

What's Ailing our Nurses? A Discussion of the Major Issues Affecting Nursing Human Resources in Canada

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Main Messages

In 2005, the Canadian Health Services Research Foundation commissioned a review of six major research documents on Canadian nursing human resources issues. Following are the key messages from those papers.

- Canada's nursing shortage demands immediate action. The shortage creates a stressful work environment which discourages new recruits and burns out experienced nurses, making the shortage even worse.
- Patients' and nurses' welfares are closely aligned. The nursing shortage jeopardizes the smooth functioning of the healthcare system. It contributes to long waits for medical treatment, and care delayed is often care denied. In some circumstances, the shortage produces compromised workplaces, resulting in needless nurse staff injuries and, sometimes, patient deaths.
- Fortunately, efforts are underway to increase the supply of nurses. Canadian schools of nursing have increased their enrolment. However, forecasters predict that more nursing graduates will not stem the tide of nurses leaving the profession, mainly because one in three nurses is 50 years of age or older and approaching retirement. Therefore, the main focus needs to be on retaining existing nurses rather than on boosting the number of training seats.
- Improving the work environment is the key to retaining existing nurses and attracting new recruits. Nurses need reasonable workloads, supportive management, flexible work schedules, safe workplaces, and opportunities to perform to their full scope of practice.
- There are many ways to address the crisis. Research has produced many practical policy and practice solutions. A few have been put into action. Most wait to be implemented.
- Barriers to implementation are not insurmountable. Overcoming them demands extraordinary co-operation between professional associations and different levels of governments and a dedicated political will.

Executive Summary

This report is intended to generate discussion and direct future initiatives aimed at improving the current nationwide shortage of nurses. It is a review, analysis, and discussion of six major research documents on Canadian nursing human resource issues produced during the last five years.

The questions this report sets out to answer are: What are the fundamental issues behind nursing human resource challenges? What solutions and strategies have been put forward to address them? What areas are being addressed? What areas have not been addressed and why?

Nursing health human resources cover a wide and complex range of topics. For practical purposes, the research divides issues into two main areas — workplace and workforce. Workplace issues include workload, leadership and professional development, scheduling, safety, and concerns about how best to balance professional and personal life. Workforce issues involve education and training, professional identity, scopes of practice, and health human resource planning.

Nursing human resource researchers have identified the nursing shortage as the greatest problem facing nursing human resources, and one that exacerbates other troubled areas. They describe the shortage as “an untenable crisis” that demands “immediate action.”ⁱ The nursing shortage places Canadians at risk because the system is not supplying enough qualified nurses to meet the public’s healthcare needs. That risk manifests itself both in and out of hospitals.

In healthcare institutions, the worsening shortage of nurses combined with inappropriate staffing practices, such as understaffing and excessive overtime, poses a serious threat to patients. Those conditions contribute to what is called “incidents of failure to rescue,” a euphemism for needless patient deaths. “Failure to rescue” refers to a clinician’s inability to save a hospitalized patient’s life when that patient’s condition takes a turn for the worse. Because nurses are often the first to detect early signs of complications — such as elevated temperatures or falling blood pressures — patients’ safety and ultimate survival depend largely on their vigilance. They also depend on nurses’ ability to mobilize hospital resources quickly, including bringing the physician to the bedside.

President-elect of the Canadian Nurses Association, Dr. Marlene Smadu, recently pointed out how the shortage jeopardizes Canadians in another way. Because healthcare comes from a team of health professionals, the nursing shortage contributes to longer waiting times for medical procedures. And, she says, long waiting lists for medical treatment are Canadians’ number one healthcare concern. “If you don’t have enough nurses, you can’t deliver care. So wait times will not be resolved unless we deal with nurses,” Dr. Smadu said.ⁱⁱ As anyone who has been debilitated or in pain while waiting for treatment knows, care delayed is often care denied.

Most stakeholders view increasing nurses’ job satisfaction as the key strategy in addressing the nursing shortage. Nursing today offers limited benefits and many challenges, including heavy workloads, excessive overtime, unpredictable and inflexible scheduling, health, safety, and security concerns, inadequate support from management, less-than-collegial relations with physicians and other healthcare colleagues, and few opportunities for leadership and professional development. These issues strike at the heart of why so many front-line nurses are stressed, disheartened, and on the verge of burning out.

A central health human resource issue is the rapid aging of the nursing workforce, a phenomenon described as a “demographic time bomb.” Because nurses are older now than they used to be upon graduation, they are older at all stages of their career and thus spend fewer years in the workforce. The most immediate concern, however, is that many nurses are teetering on the edge of retirement.

On a more positive note, the research has identified a large number of solutions and strategies aimed at alleviating the current shortage and preventing another. Consequently, there are many creative and practical proposals aimed at ensuring nurses exist in sufficient numbers, are appropriately trained for new models of healthcare delivery, and are equitably distributed across the country.

Furthermore, a few organizations have acted to address some of the factors engendering the shortage. Generally, progress has focused on increasing primary nursing education and nursing resource research, and on policy-level improvements such as establishing chief nursing officers. However, little has been done to address core problems. The vast majority of solutions remains in the realm of ideas. Overall, there is little evidence that front-line nurses are experiencing an improved working life.

Given that scenario, one has to examine why progress on such a critical issue has been so slow and so limited. Major barriers identified by the research include short budget cycles, lack of co-operation between healthcare professionals, lack of a national health human resources policy, lack of accountability, and lack of the right kind of evidence decision makers need in order to act. This last item refers to the fact that governments tend to respond best to two things: perceived fiscal crises or fiscal mismanagement; and perceived threats to the public's health and well-being. Both issues are inextricably linked to healthcare.

However, improving nurses' worklife has not traditionally been linked to patient outcomes or to economics, even though recent research in Canada and the U.S. indicates a greater number of experienced registered nurses in hospitals is associated with decreases in patient complications and death. At a policy level, the research strongly suggests it is time to portray the issues in those terms.

A sense of urgency, unease, and dwindling patience underlies the studies and reports reviewed in this report. "The goodwill displayed by nursing stakeholders is not endless," one researcher says, "and ultimately success can only be measured by whether nurses perceive that their jobs are changing for the better." If nurses continue to perceive that their jobs are not improving they will continue to walk away, leaving remaining colleagues in ever-deteriorating conditions. It will be Canadian men, women, and children who pay the biggest price.

Final Report

What is the Problem?

Canadians are in the midst of a nursing shortage that threatens their well-being. Bluntly put, the public is at risk because the system is not supplying enough qualified nurses to meet Canadians' health needs.

Research shows the shortage encompasses three groups of nurses — registered nurses, licensed practical nurses, and registered psychiatric nurses. Because the vast majority of research deals with registered nurses, this group is more prominently discussed in this report. That emphasis, however, is understandable, given that registered nurses make up 78 percent of the total regulated nursing workforce, licensed practical nurses make up about 20 percent, and registered psychiatric nurses make up just more than 1.5 percent.ⁱⁱⁱ

Research also indicates the nursing shortage can rightfully be viewed as a catch-22 — it exacerbates the very conditions that gave rise to it in the first place. The shortage creates a stressful work setting which discourages new nurses and burns out older nurses, some of whom abandon the profession, thereby causing working conditions to deteriorate even further.

Nursing human resource researchers have described the shortage as “an untenable crisis” that demands “immediate action.”^{iv} On an optimistic note, the crisis has been well-studied, the roots of the nursing shortage are well-understood, and experts in the field have identified many achievable solutions. Furthermore, a few organizations have acted against some of the many factors that engender the shortage. However, most strategies and solutions remain in the realm of ideas.

The federal government has been formally discussing the nursing shortage for eight years. During that time, the shortage has worsened, and all indications are it will continue to do so. For the public, the consequences are serious. Healthcare leaders must put the nursing shortage at the top of the healthcare agenda.

The research provides direction for many players in the nursing human resources field:

- Provincial governments must provide adequate and targeted funding for programs that improve nurses' work environments. They must hold employers accountable for making those improvements and monitor their progress. As well, they must supply employers with stable funding to allow them to make long-term human resource decisions. Governments must also increase funding to institutions that educate nurses. Like the supply of nurses, the supply of nurse educators is diminishing, and there is a need to build capacity to handle the greater number of nursing students.
- The paramount priority of employers is to create quality work environments that attract new recruits and retain experienced nurses. That means hiring sufficient nurses to ensure a reasonable workload, addressing staff mix and full- and part-time issues, and integrating nurses into the organizational hierarchy. Ignoring these needs will result in higher human resource costs and, more importantly, greater risks to patients.
- Unions and professional associations need to support their members by working with government to build quality work environments. That includes arranging creative work schedules and providing members with educational and professional development opportunities.
- Nursing educators must match their course curriculum with the practical and theoretical skills needed in the workplace, thereby ensuring graduates are confident and fully prepared for practice. They must also equip their students with leadership skills and a basic knowledge of how the healthcare system operates.
- Researchers need to concentrate on ways to evaluate strategies aimed at improving the work environment. As well, they need to develop national human resource tools and databases and do

evidence-informed studies on nursing care impact and scope-of-practice issues. Most importantly, researchers need to document how the shortage affects patient care.

Improvements to the healthcare system, however, will not happen without a sincere spirit of co-operation on the part of all stakeholders. Uppermost in everyone's minds needs to be the best interests of patients.

Approach

This report is a review and integration of the following six research documents on Canadian nursing human resource issues. These were identified through consultation with the nursing community as being comprehensive and well-received.

- Nursing Sector Study Corporation. 2005. *Building the Future: An integrated strategy for nursing human resources in Canada*. Phase 1 of the sector study, this is a research synthesis report and the first comprehensive report on the nursing labour market in Canada to date. A large team of researchers used 15 different research steps, including literature reviews, focus groups, interviews, surveys, and secondary data sources to compile and analyse extensive data on registered nurses, licensed practical nurses, and registered psychiatric nurses. Phase two will build on these findings and recommendations to help develop a pan-Canadian health human resources strategy.
- Canadian Medical Association/Canadian Nurses Association. 2005. *Toward a Pan-Canadian Framing Network for Health Human Resources*. This green paper discusses core principles and strategic directions for a pan-Canadian health human resources plan.
- El-Jardali, Fadi and Cathy Fooks, Health Council of Canada. 2005. *An Environmental Scan of Current Views on Health Human Resources in Canada: Identified Problems, Proposed Solutions and Gap Analysis*. Information for the scan was collected through a web site search, letters to selected stakeholders, and a brief review of reports published by stakeholder organizations. It is a background paper for the National Health Human Resources Summit.
- Maslove, Lisa. 2005. *Key and Current Health Policy Issues in Canada*. This brief health policy scan was prepared for the Canadian Policy Research Networks. No methodology was described.
- Maslove, Lisa and Cathy Fooks, Canadian Policy Research Networks. 2004. *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses. A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee*. This is the first report submitted to Health Canada's Office of Nursing Policy and serves as a review of what actions had been taken to implement the Canadian Nursing Advisory Committee's 51 recommendations. Also identified, based on this review, are barriers to implementation. Data were collected in four phases — a scan of relevant web sites; a letter to 94 stakeholder organizations requesting information; interviews with 14 key informants; and a roundtable with 14 representatives from nursing stakeholders. Note that only half the stakeholder organizations responded to the information request. Response rates varied widely, with just more than one-third of employer organizations, almost all unions, and no nursing educators responding.
- Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*. This report is based on a wide-ranging survey of peer-reviewed research, an analysis of grey literature, and transcripts of focus groups and interviews with healthcare administrators, union and professional association representatives, educators, and front-line nurses.

Results

As these reports show, challenges facing nursing health human resources cover a wide and complex range of topics. For practical purposes, the research divides issues into two main areas — workplace and workforce. Workplace issues include workload, leadership and professional development, scheduling, safety, and concerns about how best to balance professional and personal life. Workforce issues involve education and training, professional identity, scopes of practice, and health human resource planning.

The Working Environment:

Caring for the sick and dying has never been easy. But not so long ago, doing so was a secure, respected, intellectually stimulating, and deeply meaningful career. Those days are fading fast. Although providing care to those in need is greatly rewarding for nurses, research shows that nursing today offers limited benefits and many challenges. The challenges include heavy workloads, excessive overtime, unpredictable and inflexible scheduling, health, safety, and security concerns, inadequate support from management, less-than-collegial relations with physicians and other healthcare colleagues, and few opportunities for leadership and professional development.

These issues strike at the heart of why so many front-line nurses are stressed, disheartened, and on the verge of burning out. According to the Canadian Nurses Association, 85 percent of registered nurses work in direct patient care and almost 60 percent work in hospital settings. Overwhelmingly, it is these nurses who feel overworked and undervalued. When asked, many say they may leave nursing in the next year. At the same time, these issues also affect people who are considering but have not yet committed to a career in nursing. The current work environment is frequently named as a major disincentive to choosing a nursing career in Canada.

The research traces many of modern nursing's problems to the cutbacks and restructuring of the 1990s when hospitals closed or reduced staff and numbers of nurses fell. But not all. Issues such as poor relations with colleagues, little control over practice, and ineffective management speak to troubles that arise from far deeper sources. For one, nursing is still viewed as a female-dominated occupation that receives unequal pay for equal work.^v Significantly, just more than five percent of registered nurses are male.

Following is a summary of the aforementioned research on major workplace concerns:

Workload — Heavy workloads are a problem in all healthcare sectors.^{vi} Although there are little data for areas outside acute care, according to the Nursing Work Index, nurses in all groups who work in hospitals and in direct care rate satisfaction with their work as low. Remember, 85 percent of registered nurses work in direct patient care.

Two major factors contribute to this workload — changing population health needs and fewer acute care beds. For example, between 1995 and 2001 — as the population grew — Ontario's acute care hospitals reduced the number of beds by almost 20 percent.^{vii} Along with bed closures came reductions in nurse numbers. However, society did not reduce its demand for healthcare by an equivalent amount. For various social, cultural, epidemiological, and demographic reasons, Canadians' improved health status has not translated into fewer demands for healthcare. To the contrary, greater numbers of seniors living longer lives than ever have put enormous pressures on hospital bed supplies. The upshot is that today's hospital patients tend to be older and more acutely ill than they were just a decade ago.

“Inadequate numbers of nurses were employed in acute care hospitals to provide the increased intensity of care required to support the policy of bed reductions while striving to continue to meet the health care needs of the population,” say the writers of *Building the Future*, the first comprehensive report on the state of nursing human resources in Canada. In other words, fewer nurses are looking after sicker patients.

Senior nurse managers report that the lowest nurse-per-patient ratios are found in long-term care. Here, caseloads for licensed practical nurses, registered nurses, and registered psychiatric nurses are so large they must delegate some care to unregulated workers.^{viii}

Sadly, one of the only ways senior nurse managers and chief executive officers of hospitals cope with the shrinking nursing labour market is by overusing the nurses they have. That means having nurses work overtime and extra shifts, sometimes involuntarily. While 80 percent of surveyed CEOs report that doing so benefits their healthcare facility, at least in the short term, that move does not benefit nurses.^{ix} Studies show working excessive overtime increases absenteeism, illness, and injury and burns out nurses more quickly.

Most importantly, overworked nurses do not benefit patients. Nurses in Canada, the United States, the United Kingdom, and Sweden report that work pressures are detrimental to patient care.^x And there is solid evidence to back them up.

A 2004 study^{xi} found that hospital nurses working more than 12.5 hours at a time are three times more likely to make mistakes, including medication errors. In fact, errors increase significantly when nurses work overtime or when they work more than 40 hours a week.^{xii} In addition, according to the study, when nurses cannot do or are delayed from doing their duties, medical incidents such as falls or medication errors can result. Such incidents are most frequent in the long-term care sector.

Heavy workloads also affect the way nurses see the quality of their work. Additional work stress brings on time pressures, contradictory demands, interruptions, need for intense concentration, skill and knowledge deficits, and insufficient or unavailable resources.^{xiii}

Studies show that more experienced nurses are least likely to rate the quality of their nursing care as good or excellent.^{xiv} That's partially because older, more experienced nurses expect to incorporate mentoring and administration as well as patient care into their clinical practice. Nurses must be able to do their jobs well. Only those who can complete their duties in a timely manner believe their nursing care is good or excellent. Those who work on wards having more patients per nurse than they should are not likely to rate their care highly.^{xv} Not surprisingly, hospital nurses do not often rate patient care as improved over time.

Numerous studies have found that low nurse-patient ratios lead to complications such as higher infection rates and poorer patient outcomes. Nurses responding to the Canadian Nursing Occupational Group survey reported that workloads were so onerous they could not provide patients with adequate care.^{xvi} Obviously, patients' and nurses' well-being are closely aligned.

Any discussion of workload issues raises the question of whether workloads can be accurately measured. So far, workload-measurement systems have failed to arrive at an accurate assessment of what nurses do. Instead of focusing on the medical and nursing complexity of patients, the characteristics of nurses providing care, and on the care-giving environment, measurement systems have focused only on basic nursing tasks. The result is insufficient recognition and measurement of and compensation for nursing effort and expertise.^{xvii} What is clear from the research, though, is that current workloads, however measured or not measured, are too high for nurses.

However, a recent study by the Canadian Federation of Nurses Unions on formal nurse-patient ratios indicates they act as a tool for matching available nursing human resources and patient care demands and are focused on attending to quality of care issues. In some jurisdictions, nurse-patient ratios also serve to retain and recruit nurses.^{xviii}

Health, safety, and security concerns — The reports studied show long hours of work and heavy workloads are taking their toll. Nurses are suffering mental and physical exhaustion, injury, and ill health. Far too often, that means being too sick to go to work. A wealth of research across occupations indicates that long periods of job strain harm personal relationships and increase sick time, conflict, job dissatisfaction, turnover, and inefficiency.

Between 1997 and 2002, the absenteeism rate for registered nurses increased by more than 16 percent; each year in that period, the rate among full-time nurses was about 50 percent higher than among part-time workers. In 2002, the absenteeism rate for full-time registered nurses was 83 percent higher than the general labour force.^{xix} The costs to the system are enormous. According to a 2002 Canadian Business and Labour Centre study, wage costs for absent registered nurses add up to an estimated \$325 to \$440 million per year.^{xx}

In the nursing sector study, absence from work was defined as absence due to short-term illness for five or more days a year. And nurses who work overtime are more likely to be absent from work than those who do not work overtime. Overtime workers were also more likely to make a worker's compensation claim. As well, nurses who experience violence at work are more likely to be absent. Interestingly, both licensed practical nurses and registered psychiatric nurses are more likely to take absences than registered nurses.^{xxi} Also interesting is that nurses working directly with patients — the vast majority — are less likely to be physically healthy than their counterparts who don't.

Research shows that job stress increases the risk of musculoskeletal injury, accidents, physical and mental illness, substance abuse, and smoking. Ironically, healthcare workers suffer more musculoskeletal injuries than other occupational groups. Nurses hurt their backs when the units they work on are short-staffed and they must lift patients by themselves. Fluctuating staff levels also affect nurses' risk of needlestick injury, with one study finding that needlestick rates are lower in magnet hospitals — institutions where staffing is stable.^{xxii} According to Statistics Canada, nurses' job-related injuries are more costly than those of high-risk occupations such as firefighters, police officers, and transportation workers.

Research indicates that heavy workloads contribute to job strain.^{xxiii} Consequently, short-term increases in productivity often result in long-term health costs. Registered nurses in most clinical units in Ontario — especially those in emergency and medical-surgical units — work at intensities that can harm their health. In fact, the study notes an almost perfect correlation between the hours of overtime worked and hours taken as sick time. Heavy workloads also explain why full-time nurses have higher rates of absenteeism than part-time or casual nurses, regardless of the total number of hours worked.

Experiencing violence in the workplace — defined as physical assault, verbal aggression, threat of assault, or emotional abuse — also affects whether nurses are absent from work.^{xxiv} Perpetrators may be colleagues, other professionals, or patients and their families. Although it is difficult to know exactly how prevalent violence is at work, a survey of selected Alberta and B.C. hospitals reported that 38 percent of nurses experienced hurtful remarks, humiliation from co-workers, or coercion. Risks of violence in all settings are increasing and understaffing may be a factor — for example, longer waiting times in emergency departments are linked with attacks on staff. Over-worked nurses — those working more than 40 hours a week or working overtime — are most likely to report incidences of violence. Broken down by occupational group, registered psychiatric nurses are more likely to experience violence than registered nurses and licensed practical nurses.^{xxv}

Ineffective management — Like other professionals, nurses need to feel their work is supported and actively monitored by supervisors, managers, and employers. Studies show that those who do feel this are more committed, less insecure, and more satisfied with their career. However, evidence from the field indicates that the commitment of many nurses to their organizations is waning, partly because they see managers and employers as unsupportive. During focus group sessions individual nurses described their managers as “ineffective leaders, not respectful of nurses, unsupportive, and having little nursing experience.”^{xxvi}

Those feelings are grounded in several realities. During restructuring, for instance, employers dismissed many chief nurses and head nurses, leaving front-line nurses with less support and guidance. As well, budget limitations meant management was often forced to compromise human resources over equipment and fiscal resources. This move diminished nurses' job satisfaction, health, and safety, as well as patients' satisfaction with their care. Although research on nursing management strategies is limited and most often focused on the hospital sector, what research there is reveals some disturbing trends. CEOs and senior nurse managers have different priorities when managing nurses: cost restraints came first with CEOs,

whereas quality of care concerns rated first with senior nurse managers. Still, despite their focus on cost, 63 percent of CEOs state that nursing staff levels were so low they became concerned about patient safety. Paradoxically, in their efforts to cope with the nursing shortage, managers often make decisions that create the very conditions driving nurses out of the field.^{xxvii}

Relations with other professionals — How nurses are treated by and interact with other healthcare professionals can make the difference between a pleasant and unpleasant work environment. But there's more to teamwork than just getting along. When it comes to relations between nurses and physicians, smooth collaboration has been shown to improve patient outcomes.^{xxviii} Interestingly, the most effective nurse-physician working relationships are reported by nurses in the north and the least effective in Ontario. Also, nurses in community services report having the least successful relationships with physicians compared to nurses in other sectors. Better relationships are found when nurses stay in their position longer, have more autonomy, more resources, or are more empowered.^{xxix}

Leadership and professional development — Nurses need strong leadership at every level of the healthcare system hierarchy. That means ensuring that nursing leaders supervise nursing practice at the bedside. It also means promoting nurses to policy-making and decision-making positions. Limiting nurses' participation is not only inefficient, it can be tragic. For example, the Manitoba Pediatric Cardiac Surgery Inquest into the deaths of 12 children found that nurses' serious and legitimate concerns were ignored and that they were never treated as equal members of the surgical team.^{xxx}

Studies show that good leaders can increase group cohesion and go a long way to relieving job stress. As well, leadership which empowers nurses has many benefits, including reducing nurses' risk of violence and reducing nurse turnover. Sadly, little of that kind of supportive direction appears to exist. Restructuring severely damaged nursing leadership by doing away with many head nurses, chief nurses, and unit managers. That move left nurses with few opportunities for promotion and little disciplinary guidance. Nurses in the restructured workplace are often supervised by non-nurses. This can lead to problems such as unreported poor practice. Particularly worrisome is the fact that registered nurses have repeatedly expressed concern about the clinical preparation and competency of newly graduated nurses.^{xxxi} When mentoring is inadequate or in short supply, nurses are even more concerned that patients are at risk.

Professional development is vital to any strategy aiming to produce a sustainable supply of qualified nurses. As professionals in a research-oriented field, nurses need to continually acquire new knowledge and learn new skills. However, nurses report that there is little support for continuing education in the workplace. Again, during restructuring, managers decreased their support for continuing education. Studies show mentoring and evaluation of junior nurses is scarce. Resources for professional development have been cut. Even when in-service sessions are offered, nurses often find it difficult to attend them because there is nobody available to replace them. Training in new technologies for patient care is vital, as research shows that technological training from employers enhances nurses' use of technology, confidence, and work satisfaction.^{xxxii}

Work-Life Balance — When it comes to a balance between professional and personal life, Canadian society has undergone nothing less than a sea change. Gone are the days when nurses happily worked however long and whatever days or nights their employers wanted. Modern and healthy workplaces allow workers some control and flexibility over their working life. But as the nursing shortage grows, nurses are pressured into working beyond their normal shifts. Nurses report that some of their colleagues use call display to screen calls to avoid working unscheduled shifts. The situation is further complicated by the mix of full-time, part-time, and casual nurses, the latter finding themselves in more demand than ever. Nursing always had some degree of work choice, but the current situation is so nurse-unfriendly, many nurses cannot find their particular work preference. Some who work full-time would rather work part-time, and younger nurses who need to work full-time to pay off educational loans often emigrate because they are offered only part-time jobs.^{xxxiii}

While having most nurses work full-time may benefit healthcare teams, decrease orientation costs, and increase continuity of patient care, these days it may not be best for individual nurses. Close to half of all registered nurses do not work full-time. Although that is far short of the Canadian Nurses Association's

goal of having 70 percent work full-time, surveys reveal that the number one reason nurses don't work full-time is because they don't want to.^{xxxiv} Other reasons include not finding full-time positions, family demands, and lack of flexible work hours. Registered nurses report being overwhelmed by family responsibilities and full-time work more often than other nursing groups. Registered psychiatric nurses are most likely to work full-time, while licensed practical nurses work the highest number of casual hours. All three groups report operating in "chaotic" environments where work hours change frequently.

The Nursing Workforce

How many nurses are currently in practice? How many will Canada have in the year 2012? And what is the nature of the work nurses do? These questions are workforce issues. They deal with predicting the supply and mix of nursing professionals, planning for future population health needs, regulating scope of practice and entry to practice, and education and training.

Professional identity, scope of practice, and control over practice — Traditionally viewed as a workforce concern, these topics relate to both workplace and workforce. They neatly illustrate the interdependence and overlap between professional and occupational concerns.

Professional and legislative bodies determine what nurses are educated, trained, and legislated to do. Yet what happens in reality, such as how much say nurses have over their practice, is shaped to a large extent by where they work. Their scope of practice depends on a number of workplace conditions, including their employer, the staff mix, their relationships with co-workers, the quality of leadership, geography, and necessity. For example, outpost nurses in the Yukon have a much larger scope of practice than nurses in a walk-in clinic in downtown Toronto, even though both are registered nurses. Research also shows responsibilities vary not only between jurisdictions but between institutions.

Complicating this already multifaceted scenario is the nursing shortage, which places heavier-than-usual demands on a healthcare workforce often stretched to the limit. The outcome is that registered nurses and licensed practical nurses often work above and/or below their regulated scope of practice. On the one hand, they often perform non-nursing duties such as answering telephones, collecting meal trays, and scrubbing bathtubs. On the other, they are often restricted from doing tasks for which they are fully qualified and regulated. In yet other circumstances, nurses may be working above their legal scope and therefore placing themselves at legal risk.^{xxxv}

Several studies find that licensed practical nurses feel the least empowered of the three groups, as do nurses who work in long-term care.^{xxxvi} Generally, nurses feel less empowered when they work in direct care, when they anticipate instabilities at work, or when they have a diploma or certificate rather than a degree.

Part of the reason for this under- and over-utilization of nurses is a sense of confusion as to who can do what. New technologies and huge organizational change have created confusion between the roles of registered nurses and licensed practical nurses, causing tension between the two groups. Overlap and professional confusion also exist between nurse practitioners and family doctors. This can sometimes lead to turf wars.

The precarious situation of nurse practitioners in Canada speaks directly to empowerment, scope of practice, and professional identity issues. There are close to 1,000 registered and practicing nurse practitioners in Canada, and their numbers are growing. Yet in many places nurse practitioners encounter resistance. For instance, the Ontario government has failed to make full use of nurse practitioners, who have difficulty finding positions despite a legal and regulatory framework passed in 1997 and research that supports their effectiveness. While they are funded to practice independently in isolated areas, few find work in urban centres even in places where there is a shortage of family doctors. Likewise, in Prince Edward Island, a pilot project for nurse practitioners recently collapsed amid professional mistrust over the nature of the doctor and nurse roles. The Collaborative Practice Demonstration Project at Beechwood Family Health Centre in O'Leary, P.E.I. ended when doctors refused to work with nurse practitioners. Dr.

Herb Dickieson, president of the province's medical society and one of the doctors who opposed the nurse practitioner program, said nurse practitioner duties intrude on the traditional role of the physician.^{xxxvii} However, not all doctors were opposed, including two who were part of the project.

Like other professionals, nurses work best when they have a sense of control over their work. That means having the freedom to act independently to the full scope of their training. Nurses need to know that their care of patients is in keeping with the standards and guidelines established by their profession. Those standards include acting as patient advocates and subscribing to a holistic philosophy of care — not easy to do in a system long dominated by a medical model of care. Nurses also need to feel their skills are recognized and valued. During restructuring many nurses were moved to positions without consideration for their specialist knowledge. Even now, nursing qualifications are often not specified in job postings. Researchers see this omission as a waste of expertise.

Nurses who practice to their full scope and who have control over their work identify strongly with their profession. They say they find their chosen career meaningful and satisfying. Unfortunately, such nurses are in the minority. If recommending nursing as a career is an indication of job satisfaction, then more than half of nurses are not happy with their choice of profession.^{xxxviii}

Nurses In, Nurses Out, Out, Out — Nursing human resource planning aims to predict and control the nursing supply. Its goal is to have an adequate nursing supply to meet the present and future health needs of Canadians. Influencing factors include the production of new nurses, career and migration paths, and the aging workforce. Given the fluid nature of the nursing workforce, however, planning is at best a predictive endeavour. The task is hampered by a lack of reliable labour market data. Researchers emphasize that sources of routine data such as population health needs, staffing mix, and career patterns are poorly developed in most provinces and territories and thus cannot be compiled for national studies. Getting a national perspective on nursing resource planning would also require conducting research across provincial and territorial boundaries, professional lines, and government departments — an initiative currently being considered at the federal level. The green paper by the Canadian Medical Association and the Canadian Nurses Association proposes the establishment of a Canadian Coordinating Office for Health Human Resources.

Increasingly, healthcare professionals live in a global workplace. Trends in world migration show that nurses, like other immigrants, move from less- to more-developed regions. Canada experienced an increase in nurse immigration, with about seven percent of registered nurses in 2003 coming from other countries, primarily the United Kingdom and the Philippines.^{xxxix} Within Canada, inter-provincial migration is not a big concern, although the urban-rural imbalance is. Most registered nurses and licensed practical nurses stay in their province of graduation. Registered nurses, however, are slightly more mobile, with Alberta, B.C., Nova Scotia, and Ontario having the highest immigration rates. Interestingly, while higher salaries are not reported as a major reason for migration, the provinces where nurses earn the most had the highest rates of migration. Most nurses who move are younger than 25 years of age. Research shows that although provincial strategies aiming to attract nurses from other provinces or countries may alleviate the shortage temporarily, they are neither sustainable nor ethical.

The good news is that Canada is training more nurses, at least registered nurses. Many universities and colleges have increased training spots for registered nurse students. However, increased enrolments in licensed practical nurse programs were predicted to end in 2005 because of funding shortages which limit schools' ability to hire faculty.^{xl} There are no reported findings from registered psychiatric nurse education programs.

The bad news is that retention rates in schools are low, with a few schools reporting that they only retained 20 percent of their students. More than half the schools offering registered nurse programs reported insufficient resources for the number of students enrolled. A shortage of clinical placements in acute care and community settings also limited schools' ability to expand their enrolments. Shortages of faculty prepared at the master's and PhD levels continued due to low enrolments in graduate training programs. On another educational note, nurses are now more likely to graduate with a university degree. Although this

may give them professional advantages, it also equips them for more career options in case they fail to find nursing rewarding.

Canada can take a little comfort in the fact that it had slightly more practicing registered nurses in 2004 than in 1998 — 246,575 versus 227,814.^{xlii} Research and simulated forecasting suggests that it takes years before increasing nursing training seats has a serious impact on supply. That's partially because the gains made by new graduates are often eroded by more experienced nurses leaving the profession. The focus, therefore, needs to be on retaining existing nurses rather than on just boosting the number of training spots.

Researchers say the most serious nursing human resource issue is the rapid aging of the nursing workforce. It is a phenomenon sometimes called a “demographic time bomb.” Because nurses are older upon graduation now than they were 20 or 30 years ago, they are older at all stages of their career and thus spend fewer years in the workforce. The most immediate concern, however, is that many nurses in all three occupational groups are teetering on the edge of retirement. Substituting one nursing group for another or for other health professions won't work. Nurses cannot be mixed and matched.

The average age for registered nurses is 44.6, compared to 44.4 for licensed practical nurses and 46.6 for registered psychiatric nurses.^{xliii} One in three nurses in Canada is 50 years of age or older. Given that most nurses retire in their mid-fifties, a large number will almost certainly leave the profession in the next 10 years. By 2006, assuming a registered nurse retirement age of 55, Canada could lose up to 64,000 practicing registered nurses. Such a drop would seriously compromise the ability of the healthcare system to meet patient needs.

Interestingly, this approaching crisis is unique to our time and place. It is the legacy of a past which saw large groups of same-age nurses enter and exit the workforce at the same time. Chances are future age distributions will be younger and less clustered around the latter years.^{xliii}

Common themes and differences

Nursing human resource research is a broad and complex subject, touching on topics such as demographics, training and education, public policy, and provincial-federal arrangements. Yet the research reviewed in this report covers familiar territory, repeatedly focusing on a few core themes. Running through all the research is the severity of the shortage. Canada's lack of nurses is described by some researchers as an “untenable crisis” that requires “immediate action.”^{xliv} Others call it a “quiet crisis.”^{xlv} Survey respondents of yet another project state that “action must be taken quickly.”^{xlvi} The joint green paper of the Canadian Medical Association and Canadian Nurses Association puts the situation this way:

“The seriousness of Canada's health workforce situation is highlighted by a comparison to other countries. ...In the case of nursing, a 2004 OECD study reported that Canada had the highest relative nursing shortage of the 6 countries examined...”

Research consistently targets the stressful conditions of nurses' work environments as the key factor influencing nurses' decisions to stay in the profession or not. No doubt that is why the final recommendations of the Canadian Nursing Advisory Committee gave priority to improving the quality of nurses' working life.^{xlvii}

Another shared theme is a concern about how the shortage affects patients. While not everyone agrees that improving nurses' working conditions will automatically improve patient care, a strong and growing body of research indicates that the shortage compromises the ability of the healthcare system to meet its mandate of providing Canadians with quality healthcare.

Although research areas overlap, each report has its distinct range and focus. Two documents examine, in much detail, the nature and quality of the work environment and how those conditions affect nurses. The

Canadian Health Services Research Foundation's 2001 report *Commitment and Care* also looks at how those problems could possibly be addressed.

Other research focuses on barriers to change and on why progress in addressing these well-known problems has generally been slow and limited. The progress report on implementing the recommendations of the Canadian Nursing Advisory Committee focuses on factors at the policy level that either hinder or facilitate implementation. The Health Council of Canada's environmental scan concentrates on key policy positions of various stakeholder organizations and governments.

Key policy positions

Different groups in the healthcare system have different views on nursing human resources. For instance, there is no clear agreement on entry-to-practice requirements for nurse practitioners — some jurisdictions require a master's degree while others call for a post-registered nurse certificate and still others want a post-baccalaureate diploma. On this and many other issues, those responsible for funding, regulating, representing, employing, educating, and training nurses must find common ground. Without an as-yet-unseen amount of collaboration and co-operation, the nursing shortage will worsen. In the summer of 2005, in preparation for the National Health Human Resources Summit, the Health Council of Canada produced an environmental scan of the current views of certain stakeholders on health human resources. Although researchers found varied perspectives on the nature and scope of the nursing shortage, they also found that all healthcare stakeholders agree that something must be done. That was the easy part. The hard questions now are what to do and how best to do it.

Here are the policy positions of key nursing stakeholder organizations in relation to four theme areas:

1. Education and training

The **Canadian Nurses Association** and the **Canadian Association of Schools of Nursing** believe that a baccalaureate degree in nursing should be the standard educational requirement for Canadian registered nurses. Responsibility for supporting this requirement, they say, is shared by individual nurses, nursing regulatory bodies, nursing organizations, employers, educational institutions, and governments. But governments, they say, are specifically responsible for funding the conversion of diploma programs to baccalaureate programs; providing enough nursing education seats to meet population health needs; and fostering collaboration between the nursing community and ministries of health.

These two groups also support the flexible delivery of nursing education programs at the baccalaureate, master's, doctoral, specialty, and continuing education levels.

As for nurse practitioners, the Canadian Nurses Association recommends that government, policy makers, employers, unions, regulatory bodies, nursing organizations, educators, and other health professionals work together to establish a national framework which would guarantee a co-ordinated approach to effective integration of nurse practitioners into the system, facilitate competency verification, enhance labour mobility for nurse practitioners, strengthen education, and foster research that contributes to evidence-informed practice. In March, the Canadian Nurse Practitioner Initiative will recommend entry-to-practice criteria for nurse practitioners in Canada.

The Canadian Nurses Association supports the development of new ways to expand nurses' clinical experiences. These avenues include finding out how to maximize current clinical and education resources as well as carrying out research on the effectiveness of inter-professional education in terms of improved patient, provider, and system outcomes. The Canadian Nurses Association supports collaborative teams and inter-professional education. Currently, it points out, there is a lack of evidence that interprofessional education will generate effective collaborative practice. Yet there is evidence that effective interdisciplinary primary healthcare teams improve outcomes, promote quality care, and improve access to the appropriate provider at the appropriate time and thus decrease unacceptable waiting times. The Canadian Nurses

Association says nurses need to have the knowledge and training to work effectively in collaborative, patient-centred teams.

2. Scopes of practice

The Canadian Nurses Association, the **Canadian Medical Association**, and the **Canadian Pharmacists Association**, believe that any policy relating to scope of practice must put patients first. Among other things, this means ensuring patients have a competent professional to co-ordinate their care and giving patients a choice of healthcare provider. At the same time they say there is a critical need for legislative and regulatory changes to support evolving scopes of practice. Health professionals, they believe, must be involved in decision-making in this area.

The **Canadian Nurses Protective Society** is a non-profit society that offers legal liability protection related to nursing practice for registered nurses. It notes there is currently no legislated title common to all Canadian jurisdictions to identify registered nurses with a legislated extended scope of practice. The society is concerned about patient safety concerns in situations when staffing is reduced to levels nurses consider unsafe. It is also concerned about nurses' ability to provide safe care when they are required to work excessive overtime, including double shifts. In a joint statement with the **Canadian Medical Protective Association**, the Canadian Nurses Protective Society says all members of the healthcare team and the institution or facility where they work should have appropriate and adequate professional liability protection.

The Canadian Nurses Association believes that nurses must be allowed to practice to the full scope of their education and experience. Also, it says nurses at all levels must be involved in decision-making affecting nursing practice, patient care, or the work environment. That includes allowing registered nurses to determine how and when unregulated healthcare workers can safely assist in tasks associated with nursing care. At no time, says the association, should the safety of patients be compromised by substituting less-qualified workers for registered nurses.

3. Workplace Issues

Four years ago, the Canadian Nurses Association stated that nurses have a duty to demand work environments that are conducive to safe, competent, and ethical nursing practice. They went on to define such environments as those which meet nurses' needs and goals while at the same time helping patients meet their health goals. These conditions must exist within the cost and framework mandated by the organization where the nursing care is provided. Given this obligation, the association says, policies must be enacted that promote health, safety, and personal well-being of nurses. These policies include zero tolerance for workplace violence; up-to-date, well maintained equipment and enough space to meet the needs of patients; and a flexible work schedule that allows nurses to balance their personal needs with the organization's needs.

The Canadian Nurses Association's biggest concern, however, is for patients and how they are affected by the nursing shortage. Two years ago it said the worsening shortage of registered nurses, combined with inappropriate staffing practices such as understaffing, poses a serious threat to patients. Those conditions, it concludes, contribute to what it calls "incidents of failure to rescue," a euphemism for needless patient deaths. The term "failure to rescue" refers to a clinician's inability to save a hospitalized patient's life when that patient's condition takes a turn for the worse. Because nurses are often the first to detect early signs of complications — such as elevated temperatures or falling blood pressures — patients' safety and ultimate survival depend largely on their vigilance. They also depend on nurses' ability to mobilize hospital resources quickly, including bringing the physician to the bedside. Yet, in any setting, the quality and quantity of nursing surveillance depends on management's hiring and staffing decisions.^{xlviii}

More recently, Dr. Marlene Smadu, the president-elect of the Canadian Nurses Association, pointed out that patients suffer in yet another way. Because healthcare comes from a team of health professionals, the nursing shortage contributes to longer waiting times for medical procedures. "If you don't have enough nurses, you can't deliver care. So wait times will not be resolved unless we deal with nurses," Dr. Smadu

said.^{xlix} As anyone who has been debilitated or in pain while waiting for treatment knows, care delayed is often care denied.

The Canadian Nurses Association supports several solutions arising from the 2005 Nursing Sector Study *Building the Future*. They include making staffing decisions based on evidence-informed practices; maximizing nurses' ability to work to their full scope of practice; and implementing effective mechanisms to address workload issues.

4. Nursing Human Resource Planning

In a 2002 briefing to the House of Commons Standing Committee on Finance, the Canadian Nurses Association laid out its position on health human resource planning. It believes the federal government must lead the development of a pan-Canadian health human resource framework within which provincial and territorial governments can co-ordinate their plans for recruiting and retaining healthcare workers. The framework would be based on principles such as interdisciplinary practice, needs-based care, and using health providers to their maximum capability.

The association also wants the federal government to create an Institute of Health Human Resources. This group would conduct research on productivity and organization of health human resources, provide support for nursing education and capacity-building, facilitate access to continuing education, and co-ordinate incentives to attract health professionals to rural and remote areas.

In a previous position statement, the Canadian Nurses Association said registered nurses and other health professionals need information on how nursing practice affects patient outcomes. A co-ordinated system that collects, stores, and retrieves nursing data is essential for health human resource planning and for developing knowledge on quality nursing care.

Proposed Strategies and Solutions

If there is a bright spot anywhere in this dark scenario, it is the large number of solid solutions and strategies proposed to address the current nursing shortage and prevent one in the future. A wealth of research into the causes of the crisis has produced many creative and practical ideas aimed at ensuring nurses exist in sufficient numbers, are appropriately trained for new models of health delivery, and are equitably distributed across the country. Proposals range from increasing the number of nurse training seats to improving education and maximizing scope of practice to improving working conditions. Canadian healthcare researchers know a lot about many aspects of the nursing world.

Most stakeholders view increasing nurses' job satisfaction as the key to solving the nursing shortage. That is why the action-oriented Canadian Nursing Advisory Committee gave priority to improving the quality of worklife for nurses. The committee's 51 recommendations were based on a review of a large body of evidence on nursing life as well as six commissioned projects.¹

The Quality of Nursing Worklife model^{li} is a useful framework for visualizing forces inside and outside the workplace that influence the well-being of nurses and, ultimately, their patients. Internal influences affect the workplace. They include administration and organizational policy, the physical and social work environment, and other factors relevant to individual nurses. External factors involve the workforce. They include healthcare policy, the nursing labour market, and public demands on the healthcare system.^{lii}

The following solutions proposed by the research are organized into the workforce and worklife issues previously discussed.

Worklife

Workloads

Heavy workloads, excessive overtime, and unpredictable work schedules are major sources of stress for front-line nurses. Managers can help by ensuring a fit between nurses' needs and the demands of the job. They can:

- hire more nurses;
- create senior nursing positions, which would allow bedside nurses to concentrate on patient care;
- hire more clerical staff and personal care attendants;
- convert casual and float positions to new full-time positions; and
- retain older nurses by providing work options such as phased-in retirement plans, which allow them to work part-time without negatively affecting their pension benefits.

Health and Safety

Many injuries and much illness are related to heavy workload, so strategies that decrease workload can result in a healthier workforce. So can maintaining equipment and supplies at adequate levels. Ways to decrease risk of violence in the workplace include:

- firm policies on abusive behaviour;
- using volunteers to provide personal contact for patients frustrated with delays;
- safe parking spots for staff;
- lifeline buzzers for community nurses;
- more support for staff dealing with patients and families; and
- counselling services and procedures for reporting abusive behaviour.

Management

CEOs, nurse managers, supervisors, and others must give nurses the social support they need. They can:

- concentrate on patients' needs rather than their own;
- offer nurses excellent working conditions in return for high standards of work; and
- hire middle managers to facilitate relations between all workers.

Relations with other healthcare professionals

Better communication and closer relations with team members help reduce job stress. Managers can:

- re-establish regular team meetings; and
- encourage frequent informal communications and activities among members of the healthcare team.

Leadership and Professional Development

Mentoring, continuing education, and opportunities for career advancement are all ways nurses can pursue lifelong learning. Employers can:

- reinstate head nurses and chief nursing officers;
- allow nursing practice committees to address nursing concerns;
- provide resources for educational and professional development;
- provide working nurses with replacement staff so they can take advantage of continuing education sessions;
- offer career options in both clinical and bureaucratic settings; and
- re-establish performance evaluation and mentoring in nursing teams.

Work-Life Balance

Employers, other healthcare workers, and patients benefit when nurses achieve a balance between their professional and personal lives. Human resource managers and employers can:

- allow nurses to work full-time but with hours that suit their lifestyle;
- offer part-time workers similar benefits to full-time staff;
- introduce flexible scheduling or self-scheduling options where possible;
- ensure nurses can take breaks in their workday; and
- establish child care, elder care, and 24-hour cafeteria services.

Workforce

Professional Identity, Scope of Practice, and Control over Practice

Nurses who feel valued, empowered, and involved in their work are more committed to their profession. Healthcare leaders can:

- allow nurse practitioners to practice independently wherever they are needed and within their scope of practice;
- find a way for nurses to progress in their careers without abandoning patient care;
- recognize significant achievements by nurses;
- include licensed practical nurses and registered nurses in job designs for healthcare aides;
- allow nurses to participate in patient-care decisions related to their practice;
- allow nurses to participate in policy-making decisions that relate to patient care;
- recognize nurses' specialist knowledge when advertising for clinical positions; and
- clarify roles of regulated and unregulated nursing staff.

Nursing Human Resource Planning

Federal and provincial governments can work together to:

- establish a pan-Canadian health human resources strategy;
- ensure stable funding that permits long-term planning and the creation of a more stable system;
- educate and graduate more nurses;
- assign adequate funds for nursing needs, such as hiring sufficient nurses and support staff and professional development;
- set rules for employers on how they use nursing funds and then enforce those rules;
- change policies to ensure equal pay for work of equal value; and
- retain older nurses by providing work options such as phased-in retirement plans, which allow them to work part-time without negatively affecting their pension benefits.

What progress has been made?

The Canadian Nursing Advisory Committee's final report *Our Health, Our Future: Creating Healthy Workplaces for Canadian Nurses* was widely viewed as an essential document for those struggling with the complexity of nursing resource issues. It gave stakeholders 51 ways — many practical and concrete — to address the crisis. A subsequent study outlining which recommendations had been implemented revealed that progress has been slow and spotty at best. Still, it is critical to recognize that at least some recommendations have been implemented in every jurisdiction across Canada.

Other studies describe sporadic initiatives by individual employers, governments, and nursing associations that aim to increase the supply of nurses and foster healthy workplaces. Here are highlights of positive actions documented by the research.

Education — An increase in the number of nursing seats is the most visible and successful sign of progress. In 2001, education seats for registered nurses, licensed practical nurses, and registered psychiatric nurses increased by 43 percent over 1998 levels. British Columbia, Saskatchewan, and Nova Scotia recently reported even more increases in seats. Many nursing schools are offering distance education programs; for example, in Newfoundland and Labrador distance technology is used for the bachelor, master's, and post-graduate programs as well as for continuing education. Also, B.C., Alberta, New Brunswick, P.E.I., and Newfoundland and Labrador have established paid co-operative placement programs for upper-year registered nurse students, which provide students with income and work experience.

In terms of continuing education, a number of employers have instituted supportive education programs. For example, the Hospital for Sick Children pays for nurses to attend conferences, a nursing scholarship program, and a research training competition to support graduate education.

Workload — Workload measurement systems are in place in the acute care sector across the country. But that does not mean workloads have eased. Respondents point out that these systems do not paint a true picture of the work carried out by registered nurses, licensed practical nurses, and registered psychiatric nurses. And even when they do reveal high workloads, nothing changes. However, nursing unions in at least five provinces are bringing workload issues into contract negotiations. On a positive note, a few individual organizations have taken progressive steps. For example, the Calgary Health Region addressed nursing workload by hiring more nurses, converting overtime expenses to full-time positions, and hiring additional clerical staff, nursing attendants, and personal care aids.^{liii}

Health, Safety, and Violence — Site-specific safety programs are common, but overall assessments of healthcare workplaces are not. Still, some employers acknowledge the importance of providing nurses with a good quality worksite. St. Michael's Hospital in Toronto, for instance, is creating a healthy workplace scorecard that includes both mental and physical exposure to workplace hazards. As for absenteeism, reviews or programs on this problem are being funded under provincial nursing strategies in Manitoba and P.E.I.

Zero-tolerance and harassment policies are common in acute care settings, but some nurses still view encountering abuse as part of their job. Inroads have been made by some employers. For example, the Montreal General Hospital has implemented a number of anti-violence strategies such as 24-hour security presence in the emergency room, employee training in non-violent crisis intervention, and a code white team that is trained to respond to behavioural disturbances involving patients.

Retention of Older Workers — The most notable accomplishment in this area is New Brunswick's phased-in retirement program. The first of its kind in the country, the program allows older workers to reduce their hours and use their pension to supplement their income as an alternative to quitting. Three other provinces plan to introduce similar measures during collective bargaining.

Overtime and Responsive Scheduling — Some collective agreements contain arrangements for self-scheduling, flexible scheduling, job sharing, or other work options.

Scope of Practice Issues — The number of nurse practitioners continues to increase, and training programs exist in every province. Still, in many places nurse practitioners are not able to practice to their full scope. Some jurisdictions encourage nurses to advance their careers. In B.C., the Nursing Workplace Innovation Grant Program supports the creation of clinical nurse specialist and clinical nurse educator positions.

Management Issues — Nursing managers are stressed and stretched and putting in extra hours to complete their duties. Increasing administrative duties result in less time for clinical duties. Despite this, the only jurisdiction reporting an increased numbers of managers was the First Nations and Inuit Health Branch. Although leadership development programs are available for registered nurses, licensed practical nurses, and registered psychiatric nurses once they become managers, there are few such programs for front-line workers.

Professional Development and Continuing Education — All jurisdictions fund education and professional development programs for registered nurses, licensed practical nurses, and registered psychiatric nurses. However, attending them depends on being able to take time off. This is still reported to be a problem for many nurses.

Research and Health Human Resources — Although few provinces and territories have reported on the progress of implementing the advisory committee's 51 recommendations, healthcare research organizations are doing plenty of work in nursing human resource issues. Governments have provided funding to the Canadian Institute for Health Information for a national survey on nurses' health and for a nursing database and to the Canadian Health Services Research Foundation, among others. As well, Human Resources and Skills Development Canada is working to identify key problems in nursing human resources. The goal of the Occupational Study of Nursing is to produce an integrated labour market strategy for regulated nurses.

All provinces have nursing advisory committees and most have funded nursing strategies. These committees exist to support human resource planning and develop retention strategies to improve the quality of nurses' worklives.

What remains to be done? Barriers to action

Overall, there are few indications that front-line nurses are experiencing a better working life. Generally, progress has been limited to increasing primary nursing education, increasing nursing resource research, and policy-level improvements such as establishing chief nursing officers. Despite a lot of government talk about nursing issues and considerable government funding for nursing research, little has been done to address core problems. In a joint 2003 letter to then-federal minister of health Anne McLellan, national nursing groups concluded that "there has been very little action on the CNAC recommendations." Their letter was accompanied by a report card giving government a "failing grade in terms of a national approach to nursing human resources."^{liv}

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. If the nursing shortage is to be alleviated, these conditions must change. The Canadian Nursing Advisory Committee's recommendations offer stakeholders — particularly governments and employers — detailed and explicit ways to do so. However, as important as knowing what still needs to be done is understanding why progress on such a critical issue has been so limited. Major barriers identified by the research include:

Lack of funds and short budget cycles — Insufficient funds was the most frequently cited barrier to implementing the recommendations. But funding decisions are simply a reflection of funders' priorities.

More problematic are short budget cycles and the competition for funds which are not targeted specifically for nursing workplace improvements.

Lack of co-operation between health professionals — Changing how the healthcare system operates affects peoples’ jobs and incomes and thus produces a diversity of opinion on how best to enact change. Messages vary about how to use licensed practical nurses, how much control of practice to give registered nurses, and the overlapping roles of nurse practitioners and family doctors. Research on the licensed practical nurse situation is poor, although there is solid research concerning registered nurses and nurse practitioners. Improvements to the system, however, demand nothing less than extraordinary co-operation from stakeholders at every level, from employers to the federal government.

Lack of the kind of evidence decision makers need — Governments tend to respond best to two things: perceived fiscal crises or fiscal mismanagement; and perceived threats to the public’s health and well-being. Both issues are inextricably linked to healthcare. Yet improving nurses’ worklife has not traditionally been linked to patient outcomes or to economics, even though recent research in Canada and the U.S. indicates a greater number of experienced registered nurses in hospitals is associated with decreases in patient complications and death. Nursing is about life and death and the allocation of taxpayer’s money. At a policy level, the research strongly suggests that it is time to portray the issue in those terms.

Lack of a long-term, national strategy — Although provinces and territories have developed their own plans, they have said they are incapable of solving the nursing shortage alone. Yet Canada does not have a health human resource strategy at the national level. That could soon change. There is widespread support for a pan-Canadian plan for a sustainable healthcare workforce.

Lack of accountability — Who is responsible for implementing the advisory committee’s recommendations? Because the answer to that question is unclear, ultimately no one is. Even though many recommendations name specific stakeholders charged with implementing change, there is no governing body ensuring they do so. For example, recommendation seven states that by January 2003 employers must work to “minimize and, where possible, eliminate” overtime hours. Two years after that deadline, nurses continue to work unacceptable amounts of overtime. Employers argue they are bound by their budgets — often described as inadequate — and cannot afford to hire more nurses, a move that would lessen the need for overtime. But governments counter that, first, they allocate more funds than ever for healthcare, and, second, they cannot set spending priorities for employers. Caught in the middle of this ping-pong exercise are stressed-out nurses and an increasingly vulnerable public.

A sense of urgency, unease, and dwindling patience underlies the studies reviewed in this report. “The goodwill displayed by nursing stakeholders is not endless,” one writer says, “and ultimately success can only be measured by whether nurses perceive that their jobs are changing for the better.”^{iv} If nurses continue to perceive that their jobs are not improving they will continue to walk away, leaving remaining colleagues in ever-deteriorating conditions. It will be Canadian men, women, and children who pay the biggest price.

References and Bibliography

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- ⁱ Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ⁱⁱ Globe and Mail. October 27, 2005. *Nurse shortage set to worsen, report warns*.
- ⁱⁱⁱ Canadian Institute for Health Information. 2005. *Workforce Trends of Registered Nurses in Canada*.
- ^{iv} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^v Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{vi} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{vii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{viii} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{ix} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^x Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{xi} Rogers, AE, Hwang, WT, Scott, LD, Aiken, LH, and Dinges, DF. 2004. The working hours of hospital staff nurses and patient safety. *Health Affairs*; 23(4), 202-212.
- ^{xii} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xiii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{xiv} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xv} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xvi} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xvii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{xviii} Canadian Federation of Nurses Unions. 2005. *Enhancement of Patient Safety through Formal Nurse-Patient Ratios: A Discussion Paper*.

-
- ^{xix} El-Jardali, F and Fooks, C. Health Council of Canada. 2005. *An Environmental Scan of Current Views on Health Human Resources in Canada: Identified Problems, Proposed Solutions and Gap Analysis*.
- ^{xx} Canadian Labour and Business Centre. 2002. *Full-time Equivalents and Financial Costs Associated with Absenteeism, Overtime, and Involuntary Part-time Employment in the Nursing Profession*.
- ^{xxi} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{xxiii} O'Brien-Pallas, L, Thomson, D, Alksnis, C, and Bruce, S. 2001. The economic impact of nurse staffing decisions: Time to turn down another road? *Hospital Quarterly*; 4(3), 42-50.
- ^{xxiv} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxv} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxvi} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxvii} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxviii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{xxix} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxx} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{xxxi} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxxii} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxxiii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.
- ^{xxxiv} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.
- ^{xxxv} El-Jardali, F and Fooks, C. Health Council of Canada. 2005. *An Environmental Scan of Current Views on Health Human Resources in Canada: Identified Problems, Proposed Solutions and Gap Analysis*.
- ^{xxxvi} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.

^{xxxvii} Canadian Press. October 11, 2005. *Nurse practitioners say they face barriers*. http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20051011/nurse_practitioners_051011/20051011/

^{xxxviii} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.

^{xxxix} Canadian Institute for Health Information. 2004. *Workforce Trends of Registered Nurses in Canada, 2003*.

^{xl} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.

^{xli} Canadian Institute for Health Information. 2005. *Workforce Trends of Registered Nurses in Canada*.

^{xlii} Canadian Institute for Health Information. 2005. *Workforce Trends of Registered Nurses in Canada*.

^{xliii} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.

^{xliv} Nursing Sector Study Corporation. 2005. *Building the Future: an integrated strategy for nursing human resources in Canada*.

^{xlv} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.

^{xlvi} Maslove, L and Fooks, C. Canadian Policy Research Networks. 2004. *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses. A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee*.

^{xlvii} Maslove, L and Fooks, C. Canadian Policy Research Networks. 2004. *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses. A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee*.

^{xlviii} Clarke, SP, Aiken, LH. 2003. Failure to Rescue. *American Journal of Nursing*; 103(1), 42-47.

^{xlix} Globe and Mail. October 27, 2005. *Nurse shortage set to worsen, report warns*.

^l Maslove, L and Fooks, C. Canadian Policy Research Networks. 2004. *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses. A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee*.

^{li} O'Brien-Pallas, L and Baumann, A. 1992. Quality of nursing worklife issues. A unifying framework. *Canadian Journal of Nursing Administration*; 5(2), 12-16.

^{lii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients, and the system*.

^{liii} Canadian Health Services Research Foundation. 2001. *Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system*.

^{liv} Canadian Association of Schools of Nursing. 2003. Joint Letter to Health Minister.

^{iv} Maslove, L and Fooks, C. Canadian Policy Research Networks. 2004. *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses. A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee.*