



CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

Quality of Worklife Indicators for Nurses in Canada

Workshop Report

To:
Canadian Council on Health Services Accreditation

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Executive Summary

The Canadian Nurses Association (CNA) convened a national workshop in Ottawa, April 2002, to develop quality of worklife indicators for nurses in Canada. Using a collaborative, consensus-building process, the workshop actively engaged participants in identifying a set of eight quality of worklife indicators (QWIs) that will make a measurable difference for professional (regulated) nurses. The workshop's major recommendation is that these indicators be incorporated into the Canadian Council on Health Services Accreditation's (CCHSA's) 2004 Achieving Improved Measurement (AIM) Accreditation Program, which is used to accredit healthcare organizations in Canada.

Graham S. Lowe, a Canadian expert on worklife indicators, facilitated this day and a half workshop. Participants attending the workshop represented professional nursing bodies from across Canada: Health Canada's Office of Nursing Policy, CCHSA, executive nurses, registered nurses' associations in six provinces, nurse researchers, nurses' unions, health care employers, CNA, the nursing informatics field, licensed practical nurses and practising registered nurses. CNA has pledged to work closely with the other workshop sponsors, Health Canada's Office of Nursing Policy and CCHSA, as well as other stakeholder groups to act on the recommendations.

Workshop participants underscored the urgency of advancing the nursing quality of worklife agenda. At stake is far more than the work environments of individual nurses. Indeed, the issues discussed at the workshop are central to the broader public policy goal of creating a cost-effective health care system that delivers excellent client care.

From a list of 32 suggested indicators, the following eight were chosen:

- Span of control (average number of direct reports for each nursing supervisor);
- Leadership (corporate nursing leader at senior level with budget line responsibility);
- Overtime hours (per cent of total nursing staff earned hours that are overtime hours);
- Full-time/part-time/casual ratios (per cent of total nursing staff earned hours that are full-time, part-time and casual, reported annually);
- Autonomy/scope of practice (per cent nurses reporting in a staff survey that they have adequate control over their professional practice);
- Professional development opportunities (per cent of nurses participating in in-service training session and/or off-site education and training programs, with the average number of hours for each type of session, reported annually);
- Absenteeism (average number of days absent per nurse, reported annually OR absenteeism as per cent of total earned hours for nurses); and
- Grievances (total number of unresolved grievances).

The workshop significantly advanced the Canadian nursing community's commitment to improving the worklife of professional nurses. The event was a major step forward in developing a comprehensive framework of indicators that will ensure a high quality workplace for nurses and optimal client outcomes. The workshop's recommendations come from a group broadly representative of the national nursing community. As such, the workshop's consensus-building

process offers strong validation of the relevance of specific quality of worklife dimensions and indicators.

There will be opportunities to gain support and move the agenda forward at various upcoming national nursing and health service conferences. The next steps may include developing a report, intended to educate professional nurses and employers, about the importance of applying the quality improvement philosophy to work environments. Several participants also called for a national nursing summit to study the quality of worklife issues.

As a guidepost for the future, the regulated professional nursing community in Canada has articulated a vision of the ideal professional practice environment. With this vision as a beacon, an incremental approach to improvements in nurses' work environments may not seem such a daunting task. Nurses, healthcare service organizations and clients will all benefit from moving in this direction.

Workshop Objectives

On 23 and 24 April 2002, the Canadian Nurses Association (CNA) convened a national workshop in Ottawa to develop Quality of Worklife Indicators, or QWIs, for nurses in Canada. A collaborative, active, consensus-building process engaged participants in identifying a set of practical QWIs that would make a measurable difference for professional (regulated) nurses. The workshop's major recommendation was to incorporate these into the Indicators section of the Canadian Council on Health Services Accreditation's (CCHSA's) 4004 Achieving Improved Measurement (AIM) Accreditation Program, to use in accrediting health care organizations.

The workshop significantly advanced the nursing community's commitment to improving the worklife of professional nurses in Canada. The event was a major step in developing a comprehensive framework of indicators that will ensure a high quality workplace for nurses and optimal client outcomes. Recommendations, outlined below, come from a group broadly representative of the national nursing community (see Appendix 1 for a participant list). Its consensus strongly validates the relevance of specific quality of worklife dimensions and indicators. CNA has pledged to work closely with the other workshop sponsors, Health Canada's Office of Nursing Policy and the CCHSA, as well as other stakeholder groups to act on these recommendations.

Above all, workshop participants underscored the urgency of advancing the nursing quality of worklife agenda. At stake is far more than the work environments of individual nurses. Indeed, the issues they have raised are central to the broader public policy goal of creating a cost-effective health care system that delivers excellent client care.

Creating Consensus

Participants at the workshop represented professional nursing bodies and key stakeholder groups from across Canada: Health Canada's Office of Nursing Policy, CCHSA, executive nurses, registered nurses' associations in six provinces, nurse researchers, nurses' unions, health care employers, CNA, the nursing informatics field, licensed practical nurses and practising registered nurses. Participants shared their experiences and learned from each other in rich discussions that followed a process, designed to reach a consensus on major recommendations.

This process is outlined in the box to the right.

Discussions also recognized the complex interaction of organizational and individual factors that influence the quality of worklife. Participants felt this insight must inform any use of quality worklife indicators to improve working conditions.

Workshop Foundations

This workshop built firmly on the work of many organizations and researchers. Participants' background reading included the Canadian Health Services Research Foundation's paper *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System*.¹ A CNA background paper synthesized the current state of research and practice on QWIs.² In addition, researchers from the University of Toronto's Nursing Effectiveness, Utilization and Outcomes Research Unit also gave an overview of the quality and availability of data on quality of worklife.

Workshop participants reached their recommendations by:

- *Sharing current quality worklife initiatives;*
- *Assessing available data;*
- *Agreeing on criteria to use in order to select the QWIs;*
- *Reaching consensus on key indicators;*
- *Developing principles that will guide the application of the QWIs; and*
- *Developing strategies for using QWIs to continuously improve nursing professional*

Other presentations documented a range of complementary initiatives from across the country. For example, the Registered Nurses Association of British Columbia and the College of Nurses of Ontario have developed consultation programs on quality practice environment standards that include control over workload, professional development, nursing leadership, control over practice, and organizational support. Saskatchewan's provincial Health Services Utilization Review Commission recommended empowering local work units, and emphasized the importance of tracking job satisfaction, illness/injury rates, and resources available to local units. Hospitals in Ontario and New Brunswick use various measures for reporting nursing workload in hospitals. In April 2002, it became mandatory to report sick time and overtime in Ontario. Nova Scotia and Manitoba also support ongoing initiatives to improve professional nurses' practice environments. Nationally, a forthcoming report by the Canadian Nursing Advisory Committee will focus on the need to improve work environments, especially by addressing workload.

This information prompted many workshop participants to suggest that the group may be at a turning point in addressing nursing quality of worklife. As one participant said, "We are on the verge of a leap." Helping generate this optimism were two broadly-based initiatives that set the boundaries for the workshop: CNA's on-going work on quality professional practice environments, and CCHSA's commitment to include Quality of Worklife Indicators in its 2004 accreditation program.

¹ Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., et al. (2001). *Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system. A policy synthesis*. Ottawa: Canadian Health Services Research Foundation & The Change Foundation.

² Canadian Nurses Association (2002). *Workshop on Worklife Indicators for Nurses in Canada. Background Paper*. Ottawa: Author.

CNA's Quality Professional Practice Environment Initiative

CNA's position statement on quality professional practice environments for registered nurses set the stage for workshop deliberations.³ A high quality practice environment embodies what's best for both nurses and patients. CNA's 2001 position statement specifies that a quality nursing professional practice environment "is one in which the needs and goals of the individual nurse are met at the same time as the patient or client is assisted to reach his or her individual health goals, within the costs and quality framework mandated by the organization where the care is provided."

CNA's position statement identifies the following elements for which stakeholders in the health care field have a responsibility:

- staffing decisions based on evidence, to ensure appropriate skill mixes and numbers of positions to achieve good client outcomes, with direct input from professional nurses;
- opportunities for nurses at all levels to participate in decision making that affects nursing practice, client care or work environment;
- policies promoting the health, safety and personal well-being of nurses; and
- support for nurses to use evidence-based decision making.

These conditions correlate with job satisfaction, productivity, recruitment and retention, care quality and client outcomes.

However, workshop discussions offered a reality check: many health care organizations are stretched to the limit and preoccupied with alleviating immediate crises. These circumstances do not foster the full range of resources and supports needed to optimize quality practice environments for nurses – or other health professionals. Ideally, the Canadian nursing community hopes the recommended QWIs will enable organizations to address the root causes of worklife quality problems more efficiently and effectively, and create tangible progress.

CCHSA's Achieving Improved Measurement Program:

While the workshop built on prior work of CNA, its affiliates, allied organizations and researchers, the Canadian Council on Health Service Accreditation set clear boundaries for the discussion. Indeed, the workshop recommendations are directed to CCHSA. Participants were mindful of the Achieving Improved Measurement (AIM) accreditation program's history, principles and objectives, and focused on how to integrate QWIs for nurses.⁴

CCHSA is dedicated to promoting excellence in providing quality health care and the efficient use of resources in Canadian health services organizations. Its accreditation program indicators are not limited to nurses, but reinforce the need to use nursing research and experience to build bridges to other health professions, to improve health care work environments overall. Accreditation is based on comparing an organization with national standards, and involves both self-assessment and independent review.

³ Canadian Nurses Association (2001). Position Statement: *Quality Professional Practice Environments for Registered Nurses*. Ottawa: Author.

⁴ For details of the AIM Accreditation Program, see the CCHSA website: www.cchsa.ca.

Accreditation rests on the principle of continuous quality improvement. Recommendations flowing from the review are designed to assist an organization to address its weaknesses while maintaining its strengths. AIM standards are client-focused, evolve to meet the needs of changing environments, use a population health approach, and emphasize measurement and outcomes. The AIM program is the basis for quality improvement plans at work sites. Indicators are used to monitor, assess and improve client care, support services and organizational procedures that affect client outcomes.

It was also important for participants to know that CCHSA's accreditation process defines quality in four dimensions: competence, responsiveness, client/community focus, and worklife. AIM uses this understanding of worklife: "The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well-being, and satisfaction."⁵ Descriptors of good worklife include open communication, role clarity, participation in decision-making, learning environment, and individual staff member's wellbeing.

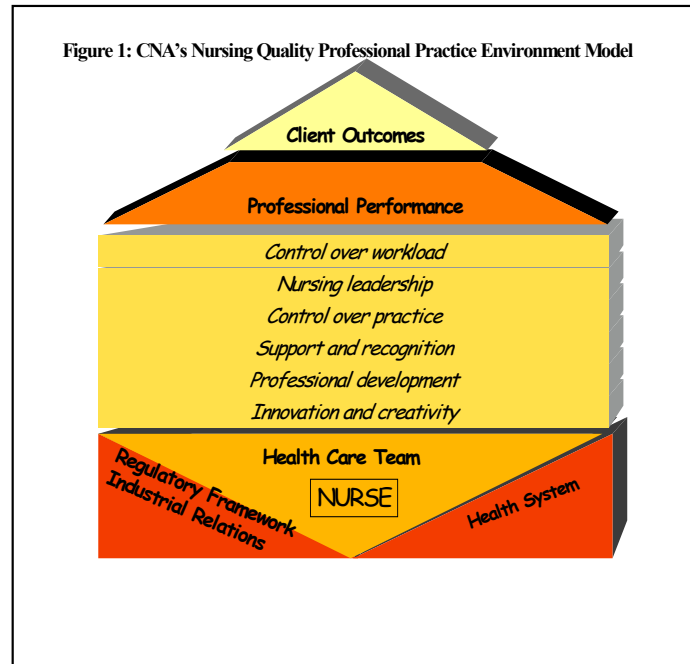
AIM supports organizations to use their own indicators, emphasizing ways that these indicators feed into a continuous improvement process. At the same time, the program encourages organizations to develop indicators that can link to AIM. This is especially important to developing and using QWIs, because this is an area where measurement issues are still being resolved, standards are still being developed, and much causal analysis remains to be done.

Recommended Quality of Worklife Indicators

Participants emphasized the usefulness of a model that helps them think about possible causal influences and that offers a holistic perspective on how quality of worklife issues fit into the health care system overall. A starting point was CNA's model of quality professional practice environments (Figure 1).

⁵ Canadian Council on Health Services Accreditation. (2002). *The Dimensions of Quality: CCHSA's Definition of Quality*. Ottawa: Author, p. 4.

Figure 1
CNA’s model of quality professional practice environments



From presentation “Quality Professional Practice Environments. CNA Framework for Action,” by CNA, 2001.

This model, based on cumulative research, lists six attributes of healthy workplaces (see middle of Figure 1) that enable and support high levels of professional nursing performance and that, in turn, contribute to positive client outcomes. The same logic underpins workshop recommendations. At the same time, participants took into account existing CCHSA worklife descriptors.

Figure 2 (below) illustrates relationships between the CNA and CCHSA approaches, and the key QWIs recommended by the workshop. There are clear areas of overlap, and gaps indicate areas for further development. The workshop’s approach also includes two new outcomes – absenteeism and grievances – that affect system operations. Faced with the task of selecting key indicators, workshop participants were particularly sensitive to data availability and quality issues. In the end, they accepted that these particular QWIs are, as one research expert put it, “crude measures of the right things.”

Figure 2
Alignment of CNA Healthy Workplace Attributes, CCHSA Worklife Descriptors, and
Workshop on Quality of Worklife Indicators Recommendations

CNA Healthy Workplace Attributes	CCHSA Worklife Descriptors	Recommended Key Quality of Worklife Indicators
Control over workload		Overtime hours Full-time/part-time/casual ratios
Leadership		Span of control Leadership
Control over practice	Participation in decision making Role clarity	Autonomy/Scope of practice
Support and recognition in the workplace	Well-being	
Professional development systems	Learning environment	Professional development opportunities
Innovation and creativity	Open communication	
		Outcomes: Absenteeism; Grievances

How did participants arrive at this short list of QWIs? Given a substantial amount of background information and their own experience, they compiled a list (see box to the right) of all relevant quality worklife indicators used in nursing research, policy and practice.

Next, they developed a set of criteria (see box on following page) to guide how they would select high-priority indicators to be included in the revised AIM program for accreditation. Beyond these criteria, participants recognized that different QWIs might be incorporated into CCHSA accreditation at different times, as new data become available.

Thus, the recommended indicators form a menu that encourages organizations to adapt what they can, learn from the experience and strive to develop more rigorous measures. The workshop also recognized the need to balance locally-relevant indicators with national benchmarks against which an organization may track its progress in improving its work environment.

Reviewing the list of suggested indicators, participants then set priorities. This resulted in five ‘clusters,’ or dimensions, of quality of worklife factors. These include leadership and culture, control over workload, control over practice, resource adequacy, and outcomes for individuals and organizations. This step helped organize the specific indicators. Using the selection

Suggested indicators:

- Absenteeism
- Control over practice
- Employee supports (e.g., Employee assistance programs)
- Empowered local units
- Error rates
- Flexible schedules
- Food service/healthy lifestyle
- Full-time/part-time ratios
- Influence in decision making
- Injury/illness rates
- Job satisfaction / Stress
- Labour relations
- Leadership
- Organizational structure
- Organizational supports
- Overtime hours
- Parking, security
- Peer competence
- Peers who can fill in
- Professional development
- Quality Practice Settings Survey® scores (CNO)
- Role in governance
- Scope of practice
- Skill mix
- Span of control
- Supplies and equipment
- Turnover
- Value / respect
- Whistle blower protection
- Work allocation
- Work-life balance
- Workload

criteria, the workshop then identified eight indicators that should be included in the 2004 AIM program. The remaining 11 indicators need more development, or could be used by organizations undergoing accreditation if available.

Indicator selection criteria

- Fit into a model that links quality of work life to nurse, patient and unit outcomes.
- Are based on research evidence and supports future research.
- Are useful for all regulated nursing groups, units, sectors and regions.
- Are meaningful to individual nurses and clients.
- Signals organizational strengths and weaknesses.
- Feeds into national tracking (e.g., by CIHI).
- Can be generalized to other health care professions.
- Include data availability, quality and cost of retrieval and processing.

Key Quality of Worklife Indicators

The theme of developing standardized measures and reporting procedures for these indicators was prominent in the workshop discussions. Participants felt that developing QWIs must be seen as an evolving process guided by shared learning and continuous improvement. There were also concerns voiced about how indicator data would be used – all participants wanted to ensure that QWIs act as catalysts for action.

Other important caveats were attached to specific indicators. For example:

- While most management information systems track *grievances*, these may be underreported when unions file policy grievances on behalf of many members. These may be counted as a single grievance.
- The traditional measure of *span of control* is the ratio of nursing supervisors to nursing staff. However, front-line nurses increasingly need access to mentoring and coaching. The span-of-control measure is a blunt tool for evaluating this. It is further confounded by the growing use of non-nurse managers who are unable to offer professional advice to nurses.
- For *overtime*, only paid overtime typically is reported, even though Statistics Canada's Labour Force Survey shows that many professions including nursing also require unpaid overtime.⁶ Again, this results in underreporting.
- Finally, the hidden side of *professional development* is workload added when staffers away on training programs are not replaced.

Consideration of two indicators –autonomy/scope of practice and absenteeism – was particularly extensive. It is worth summarizing main points of these discussions to stress the need for meaningful, reliable, standardized measures that are useful in diverse settings locally and nationally.

⁶ Statistics Canada. (2001). *Labour Force Survey, microdata file*. Ottawa: Statistics Canada.

Autonomy/Scope of Practice: Autonomy and scope of practice are linked. Autonomy means having substantial freedom, independence, and discretion at work, and is linked to experiencing responsibility for work outcomes. A March 2002 CNA discussion paper defines scope of practice as “the range of roles, functions, responsibilities, and activities which members of a discipline are educated and authorized to perform.”⁷ The relationship between the care context, client factors, and a nurse’s knowledge and skills is central to understanding scope of practice.

At issue, then, is the extent to which nurses are able to regularly exercise autonomy over their professional practice. This is crucial, given evidence that links scope of practice to job satisfaction, skill use, and returns to training and development. Therefore, tracking indicators of autonomy/scope of practice should enable health service providers to improve cost effectiveness and productivity.

Absenteeism: Statistics Canada’s national Labour Force Survey indicates that professional nurses have the highest rates of absenteeism of any occupation.⁸ It is a lagging indicator, reflecting the cumulative impact of a range of workplace problems. Absenteeism also correlates highly with turnover, and so becomes an early warning of retention problems. Addressing its root causes would contribute significantly to nursing quality of life and the health care system’s overall efficiency and cost-effectiveness. In other words, high absenteeism among nurses should be an urgent public policy concern.

However, tracking absenteeism is not very straightforward. All hospitals and most other health care facilities have absenteeism data, but lack a common definition. Several workshop participants called for mandatory reporting of absenteeism to the Canadian Institutes for Health Research, which would require national measurement standards. Moving in this direction would require a multidimensional approach to measuring absenteeism. For example, it is relevant to separately track short and long-term disability days (very costly to supplementary health benefits programs), absences due to injury (which affect workers’ compensation levies), and absences for family reasons (signalling a need for work-life balance programs). At a minimum, work units should track absence rates over time to identify unique contributing factors in the work environments of different types of nursing units.

Workshop participants offered other cautions about absenteeism. Regardless of the reasons for them, absences can add to the workload and stress of other staff members if adequate replacement personnel are unavailable. Furthermore, under some circumstances, sick workers may show up at work (‘presenteeism’) even if staying home to recover may be in the best interests of the individual, her/his co-workers and clients. Finally, a number of workshop participants voiced concerns that employers might potentially try to use absenteeism data as a reason to introduce ‘absence management’ programs. This would do nothing to address root causes of the problem.

⁷ Canadian Nurses Association. (2002). Draft *Discussion Paper: The Unique Contributions of the Professional Nurse*. Ottawa: Author, p. 13. Unpublished.

⁸ Statistics Canada. (2001). *Labour Force Survey, microdata file*. Ottawa: Statistics Canada.

Figure 3
Workshop Recommendations for Quality of Worklife Indicators

QWI Dimensions	Key QWIs for 2004 AIM Accreditation Program	Additional QWIs for AIM Development
Leadership and culture	<ul style="list-style-type: none"> ▪ Span of control ▪ Leadership 	<ul style="list-style-type: none"> ▪ Value and respect ▪ Influence in decisions
Control over workload	<ul style="list-style-type: none"> ▪ Overtime hours ▪ Full-time/part-time/casual ratios 	<ul style="list-style-type: none"> ▪ Workload ▪ Peer competence
Control over practice	<ul style="list-style-type: none"> ▪ Autonomy / scope of practice 	
Resource adequacy	<ul style="list-style-type: none"> ▪ Professional development opportunities 	<ul style="list-style-type: none"> ▪ Supplies and equipment
Organisational and individual outcomes	<ul style="list-style-type: none"> ▪ Absenteeism ▪ Grievances 	<ul style="list-style-type: none"> ▪ Job satisfaction ▪ Stress ▪ Work-life balance ▪ Joint initiatives involving management, unions, professional associations ▪ Turnover ▪ Error rates

Measuring the Indicators

The dimensions and their associated indicators provide a framework for actually measuring quality of worklife (See Figure 3). Each indicator has a range of possible measures. For most, researchers have agreed upon no ‘gold standard’ measure. Consequently, the workshop’s approach was to suggest what seemed to be the most readily-available measures of adequate quality, and recognize that some organizations will see merit in replacing these with their own measures.

Appendix 2 lists specific measures that can be used to document the eight QWIs for inclusion in the Indicators section of the 2004 AIM Accreditation Program. It also suggests measures for other high-priority QWIs the workshop participants saw value in developing, and, where possible incorporating into, CCHSA accreditation.

For the AIM 2004 Accreditation Program, seven of the eight recommended indicators can be measured using widely-available administrative data, at least in large organizations. The ability of smaller facilities to accurately report this information may be limited. The one measure not already available in routine administrative data may be obtained through an annual staff survey that asks nurses to assess the extent to which they have control over their professional practices (some existing tools, such as QPaSS[®] described below, contain this type of measure).

In contrast, most of the 11 suggested measures in Appendix 2 – those indicators the participants recommends be developed further, or used if available – would have to rely on staff surveys as the data collection vehicle. Question wording and response scales (for example, five- or seven-point “agree-disagree” Likert-type items) are suggested. Of course, adequate alternative measures may already be included in existing staff surveys, such as the five-country survey of nurses’ hospital work climates.⁹ The ideal reporting period for administrative data would be monthly, but annual roll-ups would be a minimum requirement. Retrospective trend data going back several years also are recommended. Breaking down data by professional group and unit would greatly enhance the data’s usefulness in identifying an organization’s strengths and weaknesses in quality of worklife issues. Virtually all of the measures in Appendix 2 could be applied directly, or adapted to other professional groups with minor modifications.

Using the Indicators

The evolution of QWIs must be guided by the principles of accountability, visibility and continuous learning. Organizations undergoing accreditation should hold themselves accountable for monitoring and reporting ongoing progress on a range of work environment goals. This requires a commitment to create high quality work environments. QWIs must also be visible, because their best use rests on open communication. Data must be made available to stakeholders and findings spread widely, to enable collective problem solving.

At the same time, the workshop was also wary of unnecessarily ‘reinventing the wheel.’ All stakeholders have a responsibility to work together and share experiences as they address nursing quality of worklife, to avoid duplicating indicators. Participants recognized several useful initiatives are already underway, and encourage health service organizations to make full use of them. This suggests that a ‘menu’ approach would be useful, so organizations may use the best available data to actually quantify an indicator.

A leading example is the College of Nurses of Ontario’s Practice Setting Consultation Program.TM The Quality Practice Setting Survey[®] (QPaSS[®]) measurement tool, developed in collaboration with the Nursing Effectiveness, Utilization and Outcomes Research Unit at McMaster University, has been used widely in all areas of health care over the past five years. It is capable of reporting results at the facility and system levels. Organizations can use QPaSS[®] scores to initially measure and track progress on issues such as autonomy and control over work, leadership and management style, access to functional equipment, professional development

⁹ Aiken, L., Clarke, S., Sloane, D., Sochalski, J., Busse, R., Clarke, H., et al. (2001). Nurses’ reports on hospital care in five countries. *Health Affairs*, 20(3), 43-53.

opportunities, communication, and care delivery processes. It would be important to monitor how organizations actually use QPaSS[®] results in the CCHSA accreditation process.

QPaSS[®] is currently used in British Columbia, Nova Scotia and Ontario. These provinces, representing Western, Central and Eastern Canada, are well positioned to collect and report on “like-data” using the same reliable and valid instrument. This type of “national” aggregate data, regarding the system enhancers and barriers supporting or impeding professional practice environments, could add another significant piece to the national nursing practice picture.

Beyond QPaSS,[®] participants pointed out that health service organizations are also using other nationally-available tools. Specifically, Health Canada’s Healthy Workplace Model includes an employee survey that focuses on healthy workplace conditions.¹⁰ The National Quality Institute also has an assessment tool for healthy workplaces as part of its national award program.¹¹ Indeed, extensive research on the benefits to staff and productivity of workplace health promotion and ‘healthy organization’ models could readily be adapted to health care settings. Because there are a variety of measurement approaches, it will be important to co-ordinate, and where possible, to integrate these initiatives.

The Canadian Healthcare Association (CHA) also is very concerned about the quality of worklife and is becoming more proactive about it. CHA is committed to performance measurement and quality, which sets the stage for addressing quality of worklife problems. Workshop participants recommended that QWIs support the health human resource planning process. Health care organizations may also take a lead role collaborating with researchers, to document links between work environment factors on one hand, and organizational and client outcomes on the other.

Building Momentum

Workshop participants would describe their exercise as “the art of the possible.” The indicators recommended to CCHSA are based on a growing body of research. However, actual measures must be perfected – the data are far from being uniformly adequate. Even so, including QWIs in the healthcare service organization accreditation is a major step forward. As noted, many concurrent initiatives across Canada address nursing quality of worklife needs and concerns from different angles. There is also significant progress in this direction in the United States where the Joint Commission on Accreditation of Healthcare Organizations has committed to improving the quality of healthcare workplaces.¹²

Several participants observed that nurses in Canada are ready to make a breakthrough. Building on this momentum is critical to succeeding. Still, as these discussions clearly document, other major issues linked to the quality of work environments for nurses also deserve immediate attention.

¹⁰ For more information, see Health Canada’s Workplace Health Resources website: www.hc-sc.gc.ca/hppb/ahi/workplace/resources.

¹¹ See the National Quality Institute’s website: www.nqi.ca.

¹² Eisenberg, J. M., Bowman, C. C., Foster, N. E. (2001). “Does a healthy health care workplace produce higher-quality care?” *The Joint Commission Journal on Quality Improvement*, 27(9), 444-57.

Foremost is the need to support and extend current research to develop causal models that show direct and indirect effects of work environment factors and human resource management practices on organizational performance and client outcomes. The weight of evidence suggests connections, but much more analysis is required to understand these complex relationships.

In practical terms, it is useful to document examples of high quality workplaces and spread their lessons. Workshop participants emphasized the importance of identifying the ‘best practices’ that contribute to improving quality of worklife *for all nurses*. This differs from a competitive approach to best practices often found in the private sector, which pits one organization against another in a quest to become ‘the employer of choice.’ From a public policy perspective, it is in society’s interest to raise the quality floor in all health care workplaces. The process must be collaborative rather than competitive. Otherwise, Canadian health care organizations could end up raiding each other’s staff – which would cause no net gain for the system or for the nursing profession.

Beyond the QWI agenda, the workshop participants addressed is a need for whistleblower protection. This issue arose as participants discussed high-quality professional practice environments that would assure positive client outcomes. They emphasize that whistleblower protection is a shared organizational, professional and provincial/territorial responsibility. It is a major public policy issue, because adequate protection requires jurisdictional legislation. As well, CNA’s code of ethics spells out a nurse’s obligation to report anything that puts patient safety at risk. After extensive discussion, the workshop participants agreed that a starting point would be legal analysis of the effectiveness of existing approaches. A national initiative to support honest and free sharing of information on patient safety is much needed.

To build momentum for the QWI agenda, it may be necessary to publish a report intended to educate professional nurses and employers, tied to a strong communication plan to ensure wide circulation. It would give the context for the QWI initiative, a strong rationale, and tell individual nurses how they can contribute to QWI goals and guidelines for organizations. The report would help to educate the nursing community about the importance of applying the quality improvement philosophy to its work environments. This reflects a basic assumption at the workshop: that creating indicators is an ongoing process that requires continuous improvement through the active engagement of many parties. Strategically, the paper would set out short, medium, long-term QWI objectives.

All workshop participants agreed that creating effective QWIs is an evolving process. There will be opportunities to gain support and move the agenda forward at a variety of nursing and health service conferences, such as the CNA’s 2002 Biennial Convention, the 2002 Licensed Practical Nurse Registrars’ Conference, the 2002 Second Annual National Nursing Conference, the 2003 Canadian Practical Nurses Association Biennial Conference, and the 2003 Nursing Leadership Conference. Several participants also called for a national nursing summit to study quality of worklife issues. In these and other initiatives, the Canadian Nurses Association can continue to take a strong leadership role. Beyond what one workshop participant labelled “this nurses call to action,” it will be critical to engage other stakeholder groups in the process.

Canada's regulated professional nursing community has articulated a vision of the ideal professional practice environment as a beacon for the future. With this vision to illuminate the task, an incremental approach to improvements in nurses' work environments may not seem so daunting. Nurses, healthcare service organizations and clients will all benefit from moving in this direction.

Appendix 1
List of Workshop Participants

Group	Representative
Health Canada, Office of Nursing Policy	Michael Villeneuve
Canadian Council on Health Services Accreditation	Elma Heidemann
Academy of Canadian Executive Nurses	Diane Stephenson
Alberta Association of Registered Nurses	Donna Hutton
Canadian Association for Nursing Research	Riek van den Berg
Canadian Federation of Nurses Unions	Pauline Worsfold
Canadian Healthcare Association	Evelyn Schaller
Canadian Nurses Association	Sharon Nield
Canadian Nurses Association	Janet Mann
Canadian Nurses Association	Leslie Patry
Canadian Nurses Association	Lucille Auffrey
Canadian Nurses Association	Norma Freeman
Canadian Nurses Association	Joni Boyd
Canadian Nursing Informatics Association	Lisa Little
Canadian Practical Nurses Association	Ann Mann Verna Holgate
College of Nurses of Ontario	Eric Doucette
College of Registered Nurses of Manitoba	Marta Crawford
College of Registered Nurses of Nova Scotia	Julie Gregg
Nurses Association of New Brunswick	Ruth Rogers
Nursing Practice Resource Group	Pat Thornton
Nursing Practice Resource Group	Janet Carr
Registered Nurses Association of British Columbia	Wendy Winslow
Saskatchewan Registered Nurses Association	Donna Brunskill
University of Toronto's Nursing Effectiveness, Utilization and Outcomes Research Unit	Linda Lee O'Brien-Pallas Donna Thomson

Appendix 2
Workshop Recommendations for Quality of Worklife Indicator Measures

QWI Dimensions and Indicators	Suggested measures for 2004 AIM Program	Suggested measures for Development or Use Where Available
<p>Leadership and culture</p> <ul style="list-style-type: none"> ▪ Span of control ▪ Leadership ▪ Value and respect ▪ Influence in decisions 	<ul style="list-style-type: none"> ▪ average number of direct-reports for each nursing supervisor ▪ corporate nursing leader at senior level (e.g., Vice President) with budget line responsibility 	<ul style="list-style-type: none"> ▪ percent of nurses scoring at the positive end of a Likert-type assessment scale on staff survey items. E.g.: ‘being valued by your employer’; ‘being treated with respect by management’; ‘a workplace culture that values the contributions of nurses’; ‘being treated with respect by other professional staff’; ‘being treated with respect by non-professional staff’ ▪ descriptive inventory of formal mechanisms for nursing staff participation in strategic planning, nursing practice standards, other practice issues in including staffing, on multi-disciplinary planning teams (including details of mandate, consultation process, number of nurses participating, and frequency of meetings)
<p>Control over workload</p> <ul style="list-style-type: none"> ▪ Overtime hours ▪ Use of full-time, part-time and casual staff ▪ Workload ▪ Peer competence 	<ul style="list-style-type: none"> ▪ percent of total nursing staff earned hours that are overtime hours ▪ percent of total nursing staff earned hours that are full-time, part-time and casual, reported annually 	<ul style="list-style-type: none"> ▪ nurse-to-client ratio broken down by unit and reported monthly (preferred) or annually ▪ percent of nurses scoring at the positive end of a Likert-type assessment scale on staff survey items. E.g.: ‘there is a good fit between skills and knowledge of my nursing coworkers and client needs’
<p>Control over practice</p> <ul style="list-style-type: none"> ▪ Autonomy / scope of practice 	<ul style="list-style-type: none"> ▪ percent of nurses reporting in a staff survey that they have adequate control over their professional practice 	

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Resource adequacy <ul style="list-style-type: none"> ▪ Professional development opportunities ▪ Supplies and equipment 	<ul style="list-style-type: none"> ▪ percent of nurses participating in in-service training session and/or off-site education and training programs, with the average number of hours for each type of session, reported annually 	<ul style="list-style-type: none"> ▪ percent of nurses assessing the adequacy of (a) supplies and (b) equipment as 'good' or 'excellent' in annual staff survey
Organizational and individual outcomes <ul style="list-style-type: none"> ▪ Absenteeism ▪ Grievances ▪ Job satisfaction ▪ Stress ▪ Work-life balance ▪ Joint initiatives involving management, unions, professional associations ▪ Turnover ▪ Error rates 	<ul style="list-style-type: none"> ▪ average number of days absent per nurse, reported annually OR absenteeism as percent of total earned hours for nurses ▪ total number of unresolved grievances 	<ul style="list-style-type: none"> ▪ percent of nurses scoring at the positive end of a Likert-type standard job satisfaction measure on staff survey ▪ percent of nurses 'agreeing' or 'strongly agreeing' with the statement "my job is very stressful" on a staff survey ▪ percent of nurses 'agreeing' or 'strongly agreeing' with the statement "my job allows me to balance my work and my family or personal life" on a staff survey ▪ descriptive inventory of joint initiatives involving management and union, or management, union and professional association representatives ▪ percent of nursing staff who left the organization voluntarily (excluding retirements), reported annually ▪ a standard CIHI error rate indicator relevant to the facility

Notes:

- 'Nurses' refer to regulated nursing staff.
- Likert response scales typically have 5 or 7 forced-choice response categories ranging, for example, from "strongly agree" to "strongly disagree".
- It is assumed that organizations will use standardized 12-month reporting periods and provide retrospective trend data.