Not There Yet: Improving the Working Conditions of Canadian Nurses

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Executive Summary

Canadians would wholeheartedly agree that nurses are an intrinsic component of the health work force. Most have likely received excellent care from our nurses. But for such essential workers, nurses' working conditions are poor. Nurses continue to work long hours, work short-staffed, benefit from few supports (e.g. lifts, safeguards against sharps injuries), and are exposed to physical assault and emotional abuse. They have high rates of depression, injury, and job strain. Much of this can be attributed to short-term planning and an environment that views nurses as an expense rather than a significant component in-patient care. In response, several policy papers, including the seminal piece by the Canadian Nurses Advisory Committee (CNAC), have outlined recommendations for improving workplaces for Canadian nurses.

There has been some quick action in translating these recommendations into policy. For instance, in their action plans released in December of 2005, several provinces outlined targets for quality workplace improvement, and the federal government has made quality workplace improvements a cornerstone in their health human resource action plan. But, in general, there are indications that the introduction of measures to improve conditions for Canadian nurses has been slow and uneven across the country and across categories of nurses. Moreover, even where policies have been introduced, there are few evaluations being done to assess their impact on nursing and patient outcomes. In short, while there has been an acceleration of research and workplace improvements, we know very little about how well the recommendations posed by the key policy reports are being translated into practice across workplace settings and regions.

To this end, the Office of Nursing Policy asked Canadian Policy Research Networks to gauge whether or not actions undertaken by provinces and organizations to improve the work life of Canadian nurses have improved the work life of front-line nurses.[1] The yardstick for our analysis is the *2005 National Survey of the Work and Health of Nurses*, a joint report by the Canadian Institute for Health Information, Statistics Canada, and Health Canada.

There are some overall concerns being voiced by Canadian nurses in the *National Survey*. They continue to put in long hours and are expected to, they work under time pressures, they are exposed to physical and emotional abuse, and they report having to work in hostile working conditions. Not surprisingly, they continue to have high rates of job strain, injury, and mental health concerns. At the same time, workplace experiences are highly variable and uneven across the provinces and territories, settings, and categories of nurses (e.g. sex, age), which posits the need for different and targeted approaches to the recruitment and retention of nurses.

Not There Yet: Improving the Working Conditions of Canadian Nurses

1. Introduction

Canadians would wholeheartedly agree that nurses are an intrinsic component of the health work force. Most have likely received excellent care from our nurses. But for such essential workers, nurses' working conditions are poor. Nurses continue to work long hours and work short-staffed, sometimes in environments where they are exposed to unsafe conditions and are subject to physical assault and emotional abuse. They have high rates of depression, injury, and job strain. Much of this can be attributed to short-term planning and an environment that views nurses as an expense rather than a significant component in-patient care. In response, several policy papers, including the seminal piece by the Canadian Nurses Advisory Committee (CNAC), have outlined recommendations for improving workplaces for Canadian nurses.

There has been some quick action in translating some of these recommendations into policy. For instance, in their action plans released in December of 2005, several provinces outlined targets for quality workplace improvement, and the federal government has made quality workplace improvements a cornerstone in their health human resource recruitment and retention initiative. Moreover, several collaborations and partnerships have emerged to specifically focus on advocating for quality workplace improvements.[2] But, in general, there are indications that the introduction of measures to improve conditions for Canadian nurses has been slow and uneven across the country and across categories of nurses. Moreover, even where quality workplace initiatives have been introduced, there are few evaluations done which assess their impact on nursing and patient outcomes. In short, while there has been an acceleration of research and workplace improvements, we know very little about whether or not the recommendations posed by several national-level policy reports are being translated into practice.

This study, then, is an attempt to gauge whether or not the recommendations are being translated into workplace improvements for Canadian nurses.[3] The yardstick for our analysis is the *2005 National Survey of the Work and Health of Nurses*, a joint report by the Canadian Institute for Health Information, Statistics Canada, and Health Canada.

As a snapshot of the working conditions of nurses across Canada, the *National Survey* provides us with a consistent and comparable dataset on the work-life experiences of different categories of nurses. This is an achievement in itself, since to date, the evidence linking action around quality workplaces to outcomes has been fragmented. At the policy level, there is a wealth of information that could be used not only to monitor overall system change, but also to monitor if actions addressing quality workplaces are showing any improvements for nurses across regions, settings, sex, and subtype (e.g. Licensed Practical Nurses, Registered Nurses, and Registered Psychiatric Nurses).

The nurses voice several concerns around their working conditions. They report that they are still expected to work both paid and unpaid overtime, are under intense time pressures, and are exposed to physical assault and injury. They continue to have high rates of injury and absenteeism

due to health-related problems, and have high rates of depression. These experiences are associated with several factors. For one thing, location makes a difference: nurse and patient outcomes and access to quality workplace initiatives are highly variable across the country. Secondly, nurse experiences are associated with several demographic variables. For example, while the experiences of male and female nurses are often more similar than dissimilar, there are some variations that speak to targeted program needs. Thirdly, there are differences across workplace settings. The best place to work, it would appear, is in the community care setting and/or those settings designated as "other" (e.g. physician offices). While there are some instances where nurses working in hospitals raise serious concerns about their working conditions, nurses working in long-term care require drastic improvements on many fronts. Finally, there is some dissimilarity related to nurse subtype: Licensed Practical Nurses (LPNs) often report fewer supports and worse outcomes than Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs). There are some instances, though, where RNs require additional supports (e.g. related to time pressures). All in all, we can begin to pinpoint where additional supports are needed and for whom.

What emerges from our analysis is a complex web of relationships and experiences, which makes it difficult to determine, in general terms, if and where progress is being made. Related to this, a more coordinated approach to quality workplace planning is needed across Canada, including sharing information about best practices and ensuring more consistency in data definitions and measurements.

In the end, the responses given by nurses across Canada in the *National Survey* can be summed up like this: we're not there yet. And for some, it appears that we have not even begun the journey.

2. Methodology

Several key national reports were reviewed to assess if any of their recommendations are being translated into improving the work life of front-line nursing staff. This study uses the data from the *National Survey of the Work and Health of Nurses* to provide a picture of the health and well-being of nurses across nursing groups, age categories, gender, and regions. In effect, the analysis assesses whether our front-line nurses are benefiting from policies aimed at improving their work life and whether there are differences in their work-life experiences. This sets the groundwork for not only an evaluation of policy changes, but the need for targeted programs aimed at recruiting and retaining different categories of nurses.

The following key reports were reviewed to provide a baseline for the recent discussion around improving the work life of Canadian nurses:

- Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Irvine Doran, D., Kerr, M., McGillis Hall, L., Vézina, M., Butt, M., and Ryan, L. (2001). *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System.* Canadian Health Services Research Foundation.

- Canadian Nursing Advisory Committee. (2002). *Our Health, Our Future. Creating Quality Workplaces for Canadian Nurses.*
- Advisory Committee on Health Human Resources. (2003). *A Report on The Nursing Strategy for Canada.*
- Nursing Sector Study Corporation. (2005). *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada, Phase I Final Report.* Nursing Sector Study Corporation.
- Med-Emerg Inc. (2006). *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada, Phase II Final Report*. Nursing Sector Study Corporation.
- Villeneuve, M., and MacDonald, J. (2006). *Toward 2020: Visions for Nursing*. Canadian Nurses Association.

This is not to minimize other reports (e.g. reports commissioned by provincial and territorial governments), but rather to limit the scope of the review to the pan-Canadian level. This is also not inclusive of all available national papers on quality workplaces for Canadian nurses.

Comparisons between the recommendations from the earlier documents and the data provided by the *National Survey* are made using the following as thematic guides:

- Quality Workplaces
- Nurse Outcomes
- Patient Outcomes

Each of these thematic headings is further broken down into categories of nurses in order to highlight several pertinent sector and regional issues related to quality health workplaces.

The overall objective of the paper is not to evaluate specific programs *per se*, but to make general observations about whether or not the recommended actions outlined in various key policy reports are being implemented, and if there has been any progress in improving nurse and patient outcomes. We also do not address the issue of "by whom" (e.g. employers, professional associations, provinces). The key policy reports themselves provide this link. For instance, the *Commitment and Care* report explicitly contains directive policy recommendations. One area which is not fully explored, however, is understanding the role and responsibility of both private and public sector actors.

3. Quality Workplaces

The key policy reports recommend that action be taken to improve nurse and patient outcomes through quality workplace improvements. While there have been some changes in outcomes and signals that some programs are working, progress remains slow and uneven across Canada and categories of nurses.

While there has been much activity at the government and employer levels aimed at addressing quality workplaces for nurses, there is a gap between these recommendations and their implementation on the ground. Overall, Canadian nurses report that they are still understaffed, overworked, work in hostile work environments, are exposed to physical assault, are emotionally abused, and require investments in health and safety equipment (e.g. patient lifts). Ultimately these trends need to be factored into the recruitment and retention of specific categories of nurses. If, for instance, we want to attract nurses into long-term care settings, then we will need to take very seriously what those in that work environment say about their situation and act accordingly.

At the end of this section we highlight some differences in workplace experiences and supports among nurse categories (e.g. related to sex, region, workplace setting), for further research and policy.

3.1 Job Security

One important workplace concern is that of job predictability, which, as noted in *Commitment and Care*, was eroded in the 1990s, as employers sought to enhance efficiency through downsizing. For nurses, as with other employees, the loss of job predictability leads to health concerns including anxiety, depression, burnout, and poor health and sleep.[4]

According to the *National Survey*, there are indications of progress in attaining job security. Nurses have significantly greater job security than their counterparts in other sectors.[5]

The following categories of nurses require a further look into their levels of job security:

- Licensed Practical Nurses have low levels of job security compared with other nurses and the general employed population.
- Nurses working in non-hospital settings have less job insecurity than their counterparts working in hospitals.

3.2 Full-Time Hours

Another important consideration is whether there are full-time positions for nurses who want them. The CNAC report recommended that "governments, employers and unions should collaborate to increase the proportion of nurses working full-time to at least 70% of the workforce in all healthcare settings by April 2004, with an improvement of at least 10% to be completed by January 2003."[6] In *Building the Future, Phase II*, the issue of full-time hours is all the more pressing for newly graduate nurses:

> Results from the consultations highlighted the frustration among nurses that there are not enough funded full time positions for new graduates, even though nurses currently working full time are working a considerable amount of mandatory overtime.[7]

However, 6 in 10 nurses reported in the *National Survey* that they worked full-time hours; the goal of 70% has not yet been achieved to date. That said, the issue around increasing the rates of full-time employment is influenced by preferences for part-time or full-time hours. According to the nurses surveyed in the *National Survey*, about one fifth of nurses working full-time hours would prefer part-time employment. Conversely, the same proportion of nurses working part-time would prefer full-time hours.[8] Policies moving towards full-time work across the board would therefore require taking these different preferences into account.

At the same time, there are discrepancies among nurses which need further attention:

- LPNs, for instance, are least likely to have full-time hours, and of those working part-time, 42% want full-time hours.
- Long-term care nurses are the least likely to have full-time hours. Moreover, of the 46% of these nurses working part-time, 36% would prefer full-time hours.

3.3. Compensation

The issue of compensation is discussed and defined differently in the key reports and the *National Survey*, which makes any comparisons difficult. In *Building the Future, Phase I*, for instance, several recommendations revolve around the issue of remuneration, including the collection of data pertaining to remuneration and related benefits within the annually updated CIHI nursing databases. It is further suggested that action be taken for "systematically assessing nursing remuneration in order to develop concrete strategies for addressing issues related to compensation, including benefits."[9]

In the CNAC report, compensation is defined through the provision of attractive salaries:

> Competitive salaries and benefits, which are critical to retaining the current and next generation of nurses, should continue to be attractive.[10]

Disentangling the issue of compensation can therefore be tricky due to the differences in definition. The variable of "household income" is used in the *National Survey*, which makes it difficult to make any inferences about the appropriateness or attractiveness of current salaries or

access to benefits. Nonetheless, nurses are less likely than other Canadian workers to be in the lowest income quintile. Yet, there are differences in household income, which can be used to better understand how income levels relate to the recruitment and retention of different categories of nurses.

The following represent income variations among nurses, indicating the need for income supports, especially for long-term care nurses:

- Long-term care nurses are more likely to be in the lowest income quintile than nurses working in other settings, signaling a need to explore pay differentials across workplace settings.[11]
- Licensed Practical Nurses are much more likely than RNs and RPNs to be found in the lowest income quintile, though this could be explained through pay scales.
- Younger nurses (under 44) are more likely to be found in the lowest income quintile than more experienced nurses.
- Nurses working in Quebec are significantly more likely to be found in the lowest income quintile than their counterparts in other provinces.

3.4. Overtime

The key policy reports include recommendations to reduce or eliminate the excessive use of overtime hours. One recommendation from the CNAC report is that "Where overtime hours are being worked, employers should work with their managers and front-line staff to minimize and, where possible, eliminate, overtime hours by January 2003."[12] Likewise, in *Building the Future, Phase I,* the authors recommend that urgent action be taken to address the increasing use of overtime by eliminating unpaid overtime, stopping paid mandatory overtime and reducing paid overtime.

There is little evidence that these recommendations are being implemented at the organization level. Both male and female nurses described in the *National Survey* are working more paid and unpaid overtime than the general employed population.[13] Indeed, almost half of Canadian nurses continue to work unpaid overtime, with an average of four such hours per week, which is significantly higher than with other workers.[14] Employers also expect nurses to work overtime: 46% of female nurses and 55% of male nurses reported that their employer expects them to work overtime.

The following represent more specific trends related to overtime:

- Males are more likely to work paid overtime with longer hours than female nurses. They are also more likely to face employer expectations for overtime work. On the other hand, female nurses work more unpaid overtime.
- Registered nurses work more paid and unpaid overtime than other nurses. They are also expected to work overtime by their employers.
- Nurses working in hospitals work the most paid overtime, while community setting nurses work the most unpaid overtime.

- Nurses working in Alberta, Ontario and Manitoba work more unpaid overtime than nurses working in other provinces. Nurses working in Quebec face the greatest employer expectation for working overtime.

3.5 Flexible Days and Hours

The earlier reports recommend that nurses be given more control over practice and greater latitude over decision-making in order to improve job satisfaction and retention. For instance, one recommendation in *Commitment and Care* is a partnership between unions and employers to develop flexible scheduling which accommodates individual preferences, balances work and home lives, meets family care needs, and enhances the control nurses have within their workplace, including self-scheduling.[15] Likewise, the CNAC report includes a recommendation that "Employers and unions should collaborate to design, by April 2004, innovative schedules, hours of work and job-sharing arrangements that offer flexibility to the individual, meet the collective staffing needs of their work settings and respect nurses' time off work."[16]

The goal of ensuring flexibility remains an issue for Canadian nurses. Fewer than 40% of Canadian nurses in the *National Survey* reported having flexibility in terms of days and only one third have flexibility regarding their hours. The issue of flexibility is all the more pertinent for some nurses, representing the need for targeted initiatives:

- Nurses working in hospitals and long-term care facilities have significantly less flexibility in terms of hours and days worked than nurses working in community care and other settings.
- Nurses aged 45-54 reported that they are offered less flexibility in days than other age cohorts.
- Male nurses are less likely to be offered flexibility in their days and hours than female nurses.

3.6. Respect

One of the elements identified in the CNAC report is the need for a "return to respectful thinking and behaviour across the healthcare system." The authors of this report thus direct all federal, provincial and territorial Ministers and Deputy Ministers of Health to issue a strong statement on the importance of respect for all workers in the system (including managers, corporate leaders and students).

There is evidence that, for the main, nurses feel respected by their supervisors and their co-workers. For instance, the vast majority of Canadian nurses (82%) reported in the *National Survey* that they were respected by their supervisors and the vast majority reported being respected by their coworkers. Again, there are variations. Nurses in Newfoundland reported the least respect by their supervisors, while nurses in Quebec did not feel as respected by their co-workers as nurses in other provinces and territories. Nurses working in long-term care reported lower levels of respect from their supervisors and co-workers than nurses working in other settings.

3.7. Workload

The CNAC report outlines several recommendations aimed at improving the manageability of the workload for Canadian nurses. The report recommends that employers:

> [S]ubmit to governments by January 2003 a report of their existing staffing, absenteeism, overtime hours and actual care needs based on patient acuity, intensity and environmental complexity. The purpose of this exercise is to compare practices across organizations and ultimately to reduce the pace and intensity of nursing work and improve quality of care. To do so, we must understand the current workload as fully as possible, and then work with governments and employers to put in place the conditions that will foster manageable workloads.[17]

The CNAC report also recommends that employers need to get a better handle on the workload manageability for nurses: "Employers work with their managers and front-line nurses to assess and describe existing workloads and contrast them with current staffing patterns and patient/client demands by October 2002… and where workload measurements do not exist, they should be implemented by June 2003."[18]

Finally, workload manageability is related to the provision of appropriate and sufficient staffing, including support staff. Recommendation 16 of the CNAC report states that "All employers should employ sufficient numbers of staff to provide support functions (clerical, environmental, food services, porters) to allow nurses to focus fully on the direct care needs of patients and clients."[19] Likewise, *Commitment and Care* includes recommendations that governments support the welfare of nurses by providing funding to increase nursing staff and support personnel so that managers can assign workloads that allow for how sick people are. Employers are also encouraged to ensure appropriate staffing to reduce the pressure on bedside nurses and ensure sufficient nurse numbers to enhance workload manageability.

According to the National Survey, many Canadian nurses continue to work without adequate workload supports. For instance, just over half of nurses reported that there were enough support staff in place to allow them to have time with their patients. Moreover, under half of nurses reported that enough nurses are in place to provide quality patient care.

There are some variations of note, which require further targeted analysis:

- LPNs are the most likely to report inadequate staffing levels.
- Nurses working in long-term care facilities reported the highest level of inadequate staffing.
- Fewer nurses in Quebec than other provinces reported that they have enough nurses on staff to provide quality patient care.
- Nurses working in hospitals and long-term care facilities are the least likely to report having enough support staff in place to allow time for patients.

3.8. Time Pressures

Related to this, as noted in the CNAC report, nurses continue to work under time pressures, or a scenario of "rush-rush-rush." For instance, while over 60% of nurses reported that they had enough time and opportunity to discuss patient care, they are significantly more likely than the general employed population to report their work as being very hectic.[20]

The solution to this has not only been a reliance on overtime to make up for staffing shortfalls, but the tendency of nurses to work through their breaks and arrive early to have enough time to get their work done. More than half of nurses in the *National Survey* reported working through their breaks, and staying late and/or arriving early in order to have enough time to get their work done. For instance, over half of both male (52%) and female (54%) nurses reported coming in earlier to ensure enough time to complete their tasks.

3.9 Autonomy

One recommendation stemming from *Commitment and Care* is the promotion of latitude in decision-making relative to nursing practice by employers. Moreover, *Building the Future, Phase II* raises the need for meaningful involvement in decision-making (or informing decision-makers) at various levels in health organizations (including provincial and territorial policy), especially when those decisions affect nurses and patient care.

There is evidence that the issues of control over one's practice and inclusion in care decisions are being addressed. The majority of nurses reported in the *National Survey* that they have control over their practice and over 80% reported that nurses make important patient care and work decisions. Nurses working in hospitals reported the least control over their practice. Likewise, nurses from Saskatchewan, New Brunswick, PEI, Newfoundland and Ontario reported the lowest level of control over their practice.

3.10. Access to Healthy Lifestyle Programs and Employer Supports

While personal lifestyle choices and behaviors are often viewed as individual responsibilities, providing nurses with access to healthy foods and programs aimed at smoking cessation and stress management may have a bearing on their overall physical and mental health outcomes. One recommendation in B*uilding the Future, Phase I* is that research be conducted on the connections between the lifestyle choices and health of nurses and the development of innovative health promotion strategies to promote healthy lifestyles (e.g. counseling and facilities). The authors also suggest that action be taken to develop innovative health promotion strategies, such as providing facilities and counseling to nurses to assist with healthy lifestyles. Likewise, in *Commitment and Care*, employers are encouraged to address quality of life issues by providing amenities such as child care, staff lounges, access to hot food and health programs.

These supports extend to programs aimed at improving the work-life balance for Canadian nurses. In *Commitment and Care*, for instance, access to organized child care and elder care is considered to be an important mitigating factor for reducing work pressures and improving the work-life balance of Canadian nurses. In *Building the Future, Phase I*, the authors recommend that nurses be provided with assistance regarding child care and elder care, be offered life and

career counseling, sabbaticals or temporary leaves, and be provided with access to recreation facilities and other mechanisms for stress reduction.

There is evidence that health sector employers are implementing some supports for nurses. Access to employer-supported services (e.g. child care, employee assistance, and recreation and fitness services) is higher for nurses than for other working people, which signals movement in the provision of these services for Canadian nurses.

Differences remain, however, in how accessible these services are for different nurses:

- Nurses in Quebec have the best access to child care services compared with nurses elsewhere. However. they are among the least likely to have access to other employer supports (e.g. access to employee assistance).
- Nurses working in hospitals have the greatest accessibility to employer-led supports compared with nurses working in other settings.
- LPNs have less access to these programs than RNs and RPNs.

3.11. Leadership

One of the issues related to overall job satisfaction and the retention of nurses is the quality and accessibility of nurse leadership, though it is unclear if this is specifically related to the efficacy of managers or the availability of management at the front line. Nevertheless, one of the recommendations outlined in *Building the Future, Phase I* is the strengthening of leadership at all levels.[21] Likewise, the CNAC report stresses that with cuts to nurse management positions, nurses were left with "few natural allies within the system."[22] The authors recommend that a sufficient number of first-line managers be on staff to allow reasonable levels of contact with nurses in the setting. They also recommend that "employers, educators and governments should work with nurses to build in succession planning, including moving nurses through management experiences and into formal leadership."[23]

On this note, more than three quarters of nurses surveyed for the *National Survey* felt that their immediate supervisor or nurse manager is a good manager or leader. Moreover, over two thirds of nurses agreed that their supervisory staff is supportive and most nurses reported that their immediate supervisor backs them up in their decision-making, even in conflicts with physicians.

There are few variations in the level of support by supervisors and the perception of leadership. One concern here is that nurses working in hospitals do not perceive that their immediate supervisors back them up or are as supportive as supervisors in other settings. These nurses are also less likely to report that their immediate supervisor is a good leader.

3.12. Relationships

Overall, good working relationships with co-workers and immediate supervisors enhance the retention of nurses and the overall quality of care.[24] One action by employers recommended in *Commitment and Care* is strengthening organizational structures through "fostering an organizational culture that encourages strong nursing and multi-disciplinary teams through team-building and participatory decision-making." Likewise, as noted in *Building the Future, Phase I*, the quality and effectiveness of the working relationships between nurses and physicians is connected to how long a nurse has been in his/her current position, autonomy, access to resources and nurse empowerment.

The vast majority of Canadian nurses reported in the *National Survey* having good relationships with physicians. Eighty one percent also reported a lot of teamwork and 89% reported collaboration between nurses and physicians. There are few variations reported in the *National Survey*. One trend of note is that nurses from Quebec are least likely to report good working conditions with physicians.

At the same time, the nurses voiced concerns over their relationships with and supports from their co-workers. Indeed, one of the major work life issues raised in *Commitment and Care* is the level of support among co-workers. Compared with the general population of female workers (28%), a significantly higher number of female nurses (44%) reported hostility and conflict in their workplace. This is all the more true for male nurses; 50% of male nurses reported a hostile working relationship with their co-workers compared with 29% of the general male worker population.

There are some variances of note, which require further analysis:

- RPNs reported the lowest co-worker support.
- Nurses working in long-term care reported the lowest level of co-worker support. They were closely trailed by hospital nurses.
- Nurses from Quebec reported the lowest levels of co-worker support.

Finally, most of the discussion from the key policy reports and the data from the *National Survey* pertain to the relationship between physicians and nurses. What is also needed is data related to the collaboration and relationships with other providers in the workplace.

3.13. Workplace Safety

There are several recommendations around worker safety outlined in the earlier key policy reports. *Commitment and Care*, for instance, urges employers to provide a safe work environment with access to adequate and appropriate supplies. Likewise, in *Building the Future, Phase I,* the authors recommend reducing nurses' susceptibility to work-related injury by redesigning ergonomically sound designed work environments, providing patient lifting equipment and ensuring adequate staff support during patient mobilization, lifts and transfers.

The majority of nurses reported in the *National Survey* that while their jobs involve a lot of physical effort, almost two thirds have access to a mechanical lift. This is all the more of an issue for nurses working in hospitals, where 87% of them reported that their jobs involve a lot of physical effort, but only 65% reported having access to a mechanical lift.

3.14. Exposure to Physical Violence and Emotional Abuse

The recommendations posed by the key policy reports have not translated into increased protections for nurses.[25] For instance, in the CNAC report, violence and abuse are raised as critical work force issues for nurses. The CNAC thus calls for the implementation and enforcement of zero tolerance policies toward violence, abuse and harassment in the workplace by January 2003. They also recommend all employers, educators, nurses, governments, regulators and the public collaborate with police and security experts to design safer work environments, follow up infractions and punish offenders.

According to the *National Survey*, violence and abuse remain critical issues for Canadian nurses. Almost one third of nurses reported being physically assaulted by patients in the 12 months preceding the survey. In the same time period, 44% of Canadian nurses were emotionally abused by patients and 17% were emotionally abused by visitors.

Exposure to abuse and assault is an even more pressing issue for some nurses:

- Male nurses are significantly more likely to be physically assaulted by patients and others than female nurses.
- Over half of male nurses reported being emotionally abused in the year preceding the survey.
- Almost half of nurses working in long-term care reported being physically assaulted by patients in the preceding 12 months.
- Nurses under the age of 35 and LPNs reported higher rates of physical assault by patients.
- Nurses working in hospitals and long-term care facilities reported significantly higher rates of emotional abuse by patients, other nurses, and visitors than nurses in other settings.
- Registered Psychiatric Nurses reported significantly higher rates of emotional abuse by patients than other nurse subtypes.

Interestingly, sexual abuse, while being an important issue for workplace safety, is rarely raised as a work life issue for nurses. The CNAC report does mention sexual abuse by stating: "Exposure to verbal, physical, emotional and sexual abuse in the workplace is not new to nursing or unique to Canada."[26] The report does not, however, detail its prevalence or its seriousness as a workplace issue for nurses. The absence of this issue within the literature poses a fundamental gap in understating the impact of sexual abuse on the nursing work life, especially due to the fact that the vast majority of nurses are female. The needs around, and efficacy of, safeguards for nurse safety cannot be assessed without common definitions and baseline measures.

3.15. Emerging Themes

It is difficult to say whether or to what extent the recommendations made in the key policy reports have been translated into on-the-ground workplace practice. Some improvements have been made in some areas, while in others there is still much to be done through additional funding and program implementation. While a general conclusion could be made that all nurses require improved workplace supports, the experiences between and among nurses is highly variable; one group may have access to child care services, for example, but not to employee assistance. This unevenness itself points to additional challenges for provinces and employers as they sort out where and which policies would make the best sense for whom. This requires a common approach to data definitions and outcome measures for consistent evaluations of initiatives across the board. To date, we do not have a consistent and coordinated approach and strategy.[27]

With this caveat in mind, there are some general trends which emerge from the *National Survey* that require further exploration for targeted recruitment agendas, but also to make way for a shift in the composition of the nursing work force to meet future population health needs. Given an anticipated movement towards community and long-term care noted in *Toward 2020,* we need to pay special attention to nurses working in long-term care settings around various quality workplace elements and outcomes (e.g. co-worker support, physical assault by patients, access to employer supports). As noted in the section below, this is being translated into poorer mental and physical health outcomes. At the same time, nurses working in hospitals also raised some concerns about their work environment, and in some cases, their experiences are comparable to long-term care nurses.

Another important element here is the unevenness in quality workplace initiatives across Canada, which makes it difficult to make an analysis of any general trends. Nurses in Quebec reported lower levels of support and not enough staffing while at the same time have better access to child care. What this unevenness does denote is that there are challenges ahead for all provinces and territories in translating policy into quality workplace initiatives. At the same time, there are improvements being made for some nurses. This sets up the need for information exchanges among the various actors including governments, public and private sector employers, professional associations, etc.

Finally, the unevenness across provinces/territories and categories of nurses raises not only the need for making overall improvements to nursing workplaces, but rather a mix of policy options. Indeed, one recommendation stemming from *Building the Future, Phase I* is the creation and implementation of regional/sector specific strategies to address differential experiences.

There are indications that some of the recommendations posed by the key policy reports are being taken seriously by employers and governments. These include the following:

- Nurses have more job security than other Canadian workers, which indicates that action is being taken across Canada to address this issue. There are some variations, however, to keep in mind. For instance, the role of job security for nurses working in long-term and community care settings requires further analysis. This would involve understanding the role

of competitive markets, including short-term contracts and bidding, on the job security of long-term and home care nurses.

- There have been some improvements related to leadership with over three quarters of nurses reporting that their immediate supervisors or managers are good leaders. Yet, nurses working in hospitals have serious concerns over the support they receive from their immediate supervisors, indicating the need to improve leadership skills and foster supportive relationships between supervisors and nursing staff. Data are also needed on the availability of immediate supervisors who provide support for front-line nurses – for instance, the ratio of managerial to nurse staff at the front line. There is also a need to understand the quality and accessibility of succession planning across Canada.
- Nurses overall are more likely to be in the highest income quintile, though the variable itself does not speak directly to the accessibility of "attractive salaries" as recommended in the CNAC report. In the *Commitment and Care* report, the authors raise the issue of different income levels between nurses working in long-term and community care facilities and nurses working in hospitals, due in part to the reality of bidding for contracts. Indeed, they recommend pay equity between community and long-term care nurses and their hospital-based counterparts. Using the variable of "household income" to denote these differences is tricky since it is operationally different from wages and salaries. Yet, even if one looks at household income, we can make some inferences. Nurses working in long-term care facilities are disproportionately located in the lowest income quintile. What would be helpful is data on salaries, especially to understand their role in the recruitment and retention of nurses across and between provinces. We also do not have any information about the rates of accessibility to a mix of benefits across Canada.
- Generally speaking, nurses are more likely than other workers to have access to employer supports (e.g. child care, employee assistance). However, there are variations in this access. Nurses working in settings other than hospitals and LPNs require more commitment by their employers around supports, including access to healthy foods, employee assistance, etc.
- An overwhelming number of nurses report a positive relationship with physicians. The relationships with other health providers is not raised as an issue in the earlier reports nor is it benchmarked in the *National Survey*. This information would provide a richer data base on interprofessional teamwork and relationships with other providers.
- Most nurses feel respected by their supervisors and co-workers, given their achievements and efforts. Again, nurses working in long-term care facilities feel the least respected than those in the other categories of nurses on all counts, although they are closely followed by nurses working in hospitals.

On the other hand, there are some areas that remain important concerns for Canadian nurses:

- Action is urgently needed around the provision of safeguards against physical assault and emotional abuse by patients and others. While all nurses require the best safeguards against physical assault, one serious issue which raises a red flag is the inordinate rate of physical assault experienced by male nurses. Several specific actions are recommended by the key policy reports, including the implementation and enforcement of zero tolerance policies toward violence, abuse and harassment in the workplace, collaboration with policy and

security experts to design safer work environments,[28] safe parking spots, risk assessment tools, counseling services, and quick follow-up.[29]

- High rates of sharps injuries and back problems among nurses indicate the need for improved occupational health and safety initiatives across the board.
- Canadian nurses need improved staffing supports (both nursing and support staff) to manage their workloads. As a corollary, nurses are working through their breaks and coming to work early as a response. This is especially true for RNs.
- Nurses disproportionately report working in hostile working conditions and feel unsupported by their co-workers compared with other working Canadians. This is an even more pressing issue for male nurses and nurses working in long-term care and hospitals. Strategies are thus still needed to build relationships and foster teamwork among co-workers.
- We are not making any serious headway in the use of overtime hours. There is also evidence stemming from the *National Survey* that employers vary in their expectations for overtime, which signals that changes are not only needed to reduce overtime overall, but that employers need to re-evaluate how they target certain groups of nurses for overtime work, for instance male nurses and RNs.
- The recommended goal of a 70-30 ratio of full-time to part-time workers by the CNAC has not been realized, but there are important considerations for how preference factors in. One issue which needs to be addressed is the gap between the access to full-time hours by LPNs and nurses working in long-term care, and their preference for full-time hours.
- There is much still to be done around providing nurses with flexible days and hours as noted in the key policy reports. This is all the more of an issue for nurses working in hospitals and long-term care facilities.

There is still much to be done to address quality workplaces for Canadian nurses as recommended in the key policy reports. In light of nursing shortages, addressing these issues becomes all the more pressing, especially for nurses working in long-term care and hospital settings. An unevenness in approach and supports by provinces/territories will also almost certainly impact the trend towards nurse mobility and accelerated interprovincial recruitment.

4. Nurse Outcomes

All of the above factors will have an impact on not just the health of nurses, but on their personal choices around career options. The key reports have, through the years, sounded the alarm around how workplace design and practices have impacted the health of nurses and their job satisfaction. Several linkages are being made, for instance, workplaces that foster professional respect, that are friendly and collegial, that provide opportunities for professional advancement, that provide needed resources and are safe, and that provide economic rewards (e.g. job security, attractive salaries, good benefits) positively impact job satisfaction. Yet, there are differences in attaining these quality workplace initiatives across categories of nurses (e.g. sex, setting, region). This raises questions around what workplace supports are needed, for whom they are needed and how they impact the health and safety of Canadian nurses.

4.1. Physical Health

All the reports show that the physical health of nurses is often linked to various workplace practices, including mandatory overtime,[30] choice of work hours,[31] exposure to aggression and violence,[32] workplace safety,[33] and health promotion strategies. According to the *National Survey*, poor or fair health is also associated with work stress, including high job strain, low support from supervisors or co-workers, high job insecurity, high physical demands, low autonomy, poor nurse-physician working relations, low respect from superiors and high role overload.

There are several lines of analysis related to physical health and safety. First of all, nurses report rates of fair or poor general health comparable to the general working population, indicating some improvements. At the same time, nurses often have higher than average rates of chronic illness and significantly more nurses have three or more chronic illnesses than the rest of the Canadian population. Moreover, 37% of nurses reported that they had pain bad enough to affect their normal activities in the past 12 months and 27% reported that pain made it difficult to do their job.

The following are the variances in physical health, which require further exploration:

- A higher proportion of RPNs reported fair or poor physical health.
- Nurses working in long-term care reported the highest rates of poor and fair physical health.
- Female nurses reported higher rates of three or more chronic conditions than male nurses and other employed females.
- Nurses working in hospitals and long-term care facilities reported that pain made it difficult for them to do their jobs.
- Pain is a greater issue for nurses working in Newfoundland across the various measures (e.g. severe pain).

4.2 Mental Health

Little is said in the key policy reports about the effects of workplace practices on mental health outcomes. Indeed, mental health outcomes are often lumped together with physical health. Yet this issue emerges as an immediate concern. In the *National Survey,* poor mental health is associated with working evening shifts, high job strain, low supervisor and low co-worker support, low autonomy, low control over practice, poor nurse-physician working relations, a lack of respect from superiors or co-workers, and high role overload. It was also noted that working in long-term care facilities is associated with poorer mental health outcomes.

According to the *National Survey*, nurses reported significantly higher rates of depression and poor/fair mental health compared with other workers.[34] Furthermore, almost one fifth of nurses reported that their level of mental health made it difficult to handle their workload.

There are some differences of note reported by Canadian nurses:

- Male nurses reported significantly higher rates of depression and fair/poor mental health than males in other occupations.
- Nurses working in long-term care reported the highest proportion of fair/poor mental health.
- Nurses aged 35-44 reported the highest rates of poor/fair mental health and depression.
- Nurses working in Ontario reported the highest rates of poor/fair mental health.
- Nurses in Quebec reported significantly higher rates of depression than nurses from other provinces.

4.3. Injuries

Injury rates are notoriously high for Canadian nurses compared with other workers. It is linked in the key policy reports to work overload,[35] job strain,[36] and insufficient staffing.[37] Rates of injuries among nurses have been notoriously high. For instance, in 1997, nurses in British Columbia had higher rates of musculoskeletal injuries than other occupational groups, and lost a total of 169,579 days to strain-related disability and in 1999, the costs related to these injuries was higher for nurses than for police officers, firefighters and transportation workers.[38]

According to the *National Survey*, there is still much to be done to reduce injury rates among Canadian nurses, as almost one in ten nurses reported being injured while on the job. Finally, almost half of all nurses reported that they had ever been injured by a sharp, with about one in ten reporting that this had happened in the last 12 months.

The following are variations in responses related to regional variations:

- Saskatchewan nurses reported the highest rates of back problems and musculoskeletal injuries.
- Nurses working in Saskatchewan and British Columbia reported higher rates of workplace injuries.
- The highest rates of sharps injuries were reported by nurses from Quebec.

4.4. Job Strain

There are several connections made in all the reports between working conditions and job strain. For instance, in *Commitment and Care*, research has linked long periods of job strain with various workplace factors including the quality of personal relationships, increased sick time and higher levels of conflict. Job strain is also linked to other outcomes including job dissatisfaction, higher levels of musculoskeletal injury, accidents, burnout, illness, turnover and inefficiency.[39] In the *National Survey*, high job strain is associated with poor health.

Job strain is higher among females than males, while female nurses surveyed in the *National Survey* reported significantly higher rates of job strain (31%) than females in other occupations (26%).[40] As well, nurses working in long-term care facilities, LPNs, and nurses aged 45 to 54 reported the highest levels of job strain compared with their respective counterparts. Moreover, nurses from Ontario, Saskatchewan, British Columbia, and Newfoundland reported higher rates of job strain than the average.

4.5. Job Satisfaction

In the CNAC report, low job satisfaction is linked to higher rates of absenteeism and a decline in nurses' ability to provide quality care for their patients.[41] In the *National Survey*, both male and female nurses reported significantly higher levels of job dissatisfaction (12%) than the general employed population (8%). Moreover, 10% were dissatisfied with nursing as a profession, although few (4%) planned to leave nursing with most reporting retirement as the reason. That said, one in ten nurses were dissatisfied with nursing as a profession.[42]

There are variances which require further analysis and consideration:

- When broken down by nurse subset, more LPNs than other nurses reported being dissatisfied with their job.
- Nurses working in long-term care and hospital settings were the most dissatisfied with their jobs.
- RNs were the least satisfied with being a nurse.
- Nurses from Quebec had the highest rates of job dissatisfaction.

4.6. Absenteeism

Several recommendations are outlined in the key policy papers to address the disproportionately high rates of absenteeism due to injury, and mental and physical health problems among nurses. The CNAC report, for instance, recommends that "All employers should implement targeted programs by April 2003 that will examine the reasons for absenteeism and strive to reduce absenteeism to the equivalent of the national average for full-time workers by April 2004."[43] One of the "visions" for nursing, as noted in *Toward 2020*, is that absenteeism rates for nurses be on par with other professions.[44] There are several factors which contribute to absences over 20 days noted in the *National Survey*, including respect from superiors/co-workers, supervisory support,

job strain, and high physical demands. There is also a relationship between holding multiple jobs, working multiple shifts, unionization and length of work absence.

Absenteeism by Canadian nurses remains an issue. For instance, nurses spent an average of 23.9 days over the year absent from work, and 13.6% reported being absent 20 or more days over the past year due to a health problem.[45]

There are some trends of note which require further analysis:

- Hospital nurses are more likely than those in other workplace settings to be absent for health-related reasons.
- Nurses employed in long-term care take more days off than their counterparts in other settings and are more likely to be absent for 20 or more days.
- RPNs are more likely than RNs or LPNs to have been absent from work due to a health problem.
- Nurses under the age of 45 are more likely to take absence for health reasons but did not take as many days off as nurses aged 55 and older.
- While nurses in Quebec are less likely to take time off for health-related reasons, they reported taking significantly more time off.

4.7. Emerging Themes

For the most part, we are not seeing much by way of improvements in the health and safety of nurses. There is one positive trend of note. Nurses report rates of poor/fair general health comparable to other workers. Otherwise, the other outcome measures for nurses indicate that we have not made much headway towards improving workplaces for nurses. They still report high rates of back problems and more than one in three report at least one musculoskeletal condition. Nurses are also reporting lower levels of job satisfaction, high rates of absenteeism related to physical health, depression, and higher than average rates of job strain. Simply put, according to Canadian nurses, the policy recommendations posed in the key policy reports have not filtered down to the front lines. There is still a long way to go.

At the same time, there are striking differences among categories of nurses, which require immediate attention. Nurses working in long-term care and LPNs report worse outcomes than their counterparts. There are also variances in outcomes across the provinces and territories, which speaks to the need for provincial/territorial specific initiatives. For instance, nurses in Quebec are reporting higher levels of depression while nurses from Ontario report higher levels of poor/fair mental health. Rates of absenteeism are even trickier. While nurses in Quebec are least likely to take time off for health-related reasons, when they do take time off, it is for longer periods.

5. Patient Outcomes

All Canadians have an interest in ensuring that nurses work in quality workplaces. Although caring people are drawn to nursing and nurses themselves will go above and beyond to provide care for their patients and clients, there are limits to what we can expect in terms of quality of care when nurses are short-staffed, strained, and/or rushed. Front-line nurses were surveyed for the *National Survey* on their perceptions of quality of care and patient safety. Because nurses contribute significantly to front-line care, this data signals urgent action around understanding the linkages between quality workplaces and patient care.

5.1. Quality Patient Care

Most of the key reports connect various determinants of quality workplaces (e.g. staffing levels) and nurse outcomes (e.g. job satisfaction) with the provision of quality patient care and patient safety. In *Building the Future, Phase I,* explicit linkages are made between the quality of patient care and the provision of additional resources, more effective nurse-physician relationships, higher levels of empowerment, stronger leadership and fewer intervention delays in the delivery of patient care. Nurses need access to appropriate resources in order to provide optimal care.[46] Finally, according to the CNAC report, there is also a direct correlation between the ratio of nurses to patients and the health outcomes of those patients.

According to the nurses interviewed for the *National Survey*, there is little to indicate any substantial improvements in the past few years related to quality care. Most nurses reported that the quality of care has stayed the same (57%) or decreased (27%), with only 16% reporting that the quality of care for their patients has improved in the past year.

There are some differences among categories of nurses. The issue of quality care is more pertinent in British Columbia, which has the highest number of nurses reporting a deterioration in-patient care. Moreover, more nurses working in community care settings (23%) reported that the quality of care has improved in the last 12 months compared with those working in hospitals (12%), and hospital nurses were much more likely to report that quality care has deteriorated. Almost 40% of nurses also reported having to field complaints from patients or their families.

5.2. Adverse Events

Another concern is around the incidence of adverse events. Covering the year preceding the *National Survey*, almost one fifth or nurses reported that their patients had received the wrong medication or dose, one third reported that patients were exposed to nosocomial infections, and almost one third reported that patients either occasionally or frequently had been injured in a fall.[47] There are some areas for further investigation. Quebec nurses reported the highest rates of wrong medications being given to patients, higher exposure to nosocomial infections, and patients being injured in a fall.

5.3. Emerging Themes

According to Canadian nurses, there are urgent issues around their ability to ensure that patients and clients receive quality care and are protected against adverse events. As noted in the key policy reports, there are various intersections between quality health workplaces (e.g. staffing supports, time pressures) and patient outcomes which require actions. Addressing the variations across regions, settings, and categories of nurses requires a mix of targeted and specific approaches.

6. Policy Recommendations

There has been a lot of movement at the national, provincial, and employer levels aimed at making improvements to nurse work environments.[48] What is revealed in the *National Survey* is that, while there have been some improvements (e.g. job security), there are serious gaps in how these policies filter down to the workplace. As Lashinger (2007) notes, it is now time to act on the evidence.[49]

According to Canadian nurses, they are still exposed to unsafe working conditions, they face unrealistic expectations for working overtime, they are understaffed and feel unsupported and disrespected. They continue to have high rates of depression and physical pain. They also feel that the quality of patient care has deteriorated or stayed the same, and that patients are being exposed to adverse events. They have some solutions: ensure appropriate levels and mixes of staff so that nurses can do their jobs, and implement workplace strategies at the front line so that *all* nurses across Canada are respected and valued and have improved outcomes.

The question then goes beyond the "what," since we are making some progress in making the connections between nurse work environments, their health and quality of care.[50] The issue here is *why*, given the emerging evidence, do nurses continue to report high rates of fair/poor mental illness, absenteeism, and injury? At the same time, there are differences in work life experience across nursing categories, which point to the need not only to take stock and evaluate the efficacy of current initiatives policy across different groups and regions, but also to the possibility of a targeted approach to address differences in health outcomes and work environments.

6.1 Gender Analysis

For the most part, there are few significant differences between male and female nurses with regard to the determinants of quality workplaces and their overall health and well- being. There are some reported differences, however, which highlight the different roles and work force experiences of male and female nurses. Females do report higher instances of job strain and back injury and exposure to hostile working relationships with co-workers. On the other hand, male nurses are inordinately exposed to physical violence and have significantly higher rates of mental illness than other working males. This opens up two important considerations. Firstly, we need to address work life issues specific to male and female nurses to ensure the retention of both in the workplace. Secondly, meeting the goal envisioned in *Toward 2020* of increasing the number of

male nurses to 10% of the overall Canadian nursing work force means recruitment and retention agendas tailored to the male labour pool.[51] This includes addressing gendered stereotypes in curriculum and clinical practice, promoting nursing as a career option for males, and providing male role models in the media and in practice.[52]

A comprehensive gender analysis of workplace experiences, which includes targeted gender-specific policies for retention and recruitment, is needed.

6.2. Addressing Differences across Workplace Settings

There are several lines of inquiry which arise from the *National Survey*. If, for instance, one looks at the experiences of nurses across various workplace settings, some trends emerge which require further analysis and thought. The *National Survey*, by breaking down the data by setting, provides a fulsome dataset on the experiences of nurses working outside of acute care settings.[53] In particular, nurses working in long-term care facilities report higher rates of fair/poor mental and physical health, and higher rates of job strain. They also, almost consistently, report the fewest improvements being made to their workplace. Unless we address the work conditions of nurses working in long-term care, we are going to have serious problems in recruiting and retaining these nurses.[54] This is all the more pressing as we begin to match future population needs for long-term care and community care with the appropriate mix and number of nurse resources.

This is, however, not limited to nurses working in long-term care facilities. Nurses working in hospitals also report demanding workplace conditions. For instance, if one looks at the issue of autonomy alone, nurses working in hospitals also report unsupportive relationships with their supervisors and have the least control over their own practice. Yet pinpointing the level of action needed is difficult given the private-public split in operations and funding. Funding for long-term care is very uneven across the provinces and to reiterate an already present issue, most of the attention has been paid to the mainly public sector acute care setting. Another consideration is to get a handle on the role of employers, though that comes with its own complications.[55] It also opens up the whole issue around accountability for making improvements.[56]

The differences in the experiences among nurses working in different settings need immediate action. This includes a better understanding of the work life conditions of both nurses working in acute care and those working in community and long-term care. Another aspect of this is to better understand the role and responsibility of private and public sector employers in addressing and implementing quality workplace initiatives.

6.3. Intergenerational Experiences

That the nursing work force is aging is not a new concern, nor can it be understated given the number of nurses set to retire in the next few years. The average age of nurses has been incrementally increasing, which speaks to the pressing need for intensified recruitment (both nationally and internationally) and effective retention strategies for both experienced and novice nurses. In 1990, the average age of nurses was 39,[57] which increased to 43.3 in 2001. According to the *National Survey*, the average age of Canadian nurses is about 44.3 years, which is significantly higher than the average age of the general employed population aged 21 and over.

RPNs are slightly older, with an average age of 46.4 years – thus the issue of an aging nurse work force is all the more pressing for mental health service.

The experiences of different age cohorts are reported throughout the *National Survey*. For the most part, there are more similarities than differences between age groups, though there are some trends of note which are related to the policy options designed to retain nurses from different age cohorts. For instance, in *Building the Future, Phase II*, participants in a series of consultations expressed concern about the physical health of more experienced nurses and the mental health of younger nurses.

The CNAC report explicitly recommends that strategies be implemented to retain older workers, including phased-in retirement programs, and work opportunities which are sensitive to the needs of older workers. While nurses aged 45-54 reported in the *National Survey* greater access to permanent full-time employment compared with other age cohorts, they also reported, *inter alia*, significantly higher rates of job strain, job dissatisfaction, working more unpaid overtime, less time to complete their duties, and less flexibility in terms of days worked. There is much that can be related to the length of tenure, such as higher rates of sharps injuries ever experienced, and factors related to seniority (e.g. job security and shifts). At the same time, some of the concerns raised by the nurses in this age group and how they factor into their retention, especially in light of nursing shortages, will require further evaluation and analysis.[58]

At the same time, retaining novice nurses will continue to be an issue. As noted in the report *Building the Future, Phase I*, given that new nurses (defined as having registered with a provincial licensing body within the last three years) are more likely to leave their current position, we need to get a handle on the factors which influence the desire of novice or younger nurses to stay in nursing. There are some variances of note here. Nurses under the age of 35 have more flexibility and are more satisfied with their job, but at the same time, they report significantly higher rates of physical assault by patients.

Policy options regarding the retention of these nurses will need to be further explored and evaluated. One suggestion, for instance, raised in *Building the Future, Phase I*, is the provision of permanent employment for novice nurses "to enable them to consolidate their knowledge and skills, and providing mentoring by more experienced nurses."[59] Moreover, there are not enough funded full-time positions for new graduates.

Another important element in all this is the role of generational differences and workplace expectations. Younger nurses, for instance, as noted in *Toward 2020*, will "not work in jobs where their mental and physical health is compromised for the bottom line."[60] What works to recruit and retain one generational nursing cohort does not necessarily work for another.[61] The relationships between generations in the nursing work environment also need further exploration in order to understand the factors that retain different age and generational cohorts.

Further research is needed around the intersections between the age cohorts and their work life expectations. This could include further investigation into work life relationships and experiences between generational cohorts in order to more fully understand the factors related to their recruitment and retention.

6.4 Knowledge Translation

The first issue is around knowledge transfer, that is, how the recommendations, information and evidence is being translated at the level of governments and employers. This is difficult to determine given the relative lack of information on the transfer of knowledge among health policy planners, employers, front-line supervisors and nurses. We do know from several Health Canada funded projects, including the Nursing Environments: Knowledge to Action (NEKTA)[62] and "Learning from Saskatchewan,"[63] that nurses working at the front line seldom knew about the key policy reports.[64] Smadu et al. (2006), for instance, identified several facilitators of knowledge translation including deliberative processes that allowed for face-to-face interaction between different levels of decision-makers, and knowledge utilization networks.[65]

The role of local administrators and employers in translating the recommendations posed by the key policy reports into front-line workplace practices requires further analysis. This includes an analysis of the role and responsibility of both private and public sectors through the identification of barriers[66] and the communication of best practices among employers, provinces, professional associations, unions, educational institutions, etc.[67]

6.5. Interregional Coordination and Collaboration

Drawing any conclusions about regional variances is difficult since the needs for support are highly variable across the provinces and territories. Provinces and territories need to take a hard look at the experiences of nurses in their jurisdictions, in order to focus not only on what they are doing right but also where they need to make improvements. One possible strategy is the development and implementation of a pan-Canadian permanent mechanism which serves to communicate best practices, tools and data definitions, and coordinate strategies across Canada.

In part, this stems from the recommendations made in *Building the Future, Phase II*, around the sharing of information. This possibility is raised in *Building the Future, Phase II*: "There is a need to create networks and forums among interested stakeholders at a national level and among provinces and territories to foster communication and constructive dialogue on nursing issues that affect all regions of Canada."[68] The report recommends establishing a clearinghouse for best practices around nursing recruitment, retention and education. This includes information exchange around technology, staffing patterns, workload measurement, workload management, and health and safety policies.

There is a need for a more permanent interprofessional pan-Canadian health human resource planning mechanism, clearinghouse or forum in order to share best practices, standards, and tools for quality workplaces across Canada.[69]

7. Conclusions

There are some conclusions that can be drawn. Firstly, the *National Survey* in and of itself marks an achievement in monitoring the work life practices of Canadian nurses. Moreover, by breaking down the data by specific categories (e.g. sex, region, setting), it provides a richer, more fulsome set of benchmarks by which to monitor progress for different categories of nurses. Secondly, according to Canadian nurses, policies aimed at improving their work environment are not having any real effect on their on-the-ground experiences. There are some indications of progress. Nurses have more job security and there is some progress in the accessibility of full-time employment against expectations. Nurses also report good working relationships and collaboration with physicians. On the other hand, Canadian nurses continue to work more overtime than other workers, are under time pressures, and report being short staffed stemming from past decisions to increase efficiency and cut costs by making cuts to staffing and supports. While there is currently a climate for making improvements at the high levels, on-the-ground change has been slow thus far and does not reflect a coordinated system-wide approach.

Thirdly, there are some red flags which require immediate action. Canadian nurses report higher levels of depression than other workers and there are serious needs for improvements to protect them from physical violence and on-the-job injuries, including sharps injuries. Nurses also report being emotionally abused, not only by patients and their families, but by their co-workers, and there continues to be a high rate of overtime for nurses. There are also less tangible improvements needed around co-worker support and relationships.

Finally, while a general conclusion could be drawn that all nurses require improved workplace supports, the experiences between and among nurses in different categories is highly variable; one group may have access to child care services, for example, but not to employee assistance. This unevenness itself points to additional challenges for provinces and employers as they sort out where and which policies would make the best sense for whom.

In the end, the *National Survey* signals both a commitment to fully understanding what we expect from nurses in terms of quality care and what resources are being made available to move this expectation forward. The alarms have been sounding for a number of years. Thus, many of the recommendations posited by the earlier policy reports still need to be addressed given that the movement in addressing quality workplaces has not yet been uniformly translated into front-line experiences.

Endnotes

[1] This is not intended to be a tally of current initiatives being conducted across Canada. There has been some work in synthesizing the current activities around improving the work life for health care workers. See for instance, Shamian, J., and El-Jardali, F. (2007). Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice. *Healthcare Papers*. Vol. 7. Special Issue.

[2] One example is the Quality Worklife-Quality Health Care Collaborative which is a partnership involving the Canadian Council on Health Services Accreditation (CCHSA), the Academy of Canadian Executive Nurses (ACEN), the Association of Canadian Academic Healthcare Organizations (ACAHO), the Canadian College of Health Service Executives (CCHSE), the Canadian Federation of Nurses Unions (CFNU), the Canadian Healthcare Association (CHA), the Canadian Health Services Research Foundation (CHSRF), the Canadian Medical Association (CMA), the Canadian Nurses Association (CNA), and the National Quality Institute (NQI).

[3] This is not intended to be a tally of current initiatives being conducted across Canada. There has been some work in synthesizing the current activities around improving the work life of health care workers. See for instance, Shamian, J., and El-Jardali, F. (2007). Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice. *Healthcare Papers*. Vol 7. Special Issue. To some extent, the review by Shamian and El-Jardali (2007) reflects the position that while there is currently a climate for making improvements, on-the-ground change has been slow thus far and does not reflect a coordinated system wide-approach.

[4] Baumann, A., et al. (2001). *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System.* Canadian Health Services Research Foundation.

[5] 11% of female nurses and 9% of male nurses reported in the *2005 National Survey* lower job security compared with 13% of employed females and 12% of employed males.

[6] Commission on the Future of Health Care in Canada. (2002). *Building on Values: The Future of Health Care in Canada*, p. 37.

[7] Med-Emerg Inc. (2006). *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada, Phase II Final Report*. Nursing Sector Study Corporation, p. 10.

[8] According to the *2005 National Survey*, this is all the more an issue for LPNs where 40% of those working part-time wanted full-time employment. Likewise, there is a gap between preference and actual hours reported by nurses working in Alberta, which has the smallest proportion of nurses working full-time, and those working in long-term care.

[9] Nursing Sector Study Corporation. (2005). *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada*, p. 4.

[10] Canadian Nursing Advisory Committee (2002). *Our Health, Our Future: Creating Quality Workplaces*, p. 38.

[11] Differences in pay scales between nurses working in hospitals versus those in community care settings are raised in the *Commitment and Care report*. The differences can be linked to the system of bidding for contracts for community care delivery, which has driven the wages of community care nurses far below the wage scales of hospitals. Indeed, the authors recommend pay equity for community and long-term care nurses with their hospital-based counterparts. See Baumann, A., et al. (2001).

[12] Canadian Nursing Advisory Committee (2002), p. 37.

[13] In contrast, 13% of the general female working population and 28% of the general male employed population reported working paid overtime. Moreover, unpaid overtime is more common than paid overtime with up to 50% of nurses reporting working unpaid overtime at their main job with an average of four hours per week. This is significantly higher than the general employed population where 26% of females and 30% of males work unpaid overtime.

[14] According to the *2005 National Survey*, 26% of employed females and 30% of employed males work unpaid overtime.

[15] Baumann, A., et al. (2001). This is also reported in Canadian Nursing Advisory Committee (2002).

[16] Canadian Nursing Advisory Committee (2002), p. 37.

[17] Ibid., p. 36.

[18] Ibid., p. 36.

[19] Ibid., p. 38.

[20] Over 80% of both male and female nurses reported in the *2005 National Survey* that their work is very hectic compared with 64% of all employed females and 58% of all employed males.

[21] Nursing Sector Study Corporation. (2005). *Building the Future: An Integrated Strategy for Nursing Human Resources for Canada, Phase I Final Report*.

[22] Commission on the Future of Health Care in Canada. (2002), p. 19.

[23] Canadian Nursing Advisory Committee (2002), p. 40.

[24] Advisory Committee Health Delivery and Human Resources (2003). *A Report on the Nursing Strategy for Canada*. These connections are also found within the other key reports. For instance, in the CNAC report, one predictor of job satisfaction is the quality of the relationship with one's immediate supervisor.

[25] The key policy reports are very specific about actions relating to protections against physical assault and abuse. These actions include zero tolerance polices which include an incidence review and visible consequences for the perpetrator. See for instance, the Nursing Sector Study Corporation. (2005).

[26] Canadian Nursing Advisory Committee. (2002), p. 20.

[27] There are some actions being taken to address this. The national Quality Workplace-Quality Healthcare Collaborative is one example, though it is not a permanent structure. See Quality Workplace-Quality Healthcare Collaborative (2007). *Within Our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System***.** Canadian Council on Health Service Accreditation.

[28] Canadian Nursing Advisory Committee. (2002).

[29] Nursing Sector Study Corporation. (2005).

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Ibid.

[34] The data used for the general working population comes from the 2005 Canadian Community Health Survey in the provinces of Prince Edward Island, Nova Scotia, Quebec, Saskatchewan, Alberta, and British Columbia.

[35] Canadian Nursing Advisory Committee (2002).

[36] Ibid.

[37] Ibid.

[38] Baumann, A., et al. (2001). *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System.* The Canadian Health Services Research Foundation.

[39] Ibid.

[40] According to the *2005 National Survey*, male nurses also reported significantly higher rates of job strain (27%) than other male workers (18%).

[41] Canadian Nursing Advisory Committee. (2002).

[42] When broken down by nurse subset, more LPNs than other nurses reported being dissatisfied with their job and nurses working in long-term care and hospital settings expressed the most job dissatisfaction.

[43] Canadian Nursing Advisory Committee. (2002), p. 37.

[44] Villeneuve, M., and MacDonald, J. (2006). *Toward 2020: Visions for Nursing*. Canadian Nurses Association.

[45] There are some trends when breaking the data down by workplace setting: hospital nurses had higher rates of absenteeism related to health issues, while long-term care nurses reported more days absent than their counterparts.

[46] Nursing Sector Study Corporation. (2005).

[47] These differ according to work setting. Taking into account the frailty of their clients/patients, nurses working in long-term care reported the highest incidence of patients being injured in a fall.

[48] See Shamain, J., and El-Jadarli, F. (2007).

[49] Laschinger, H. (2007). Building Healthy Workplaces: Time to Act on the Evidence. *Healthcare Papers*. Vol 7. Special Issue.

[50] This is a debatable point. A good deal of research into these connections has been around for decades. As always, however, good data and evidence are needed. This is particularly true if the research involves the working lives of nurses outside of the acute care setting in the public health sector. If, for instance, most unionized nurses work in hospitals, then the role of unionization needs to be factored into the research. See for instance, Messele, T. (2007). Did You Know? *Health Policy. Health Policy Research.* Issue 13. Available on-line at: www.hc-sc.gc.ca/sr-sr/alt_formats/hpb-dgps/pdf/pubs/hpr-rps/bull/2007-nurses-infirmieres/2007-nurses-infirmieres_e.pdf. Accessed May 15, 2007.

[51] Villeneuve, M., and MacDonald, J. (2006).

[52] The gendered construction of the health workplace is being researched in order to elicit possible policy responses. The common barriers for males include sexual stereotypes, and a lack of exposure to male role models in the media. See for instance, Villeneuve, M. (1994). Recruiting and Retaining Men in Nursing: A Review of the Literature. *Journal of Professional Nursing*. 10(4):217-28.; and Meadus, R., and Twomey, J. (2007). Men in Nursing: Making the Right Choice. *Canadian Nurse* 103(2):13-6.

[53] There have been other concerns related to market forces. Governments are urged in the *Commitment and Care* report to "re-evaluate practices, such as bidding for nursing services contracts."

[54] This issue is further complicated by the structure of competition among home care agencies. Outsourcing and competitive bidding have led to nurses being viewed as contingency workers. See for instance, Hamilton, N. (2007). Working Conditions: An Underlying Policy Issue. *Health Policy Research.* Issue 13. Available on-line at: www.hc-sc.gc.ca/sr-sr/alt_formats/hpb-dgps/pdf/pubs/hpr-rps/bull/2007-nurses-infirmieres/2007-nurses-infirmieres_e.pdf. Accessed April 1, 2007.

[55] It is not easy to pinpoint the actions being taken by both private and public sector employers. The distinction between private and public sector employers, for one thing, is not made in the *2005 National Survey*. Another consideration here is that home care nurses are incorporated into the category of community care nurses in the *2005 National Survey*, which makes it difficult to speak directly to the possible work life health issues of private home care nurses. See for instance, Home Care Sector Study Corporation. (2003). *Canadian Home Care Human Resources Study*. Available on-line at: www.cacc-acssc.com/english/pdf/homecareresources/Eng Technic.pdf. Accessed May 14, 2007. Finally, while it is important for both private and public sector employers to be involved in the discussions and solutions around quality workplace improvements, it is not clear what their involvement has been, or currently is (the last point is from a personal communication with Dr. Marlene Smadu).

[56] Provinces have different approaches to their accountability relationships with private sector employers. According to Marlene Smadu: "In Saskatchewan, employers like Extendicare sign affiliation agreements with the Regional Health Authorities, so they are held to the same level of accountability. The private sector employee issue is much bigger in jurisdictions like Ontario, whereby private sector employers are not yet integrated into the Local Health Integration Networks or the public service delivery system, especially in long-term care and home care. In terms of working conditions, in Saskatchewan most nurses and allied health employers are covered by same unions whether they work for public or private employers, although some private employers have no union involvement" (personal communication). Moreover, most private employers voluntarily undergo accreditation through the Canadian Council on Health Care Accreditation, which has introduced quality workplaces within their accreditation process. Employers are also held accountable through existing provincial/territorial labour laws and occupational health and safety legislation. Another key piece is the strategy being taken by the Quality Worklife-Quality Health Care Collaborative whereby employers and others sign are urged to sign an informal Charter around quality workplaces, which includes the following actions:

- We agree with these principles and will act now to …
  - Make quality of worklife a strategic priority.
  - Assess, monitor and report on quality of worklife indicators including the standard QWL indicators identified by the QWQHC.
  - Identify one or more priority action strategies that we will implement and evaluate.
  - Identify and build knowledge on leading practices related to healthy workplaces.
  - Exchange knowledge and network with other health leaders on healthy workplace practices.

This is available in the report Quality Workplace-Quality Healthcare Collaborative. (2007). *Within Our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System***.** Canadian Council on Health Service Accreditation**.** Whether private sector employers have signed on to this Charter is not yet known (personal communication with Dr. Marlene Smadu).

[57] Canadian Nursing Advisory Committee. (2002).

[58] Several strategies around retaining more experienced nurses is available in the following report: Wortsman, A., and Janowitz, S. (2006). *Taking Steps Forward, Retaining and Valuing Experienced Nurses.* Paper prepared for the Canadian Federation of Nurses Union. Available on-line at: www.nursesunions.ca/cms/index.php/s43ce 56e024757/aen43f3b87821137. Accessed May 24, 2007.

[59] Nursing Sector Study Corporation. (2005), p. 14.

[60] Villeneuve, M., and MacDonald, J. (2006), p. 78.

[61] See for instance, Widger, K., Pye, C., Cranley, L., Wilson-Keates, B., Squires, M., and Tourangeau, A. (2007). Generational Differences in Acute Care Nurses. *Nursing Leadership* (CJNL), 20(1) 2007: 49-61.

[62] Leiter, M., et al. (2006). *Nursing Environments: Knowledge to Action Final Report submitted to Health Canada, Health Policy Research Program: Quality Workplaces for Health Professionals.*

[63] Smadu M., et al. (2006). *Promoting High Quality Health Care Workplaces: Learning from Saskatchewan*. Available on-line at: www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/results-resultats/2006-smadu_e.html. Accessed March 20, 2007.

[64] See for instance, Irwin, G., Therrien, M-J., Thornton, T., Creasey, J., and Thornton, M. (2007). *Knowledge Utilization:* How Can We Improve Nurses' Working Conditions? *Health Policy Research.* Issue 13. Available on-line at: www.hc-sc.gc.ca/sr-sr/alt_formats/hpb-dgps/pdf/pubs/hpr-rps/bull/2007-nurses-infirmieres/2007-nurses-infirmieres_e.pdf. Accessed May 15, 2007.

[65] Ibid.

[66] One barrier may be budget constraints as noted by Smadu et al. (2006).

[67] This is being addressed through the Canadian Council on Health Service Accreditation (CCHSA), which recently revised its accreditation standards to include quality of work life measures. One definition of a quality workplace is taken from the Quality Workplace-Quality Healthcare Collaborative (2007): "A work setting that takes a strategic and comprehensive approach to providing the physical, cultural, psychosocial and work/job design conditions that maximize health and wellbeing of health providers, quality of patient/client outcomes and organizational performance." One Canadian model of a magnet hospital is the Trillium Health Centre, which takes an integrated and strategic approach to healthy workplaces, resulting in improved outcomes. See for instance, Lowe, G. (2006). *Creating Healthy Health Care Workplaces in British Columbia: Evidence for Action.* Discussion paper prepared for the British Columbia Provincial Health Services Authority. Available online at: www.grahamlowe.ca/documents/156/Creating%20Healthy%20Health%20Care%20Workplaces%20in%20British%20Columbia%20-%20Evidence%20for%20Action.pdf. Accessed May 15, 2007. There are also other examples of employers drawing up and implementing frameworks for healthy workplaces. One of the key elements of the Healthy Workplace Initiative, for instance, by Health Canada is the funding of workplace initiatives by provinces and health regions around making improvements towards healthy workplaces. The specific projects can be viewed on-line at: www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/recru/applicants-requerants_e.html. Accessed May 15, 2007.

[68] Med-Emerg Inc. (2006), p.5.

[69] The possibility of permanent health human resource planning mechanism(s) is explored by McIntosh, T., Torgerson, R., and Wortsman, A., (forthcoming). *Taking the Next Step: Assessing Support for a Pan-Canadian, Multi-Professional HHR Planning Mechanism*. Policy paper prepared for HEAL, the Canadian Nurses Association, the Canadian Medical Association and the Canadian Healthcare Association.