patients through the complexity of diagnosis, treatment and aftercare in the discontinuous entity called the healthcare system. Why do patients continue to call for participation in the treatment of their disease? Why have we unsuccessfully integrated care for so many of them? Why can't we make treatment more patient friendly? Where are the navigators for other diseases?

From the National Survey on the Work and Health of Nurses

More than **one in three** nurses (37%) reported inadequate staffing levels in their last shift worked. One in eight said their nursing team had provided fair or poor care.

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

CHF is a condition that responds well to medication. Yet, the system has not successfully transferred structured patient treatment from the hospital to the home and community. Why not? How can we engage patients and their families to better manage this condition at home? If CHF could better be controlled and monitored at home, patient numbers in the emergency room should decrease. What has the system contributed to the healthy workplace of those with Alzheimer's disease who remain in their homes, particularly for the workforce that is largely composed of loved ones who are unpaid?

Each example echoes an important reminder to healthcare providers, policymakers and researchers: service to the public remains the primary purpose of the healthcare system. The unpaid workforce is critical to its sustainability and, so, should be included in strategies for research and policy initiatives. As much as we need to address policy in healthcare, we need to address policy in the community. Judith Maxwell has written to this concern. She noted "that Canada should be preparing for this demographic shift (the older elderly) by establishing the community services needed by these elderly and their family caregivers (most likely to be spouse or the children). The alternative is to accept that many will end up in far more expensive hospital or long-term care long before they should" (Maxwell 2006).

For at least two decades, healthcare leaders have stressed the importance of integrated, multidisciplinary teams in managing disease and improving health, particularly at the level of community. Clements and colleagues highlighted some of the barriers delaying its progress, and Shamian and El-Jardali noted the lack of action on implementation of many recommendations arising from the work of the Canadian Nursing Advisory Committee. I worry that vital research about the role of patient, family and community may be even further delayed by the growing focus on the current political landscape of accountability, at the federal level in particular. The value audits of many federally funded programs including the Canadian Institutes of Health Research suggest that the provinces may find it more difficult to extract more funds for healthcare research. At the provincial level, health authorities are being called

upon to demonstrate accountability, and one consequence may be increased restrictions on expenditures.

While we must pay attention to the policy realm, innovation and solutions are unlikely to come from policy or government. As Michael Peckham (2000) noted, "The impetus for innovation on which the future of the system rests will arise very largely from solutions derived and implemented by medical and other staff with the system itself." I would add patients and families as another category of solution makers. But the status quo remains, as illustrated by Clements and colleagues' reference to proceedings from a forum of researchers and decision makers on issues related to effective teamwork.

I do support the recommendation of the forum for an independent body to lead the work on teams. It is similar to a recommendation that I made in an earlier issue of this journal (Ward 2002). However, there was an absence of discussion of the role of the patient and family – which must be of discomfort to the ventilator-dependent patient at home who manages his or her care team of unprofessional employees and unpaid workers in a high-risk work environment, and to the patient who is dependent on home dialysis.

As Tuohy (1999) pointed out, changes within healthcare have accommodated the wishes of the powerful and, at best, can be described as incremental. But the healthcare system is here to serve the public by providing access to the best possible care, regardless of provider or place. Failure to acknowledge this, as we tend to do, will lead to further entrenchment of the current system and make meaningful change more difficult in the future.

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Health care Papers

The Authors Respond



Judith Shamian and Fadi El-Jardali

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The value of putting one's work in the public domain is the feedback, discourse and dialogue that the work generates. The format and the process that *Healthcare Papers* offers on timely and relevant topics for healthcare is an exceptional opportunity for feedback, discourse and dialogue. The 13 responses to our paper have made the effort worthwhile and offer incredible value added to the lead papers. The number, depth and diversity of responses to the Shamian and El-Jardali, and Clements, Dault and Priest papers are testimony to the importance of these topics and to the agenda of healthy workplaces and teamwork. Having two complementary lead essays strengthens the discussion and "moves the agenda forward" as emphasized by most commentators.

Several of the papers have made a strong case as to the importance of the integration of the two lead papers – viewing them as

being two sides of the same coin. While each paper stands on its own, the commentaries on our papers reflect some common themes, which emphasize the need to move forward the healthy workplace agenda at all levels in order to bring real changes at the front lines. Healthy workplaces for healthcare workers are an essential component of reforming the healthcare system. Changing the work environment for health workers enables us to attain the goals of our healthcare system, which are to provide access to quality, effective, patient-centred, team-based and safe health services. Strelioff, Lavoie-Tremblay and Barton point out that reducing wait times, increasing access to care and ensuring patient safety would not be achieved unless healthcare organizations become healthy workplaces. A number of authors delve into challenges and discuss ways to facilitate changing the working environments of

healthcare workers. One critical point made by many authors is the need to ensure that the positive changes that are currently occurring at the policy level are being translated at an accelerated pace into the front lines in terms of healthy healthcare workers and a better healthcare system.

Our success in translating the current changes into the practice environment and for the front-line workers will be based on a number of approaches, as emphasized by numerous authors:

- 1. The way we link healthy workplaces to critical indicators such as wait times, access and patient safety (Strelioff, Lavoie-Tremblay and Barton; Clements, Dault and Priest)
- 2. Micro-innovation and the macroresources – "coordinate, evaluate and replicate" (Laschinger; Silas)
- 3. The roles and responsibilities of governments, organizations, individuals and the general public to ensure that the healthy workplace philosophy is firmly embedded in the healthcare system (Matthews and MacDonald-Rencz)
- 4. Accreditation as a change agent (Nicklin and Barton), performance measures, indicators and public reporting (Nicklin and Barton; Matthews and MacDonald-Rencz; Strelioff, Lavoie-Tremblay and Barton; Smadu and McMillan; Kerr and Mustard)
- Collaboration among all stakeholders and the Quality Worklife-Quality
 Healthcare Collaborative (QWQHC)
 (Matthews and MacDonald-Rencz;
 Clements, Dault and Priest; Strelioff,
 Lavoie-Tremblay and Barton; O'Brien-Pallas; Laschinger)
- 6. The need for good theory, a clear framework and continued research to understand and improve the workplace,

- especially well-designed and controlled intervention studies (Leiter; O'Brien-Pallas)
- 7. A pan-Canadian inter-professional approach to developing, implementing and evaluating policy interventions (Kerr and Mustard; Smadu and McMillan); and an effective inter-professional workforce and teamwork (Grinspun; Clements, Dault and Priest; Jones and Way; Oandasan)
- 8. The integration of patients and families into the healthy workplace and team agenda (Ward)

To carry on the discussion introduced by many of the authors, this response paper focuses on common themes and messages; furthermore, we highlight additional issues for further discussion and debate.

Real Change

To move ahead with the healthy workplace agenda, a number of authors emphasize the need to build on our current empirical and practical successes in terms of policy intervention, implementation and evaluation and sharing of knowledge on best practices. The notion of bringing real positive changes to the workplace at the front lines has been emphasized in several papers. While many authors recognize the need for more work to ensure effective, faster and sustainable changes to the practice environment at the front lines, little information is provided on how best to do this consistently across the country.

The key message that can be concluded from the commentaries is that although the two lead essays are on two different topics, they surprisingly complement each other and have many common underlying concepts. As such, we note that teams are one of the essential building blocks in

attaining healthy workplaces. Furthermore, the numerous papers that discuss the role of the inter-professional agenda as a key national agenda at this time are further strengthening the team and workplace health. The inter-professional agenda is being advanced both by the federal government and several provinces, such as Ontario. This agenda requires enormous integration and collaboration among regulatory, policy, education and service sectors. The comments by Ward add an additional layer to the attainment of workplace health, teamwork and inter-professional practice. His argument that patients and families have to be considered as part of the team and take part in the workplace initiative is a powerful proposition that could advance this work to a truly more patient-centred reality with enhanced shared clinical decision making (Grinspun).

The point made by Leiter that the healthy workplace initiatives and related investments made in them were a few steps removed from the day-to-day work life of nurses needs to be debated further. While we agree with many authors about the need for faster and sustainable changes to the practice environment at the front lines, we recognize that some governments have made targeted initiatives at the front lines by investing directly into day-to-day work life. For example, Ontario and British Columbia have purchased new hospital beds and patient lifts designed to prevent back injuries among hospital and nursing home staff. Ontario has provided funding for more than 13,000 bed lifts in hospitals, long-term care homes and rehabilitation centres to help prevent injuries (Ontario Ministry of Health and Long-Term Care and Ministry of Training, Colleges and Universities 2005). In 2004-2005, Ontario provided funding to help hospitals convert to safer

medical equipment, including safety-engineered sharps devices. While we acknowledge that this one approach on its own is unlikely to make a major change at the front lines, we believe it is an important step that can contribute to a successful change.

Further Research and Evaluation

Several of the papers have put forward the areas where further work and research needs to be undertaken. Leiter argues for an enlightening framework for guiding workplace health initiatives at the front lines. His proposed Mediation Model provides a direction that focuses on experiences that are integral to staff members' day-to-day work life, and on developing and evaluating strategies for enhancing the quality of work life pertaining to workplace health. This necessitates the continuation and development of new research to understand and improve the workplace, especially well-designed and controlled intervention studies, as O'Brien-Pallas; Laschinger; Kerr and Mustard; Smadu and McMillan; Silas; and Matthews and MacDonald-Rencz point out. In addition, evaluation research and practical tools are needed to evaluate policy interventions and innovations to indicate whether the front-line healthcare workers are experiencing better working conditions. The development and dissemination of new research should continue in order to bring sustainable changes at the policy and practice levels. To change the way policy-makers think about healthy workplaces, research is needed to help develop indicators that clearly show the link between healthy workplaces, patient outcomes and system performance.

As this issue goes to print, the Findings from the 2005 National Survey of the Work and Health of Nurses (2006) has been released by Statistics Canada, Health Canada and the Canadian Institute for Health Information

(CIHI). This is the first ever national survey of the work and health of nurses. This work was undertaken to provide a national perspective and evaluation of the impact of policies and work on the ground. It is hoped that this survey will be repeated on regular intervals and will provide national monitoring and evaluation, together with other instruments like accreditation (Nicklin and Barton) and the Quality Worklife-Quality Healthcare Collaborative (QWQHC) (Strelioff, Lavoie-Tremblay and Barton).

There are several problematic findings that, unless improved, will hinder workplace health and teamwork – findings such as nurses regularly working overtime, onethird of the nurses classified as having job strains much higher than in the general female workforce, and one in five nurses holding more than one job (twice as many nurses held more than one job than in the general female employment group). The most troubling findings show that work stress, low autonomy and lack of respect are strongly associated with health problems among nurses (Statistics Canada, Health Canada and CIHI 2006). These findings and others among nursing and other professions (Smadu and McMillan; Kerr and Mustard; O'Brien-Pallas; Silas) are the source and proxy the same time of workplace health. This new report by Statistics Canada, Health Canada and CIHI – which has been developed in partnership with various nursing groups, scientists, employers and policy-makers – sets the tone for future surveys by which we can continue to evaluate the impact of policies and actions on the ground on the health of all categories of workers and patient outcomes.

Accountability

A number of authors pick up on the theme of accountability, responsibility and performance (Smadu and McMillan; Grinspun; Nicklin and Barton; Matthews and MacDonald-Rencz; Strelioff, Lavoie-Tremblay and Barton; Kerr and Mustard). We do agree with Smadu and McMillan that the public, including healthcare workers, should know the performance of healthcare organizations on healthy workplace indicators, and that employers should be accountable and responsive to healthcare workers. This necessitates the development of comparable indicators on workplace health in order to make comprehensive assessments and benchmarking. In an indirect way, Matthews and MacDonald-Rencz hint at the same issue when they emphasize the role and responsibility of governments, organizations and individuals to ensure that the healthy workplace philosophy is firmly embedded in the healthcare system. Smadu and McMillan suggest that this can be done through building on existing successful performance reporting initiatives and benchmarking tools, such as the hospital report on acute care, and expanding them beyond hospitals to include all sectors of the health system, such as home care, long-term care and public health.

Accountability, responsibility and performance should be required at three levels: macro-, meso- and micro-. At the macro-level, the Health Council of Canada can play an important role through public reporting on healthy workplace targets. This can provide the public with information on the progress achieved by provinces and territories, which will allow governments to benchmark themselves in terms of their achievements on the healthy workplace agenda across Canada. Silas points to such mechanisms in her discussion about the means for better accountability. At the meso-level, governments should integrate healthy workplace indicators within the performance contracts, and performance agreements between governments and employers. Matthews and MacDonald-Rencz argue that governments should be accountable through their policies and funding formula; hence, a possible option for consideration is the feasibility of integrating certain healthy workplace indicators within the funding formula to healthcare organizations. At the micro-level, Matthews and MacDonald-Rencz make it clear that "organizations should be accountable through performance contracts, accountability agreements and retention rates." They add that organizations should be "held accountable by the government, communities and their current and prospective employees ... individuals should be held accountable by their peers and colleagues and formally noted through performance appraisals." On this point, we add that employers should demonstrate that employee health and well-being are an integral part of their strategic plans (i.e., the way they do business). In addition, healthy workplace indicators and numerical targets should be included in their strategic plans. Overall, Clements, Dault and Priest put it right by saying that accountability needs to be shared between governments, organizations and health professionals.

The theme that was further emphasized by Silas about unions is critical. Her argument demonstrates the need for clear collective agreement language on healthy work environment factors such as workload, ratios, full- and part-time work availabilities, continuing education, mentoring responsibilities and health and safety. She lays out significant challenges that are facing nurses' unions across Canada in terms of safe staffing and professional authority. On a positive note, many unions are acknowledging that collective agreements can be a facilitator

to creating quality practice environments for healthcare professionals. The British Columbia Nurses' Union (BCNU) 2006 Collective Agreement could set a positive precedent in that regard. It highlights the importance and responsibility of unions, but at the same time alludes to the importance of a partnership with unions. To carry the discussion on this theme one step further, the challenges facing many unions show the need for a coordinated and collaborative approach to encourage stakeholders and front-line leaders to work in partnership with unions in exploring new ways and opportunities to remove barriers to workplace health.

At the leading edge in the area of workplace health is the whole use of work-life indicators within the accreditation processes. We strongly agree with Nicklin and Barton, who describe accreditation as a catalyst to move healthcare organizations toward healthier work environments. The authors highlight the significant progress achieved by the Canadian Council on Health Services Accreditation (CCHSA) in strengthening work-life standards. Those standards will be released early January and will apply to 2007 accreditation surveys. Certainly, the continued examination of work-life indicators within the accreditation processes is required to determine if the health of the workplace and its link to patient outcomes is adequately measured.

The "work-life pulse" employee survey described by Nicklin and Barton is quite interesting since it allows for the investigation of large organizational and work unit issues related to work life with an individual tool. It also allows organizations to identify specific work units that are exemplary or deficient in their quality of work life. Due to these benefits, the CCHSA will make the survey available as part of the accreditation program in Canada.

Innovation

An important pan-Canadian initiative emphasized by many authors is the QWQHC. As Nicklin and Barton observe, it is a good example of partnership and collaboration. This innovative group initiative, which is composed of 11 national stakeholder organizations and experts, is in the process of developing its action strategy, to be released in March 2007. An important part of this strategy is developing and disseminating a standard set of healthy workplace indicators at the system and organizational levels. It will embrace evidence-based management practices in healthcare organizations. This collaborative forum will help create more opportunities for innovation and knowledge exchange. It has an important role to play in disseminating best practices at the front lines, both at the national and international levels. It has the potential of being a "one-stop shop" for best practices, knowledge gaps for further research, innovation and healthy workplace initiatives. We believe that the different approaches about the next steps that are discussed in the lead papers and the commentaries will help enrich the action strategy and guide some of the priority actions of the QWQHC.

In their papers, Smadu and McMillan and Kerr and Mustard pick up on an important point related to translating healthy workplace innovations from one profession to another, which includes physicians and unregulated health professions. Smadu and McMillan bring to our attention some key findings from the Nursing Sector Study and its counterpart in the physician community, Taskforce Two: A Physician Human Resource Strategy for Canada. Both studies provide evidence on the impact of work environments on the health of nurses and physicians. For instance, the authors describe

the vulnerability of physicians to the influences of stress and burnout in the workplace.

While we agree with Smadu and McMillan's suggestion about a multidisciplinary approach to healthy workplace research, policy and practice that reflects the importance of creating a work environment to fit the inter-professional and team practice approach, we take the opportunity to raise a challenge in this regard. This challenge relates to existing organizational structures – particularly, that physicians are not employees of healthcare organizations. The challenge involves how to include them in the current and future efforts to improve workplace health. New ways of thinking and doing should be developed to address this challenge. The QWQHC could be a suitable forum to initiate this discussion. In addition, this group of experts might consider addressing the gaps mentioned by Kerr and Mustard, particularly "how healthcare workers from outside the regulated health professions can participate in and benefit from healthy workplace and teamwork activities, and how certain segments of the healthcare sector, such as long-term care and home care, have been relatively neglected in comparison with the rest of the sector."

Many authors emphasize the bottom-up approach in terms of workplace innovation. Silas and Matthews and MacDonald-Rencz bring up the importance of micro-innovations in promoting workplace health. While Silas mentions that the top-down approach may not bring positive changes fast, she points out that evidence to inform policy making should come from the workplace itself. Once again, this necessitates the development of practical mechanisms to monitor, evaluate, document and disseminate learning from micro-level innovations. This is another area where the QWQHC could play a leading role in the future.

Concluding Remarks

Almost all authors raise the discussion on the link among healthy workplaces, health human resources (HHR) retention and patient outcomes. This demonstrates the need to keep the healthy workplace agenda within the pan-Canadian HHR strategies. Early retirement, voluntary leaving of the health workforce, the active recruitment of our HHR by neighbouring countries and retention within and between provinces and territories are all serious issues for us to keep in perspective and for which we must find solutions. In reality, with all the policies and programs, unless we deal with workload and employment issues, we will not be able to turn workplaces to healthy, attractive and high-performing settings.

HHR members save lives (World Health Organization 2006). And to enable them to do this effectively, we need to save them from working in poor work environments. We must continue to find innovative ways to (1) persuade policy-makers and organizational leaders that the solution to at least some of the HHR problems in Canada is related to healthier workplaces; (2) make employers and stakeholders appreciate the costs of unhealthy workplaces so that they become eager to pay for efforts to create healthy ones; and (3) make governments,

employers, stakeholders, providers and the general public demand healthy workplaces.

Our response is that one approach on its own is unlikely to drive and accelerate a major change at the front lines. Together, the different approaches recommended by many authors might lead to successful change. Concerted efforts, innovation and collaboration are needed to ensure healthy workplaces centred in policy and practice.

We appreciate that many experts and stakeholders have taken the time to comment on our paper. Clearly, this is due to the importance of this policy agenda. Such an interest in healthy workplaces for healthcare workers should keep us motivated to stay the course and move forward.

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The Authors Respond



Dave Clements and Janet Helmer*

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A MAJOR THEME in the public policy literature of the new millennium has been that changes in society, including decentralized government and a growing private sector, require new approaches to old problems. One of the more eloquent critics has been Lester Salamon, who, in *The Tools of Government*, argued for a "new governance" where public problem-solving is a "team sport" with a range of actors engaged, including professionals, advocacy groups and the public. For Salamon, these "collaborative systems" require the engagement of both those who are willing and those who need to be urged to action (Salamon 2002).

We confess that on beginning the process of writing our paper, we intended to focus on teamwork as one component of a healthy workplace, not as a policy approach to solving the problem of unhealthy workplaces. However, these thoughtful commentaries suggest to us that it is indeed a useful way to think about engaging various actors in making healthcare workplaces healthier. This is the message we take from the commentary by Kerr and Mustard, as they remind us that the very same qualities that allow teams to flourish, including trust and respect, are the conditions that make some job sites healthy places workers want to go to every day. They also reinforce for us that leaders have an essential role in helping stay the course, beyond solving the most immediate workplace issues, such as injuries and other risks

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of staffing shortages and illness.

Indeed, these commentaries provide lessons for the relative roles of many key players as we seek to build collaborative systems for change. To begin with, Oandasan, the lead author of the teamwork synthesis commissioned by the Canadian Health Services Research Foundation (CHSRF), shows us a role for educators and those involved in professional development. While many see that collaboration is as natural as breathing, it is in fact a competency that must be nurtured among even the most skilled health professionals and, by extension, those in the policy and management spheres. It is not simply a matter of goodwill: plenty exists among the players. In addition, as we continue the task of amassing the evidence for "healthy teams," we cannot lose sight of the need to ensure the processes by which we seek to transform healthcare workplaces are equally well informed by evidence - both rigorous and more colloquial forms.

In their piece on the work of the Quality Worklife-Quality Healthcare Collaborative (QWQHC), Strelioff et al. provide a useful resource for administrators and other managers willing to make a commitment to work toward healthcare workplaces that are better for patients and providers. Beyond the will to change, these leaders must find the resources and capacity to make this work a priority in their organizations. "E-cubed" - evidence of effective engagement - is indeed the *new* math for quality workplaces and quality healthcare. The QWQHC's self-assessment tool helps organizations to understand where they are now and to chart a course for their future. The CHSRF is proud to be on board as a partner organization and to co-chair a knowledge exchange working group.

In addition, Nicklin and Barton outline

how accreditation may empower administrators to further strengthen the work-life standards. A doubling of the number of criteria that measure work life will help health services delivery organizations to see how they measure against these enhanced standards and to identify areas for improvement. The leadership of the Canadian Council on Health Services Accreditation (CCHSA) in "contributing to improving the quality of work life and to improving the health of work environment for all members of the healthcare team" positions it as a strong partner in bringing about significant change across the Canadian health services delivery landscape.

We are encouraged by the commentary by Silas, which serves as a strong voice from front-line nurses in supporting accountability, participation and leadership for policy change at all levels and sectors for "real" sustainable change. The willingness of these nurses and their associations to partner for positive change is often recognized too late in the game, and the lack of effective engagement with front-line nurses is unfortunately often the norm. Leiter's commentary reminds us of the consequences on this absence of engagement. Involving point-of-care nurses in finding and implementing solutions to improve their workplace realities is indeed a key to successful change management. The Mediation Model (Maslach and Leiter 1997), describing employees' psychological relationships with work, is a framework that provides significant opportunity for considering the contribution of workplace health initiatives. By focusing on experiences integral to staff nurses' day-to-day work life, it provides direction for developing and evaluating strategies that are aimed at enhancing the quality of work life and workplace health.

We are heartened that Laschinger,

whose research has shown that alarming numbers of hospital nurses are experiencing severe emotional exhaustion, sees effective collaboration in teams as an important component of making workplaces healthier. And we take to heart her suggestion that team members need to "retain their professional identity and [be] clear about what they bring to the healthcare process." Three major studies have shown that the primary predictor of emotional exhaustion and burnout was excessive workload, followed by a perceived lack of fairness of organizational procedures, poor interpersonal relationships in the work setting, a perceived lack of recognition for their contribution to organizational goals, a lack of congruence between their own and organizational values, and a disempowering work environment and lack of respect. With substantive evidence that nurses' work environments are less than optimal, Laschinger suggests that nursing still has a long journey ahead to create healthy work environments where basic human factors foster individual health and well-being.

An effective role for professional associations, including those representing nurses, is exemplified in Grinspun's commentary. The executive director of the Registered Nurses' Association of Ontario highlights the evidence-informed leadership and advocacy her association has brought forward in the form of Clinical Best Practice Guidelines and Healthy Work Environments. These "suites" of evidence help decision makers, whether they are at the point of care or at the program planning and budgeting level.

Jones and Way, authors on the CHSRF teamwork synthesis, point to the need for better representation from community healthcare. Indeed, much of what we know about healthy workplaces is still from the

acute care sector and is most often focused on individual professional groups. Their research tells us there is a need to implement and study effective collaboration in team-based, patient-centred care in primary healthcare. With each major health policy report since Marc Lalonde's (1975) white paper comes another call for strengthening teamwork. However, few providers have had the opportunity to experience teamwork and its contribution to patient-centred care. By finally moving toward inter-professional teams, Jones and Way suggest we will be better able to deal with the increasing complexity of care in the community.

Like the authors of the lead papers, Matthews and MacDonald-Rencz stress the need for continued efforts at the policy level in driving a healthy workforce capable of creating a quality healthcare system. The federal government's support in moving the teamwork and healthy workplace agendas forward in its strategic program funding and research through Interprofessional Education for Collaborative Patient-Centred Care healthy workplace initiatives, the QWQHC and the Canadian Interprofessional Health Collaborative (CIHC) is a major contribution. In addition, the Framework for Collaborative Pan-Canadian Health Human Resource Planning enforces the tenets of collaborative team practice and healthy work environments – potentially a very powerful tool.

A number of the commentators outline that the team-based approach to building healthier workplaces needs researchers as players, not as spectators. For example, the Canadian Nurses Association's Smadu and the Canadian Medical Association's McMillan say the role of researchers is not just to translate findings but, rather, to take a lead role in building understanding between different professional cultures. In

addition, O'Brien-Pallas emphasizes the need for ongoing Canada-wide evaluation of evidence-informed policy interventions, noting the scarcity of comprehensive, system-wide studies to date. In particular, nursing workload remains an area where we need to develop and test definitions, approaches and measures in productivity and utilization. The "next generation of workload measurement" systems need to be validated across sectors and settings and have the capacity to quantify cost, quality and outcomes if we are to influence their (workload measurement systems) uptake by decisions makers.

Finally, we end this piece where we began: the public. We note in our lead paper that effective teamwork in healthcare is something that patients assume to be in place. Ward points out that the changing face of healthcare in Canada prompts the need for new roles for patients, or at least new recognition of these roles. It will be

vital that researchers, policy makers, managers and clinicians ensure they engage the public effectively in shared decision making, as true team members.

Getting many players to work together is no easy task, in healthcare or any sector. As the "Old Perfessor" Casey Stengel once put it, "Gettin' good players is easy. Gettin' 'em to play together is the hard part." Nonetheless, the willingness of the major players to participate, as exemplified by their participation in this special issue, gives us hope for success.

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