

**GUIDELINES FOR A QUALITY PRACTICE ENVIRONMENT FOR  
REGISTERED NURSES IN BRITISH COLUMBIA**

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## **Preface**

Quality work environments are essential for the health and well-being of all health care workers. In addition, quality practice environments for registered nurses are demonstrated to correlate positively with their job satisfaction, productivity, recruitment and retention and ultimately the quality of client care and client outcomes. However, as a result of cost cutting and reengineering in healthcare in Canada, many nurses work in practice environments that do not enable them to consistently meet established standards for nursing practice. This thesis reviews the literature on work environments in both healthcare and business, reports on an extensive consultation process with nurses in BC and introduces the Registered Nurses of British Columbia Association's Guidelines for a Quality Practice Environment. Strategies for communicating the guidelines to stakeholders and evaluating the guidelines are outlined. The implications of the guidelines for government, employers and nursing organizations are described.

## **Chapter 1 - Introduction**

### **Statement of the problem**

Registered nurses (RNs) face many diverse and complex problems that have an impact on their nursing practice. At the same time, they are accountable and responsible for making decisions that are consistent with safe and appropriate nursing care. In the current climate of cost-cutting, re-engineering and nurse shortages, there are times when competent nurses are unable to consistently meet their standards for nursing practice because of deficiencies in their practice environments.

### **Strategic Importance**

The practice environment of nurses is an issue of strategic importance to health care managers because there is a direct correlation between quality practice environments, RN job satisfaction, recruitment and retention, productivity and the quality of patient care and patient outcomes (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002a; Schultz, van Servellen, Chang, McNeese-Smith, & Waxenberg, 1998; Tourangeau, Giovannetti, Tu, & Wood, 2002). Quality practice environments, not just for RNs, but also for all healthcare workers, are fundamental to the sustainability of the Canadian health care system. The need to create professional practice environments that will attract and retain a healthy, committed workforce for the 21<sup>st</sup> century was identified as an essential requirement in the Canadian Nursing Advisory Committee report *Our Health, Our Future* (Health Canada Advisory Committee on Human Health Resources, 2002)

The 1990s in Canada was a decade of downsizing and restructuring in health care, driven by cost constraint, (Aiken, Clarke, & Sloane, 2000; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002a; Schultz, van Servellen, Chang, McNeese-Smith, & Waxenberg, 1998; Sochalski, 2001; Tourangeau, Giovannetti, Tu, & Wood, 2002) often with little consideration of employees. Consequently, health care employers today are faced with a shortage of professionals, in particular RNs. The Canadian Nurses Association projects that by 2011 Canada will have a shortage of 78,000 RNs and by 2016 the shortage will increase to 113,000 (Canadian Nurses Association, 2002b). The practice environment, with its heavy workload and apparent lack of concern for employees, is a major force driving RNs out of nursing. This problem has been compounded by the decimation of nursing leadership positions. Clinical nurse specialist, nurse manager, nurse executive and nurse educator positions have been eliminated or considerably reduced across Canada, leaving nurses unsupported in practice and without their issues and concerns for patient care represented throughout the hierarchy. Little has been done to address these problems although nurses are the largest group of health care providers and in closest contact with the “customer”. Needleman et al. (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002b) in a study to determine if there is a relationship between RN staffing and the quality of patient care, identified that RN staffing makes the biggest impact on adverse patient outcomes in hospitals.

The majority of nurses are employed in acute care hospitals where they account for approximately 35% of operating costs. Healthcare facilities, which are able to recruit and retain their nurses, decrease costs associated with high turnover and reduced productivity.

Improved patient outcomes are associated with quality practice environments for nurses and include a reduced length of stay, decreased infection, mortality and morbidity and reduced readmission rates (Baumann et al., 2001; Kearsey, 2002; Kovner, 2002; Needleman et al., 2002b; O'Brien-Pallas, Thomson, Alksnis, & Bruce, 2001; Sochalski, 2001; Tourangeau et al., 2002). Cost-saving measures that also improve patient outcomes are fundamental to the sustainability of the health care system.

### **Purpose**

Most of the literature on the topic of quality practice environments for registered nurses (RNs) has been conducted in acute care hospitals in urban centres (Estabrooks et al., 2002; Buchan, 1999; Kovner & Gergen, 1998; Norrish & Rundall, 2001; Shamian, Kerr, Laschinger, & Thomson, 2002; van Servellen & Schultz, 1999). There is little information on what constitutes a quality practice environment for nurses in rural and remote regions or in long term care, community or home care settings. The purpose of this paper is to identify the components of a quality practice environment for RNs in all settings and all geographic locations in British Columbia (BC). This paper describes how, as an RNABC policy consultant, I led the development of guidelines for a quality practice environment for RNs in all practice settings (hospital, community and home) and locations (urban, rural and remote) in BC. I will also outline strategies to communicate these guidelines and propose a three-phase approach to evaluation.

### **Outline**

This chapter provides an introduction to my thesis. It describes the problem I have identified, the purpose of my research, its strategic importance and the structure of the

paper. Chapter 2 provides an outline of relevant management principles and describes a review of the grey and published literature, including a review of the resources available through nursing organizations to support quality practice environments for nurses in Canada and internationally.

Chapter 3 describes my methodology for data collection. It outlines how, concurrently with the literature review, I sought input from nurses across BC through focus groups, an index card exercise, two Web surveys, and interviews with key informants. I wanted nurses to describe their requirements for a quality practice environment in their own practice setting. I also sought their views on the existing models of quality practice environments found in the literature. Finally, I solicited their critique of the new guidelines as they emerged and their ideas as to how they should be implemented in BC. The process of collecting, organizing and analyzing data proceeded concurrently in an effort to understand and be sensitive to what nurses in all parts of the province were saying about their practice environments. The framework which was ultimately selected, with its associated guidelines and indicators, was adapted, clarified and refined through continuing focus group discussion and key informant interviews to ensure relevance to nurses in BC.

Chapter 4 presents my findings in the form of *Guidelines for a quality practice environment for registered nurses in British Columbia*©. These guidelines were developed and validated through an inductive analysis of the data collected in conjunction with the literature review. Through a process of constant comparative

analysis (Benton, 1996), nurses in all practice settings identified which components of a quality practice environment had the most relevance and meaning for them. Concepts arising through the data analysis process were compared and contrasted with concepts in the literature.

Chapter 5 describes the conclusions I reached about the significance of quality practice environments for nurses, and potentially for other healthcare professionals and healthcare workers in general, across Canada in a time of turbulence. I outline communication, change management and evaluation strategies for the guidelines. Finally I describe the implications of my findings for all stakeholders.

## **Chapter 2 - Literature Review**

This review of the literature relating to quality practice environments is divided into four sections. The first section describes the quality management principles that provide the philosophical underpinnings of any quality practice environment. The second section reviews the publications and resources in support of quality practice environments available through nursing regulatory bodies or other nursing organizations. The third section outlines the eight frameworks I identified that had the potential to provide a basis for consideration by nurses in the process of developing quality practice environments guidelines. The fourth and fifth sections provide a summary of salient articles from the health care and business literature, with a particular emphasis on recent publications. The focus is predominantly on Canada because of its unique health care system and the growing evidence available related to Canada, however international literature that has relevance to Canada is also included.

### **Management Principles**

Committed and visionary leadership and strong management abilities are required to resolve complex and intractable problems such as the deteriorating practice environment of nurses. Health care leaders need to articulate and embrace quality management principles as a way to create organizations with a focus on quality. A focus on quality is key to long-term success in any organization. Management principles provide an overall philosophy, framework and approach to managing an organization and achieving its goals. Management principles provide the basic values of the organization and assist leaders in defining what quality means to their organization.

The senior management team needs to share a common understanding of quality management principles and what their role is in implementing them. The International Organization for Standardization publication Quality Management Principles (ISO 9000:2000) is a framework which senior managers can use to guide their organizations towards improved performance (International Organization for Standardization, 2003). The principles are evidence-based. They are derived from the collective experience and knowledge of international experts and provide an international standard against which an organization can be measured or measure itself. They can be used as a guide to develop or enhance an organization's quality improvement processes .The ISO 9000 system is intended to improve customer satisfaction, reduce the costs of poor quality and improve the efficiency and effectiveness of processes. Eight quality management principles are identified in ISO 9000:2000 series and are outlined in Table 1. These principles are applicable to all industries. They can be used in healthcare organizations to achieve standards of quality that are recognized and respected internationally.

TABLE 1 - QUALITY MANAGEMENT PRINCIPLES

Principle	Standardized Description
Customer Focus	Organizations depend on their customers and therefore should understand current and future customer needs, should meet customer requirements and strive to exceed customer expectations.
Leadership	Leaders establish unity of purpose and direction of the organization. They should create and maintain the internal environment in which people can become fully involved in achieving the organization's objectives.
Involvement of people	People at all levels are the essence of an organization and their full involvement enables their abilities to be used for the organization's benefit.
Process approach	A desired result is achieved more efficiently when activities and related resources are managed as a process.
System approach to management	Identifying, understanding and managing interrelated processes as a system contributes to the organization's effectiveness and efficiency in achieving its objectives.
Continual improvement	Continual improvement of the organization's overall performance should be a permanent objective of the organization.
Factual approach to decision making	Effective decisions are based on the analysis of data and information.
Mutually beneficial supplier relationships	An organization and its suppliers are interdependent and a mutually beneficial relationship enhances the ability of both to create value.

Health care leaders can use these management principles as they guide their organizations towards quality practice environments and improved performance. Some of the benefits that arise from applying (not just espousing) these principles in organizations are greater employee commitment to the success of the organization, the creation of a high quality, and motivated workforce, increased operational problem solving and a reduction in operating costs by making internal operations more effective and efficient.

## **Publications and Resources from Nursing Organizations**

Many different nursing organizations are focusing on the issue of healthy practice environments. Many of the Canadian nursing regulatory bodies and associations have policies or programs to address practice environment issues within their jurisdiction. The Registered Nurses Association of British Columbia (RNABC) has a vision of excellence in nursing. Working towards practice environments that support quality nursing practice is one of RNABC's key strategic priorities in attaining that vision. There are two major initiatives that have been developed specifically to address registered nurses' concerns about their work environments. First, RNABC's Agency Consultation Program offers an innovative approach to assist staff nurses, nurse administrators, nurse educators and others to engage in a process that can lead to a more effective nursing practice environment. Second, the 2001 policy *Nursing Practice Environments for Safe and Appropriate Care* (Registered Nurses Association of British Columbia, 2002) outlines key elements of a quality practice environment. RNABC staff have used these programs successfully in publications (Winslow, 2002), workshops and consultations to help nurses identify what key elements are particularly relevant to their settings and make plans to achieve them. Like BC, Alberta, Manitoba, Ontario and Nova Scotia have ongoing initiatives to improve nurses' practice environments. BC, Nova Scotia and Ontario are using the same valid and reliable tool and report form to assess practice environments within health care organizations, ultimately providing the possibility of comparative data.

Professional practice environments are also a high priority for the Canadian Nurses Association (CNA). The CNA *Code of Ethics for Registered Nurses* (Canadian Nurses

Association, 2002a) has eight values central to ethical nursing practice, one of which is nurses value and advocate for quality practice environments that have the organizational structures and resources necessary to ensure safety, support and respect for all persons in the work setting. In April 2002 CNA, in collaboration with Health Canada's Office of Nursing Policy and the Canadian Council on Health Services Accreditation (CCHSA), convened a national workshop on *Quality of Worklife Indicators for Nurses in Canada*. The goal was to identify a set of quality of worklife indicators that would make a measurable difference for regulated nurses. The eight indicators identified were overtime hours, span of control, full-time employment, leadership, autonomy in clinical practice, professional development, absenteeism and grievances (Canadian Nurses Association, 2002c). These measures were acknowledged to be "crude measures of the right thing," that is, while not perfect or comprehensive indicators of a quality work environment, they may provide a proxy measure. Since it is believed the data are presently or readily collected in all jurisdictions, there will be comparative data across organizations, regions and provinces. The workshop's major recommendation was to incorporate these indicators into CCHSA's 2004 Achieving Improved Measurement (AIM) Accreditation program. The workshop concluded that there is far more at stake than the work environment of individual nurses. "The issues discussed ... are central to the broader public policy goal of creating a cost-effective health care system that delivers excellent client care" (Lowe, 2002) p 1.

Another Canadian initiative in support of quality practice environments is led by Health Canada's Office of Nursing Policy. This office was established in 1999 to bring a nursing

perspective to the many challenging health and health care issues facing the federal government. To date no Canadian quality practice environment guidelines for nurses have been identified, however, at the 2002 CNA Biennium the federal Health Minister announced \$250,000 from Health Canada to develop Healthy Workplace Guidelines. A national committee has been established and work on these guidelines has begun. It is intended that governments, employers and unions across Canada will use these guidelines to improve the nursing practice environment

The United States is a step ahead of Canada. In January 2002 the American Association of Colleges of Nursing published a white paper *Hallmarks of a Professional Nursing Practice Environment* (American Association of Colleges of Nursing, 2002a). This paper identified eight environmental characteristics that support and optimize professional nursing practice and could be construed as guidelines. The characteristics listed are philosophy of care, valuing nurses and their expertise, executive leadership, decision-making, clinical advancement, professional development, collaboration and the use of technology. Each characteristic has three to eight components that describe it further and could be considered indicators. A pamphlet has been developed from this paper that helps student nurses select a good work environments to begin practice (American Association of Colleges of Nursing, 2002b).

The Washington State Nurses Association (WSNA) has taken a different approach to protect the well being of nurses and clients. Citing anger and frustration with the work environment, in 2002 they filed a law suit against a hospital which is alleged to have

violated state law by not providing adequate staffing so nurses could take breaks. WSNA said it was a health and safety issue for nurses and their patients.

Many different nursing organizations in Canada and the United States are focusing on healthy practice environments in a variety of ways. While some organizations are contemplating working collaboratively, many are proceeding independently. Whether these independent initiatives will strengthen or weaken the ultimate goal of quality practice environments for nurses remains to be seen.

### **Frameworks for Quality Practice Environment Guidelines**

Eight potential frameworks that could be considered in the development of guidelines for a quality practice environment for nurses were identified in the literature. Table 2 provides a synopsis of each framework and highlights issues to be considered in adopting or adapting it for nurses in BC.

TABLE 2 - POTENTIAL QUALITY PRACTICE ENVIRONMENT FRAMEWORKS

Author	Name	Description	Issues to Consider
American Nurses Credentialing Center (ANCC)	Magnet Recognition Program for Excellence in Nursing Services	Eight standards for nurse administrators	<ul style="list-style-type: none"> <li>- has an extensive evidence base developed over &gt;20 years</li> <li>- based on the American health care model</li> </ul>
Baumann et al. (2001)	Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system. A policy synthesis.	Six principles of Kristensen’s model and related nursing issues	<ul style="list-style-type: none"> <li>- based on well-substantiated research evidence</li> <li>- a Canadian publication</li> <li>- Kristensen’s model for society, stress and health uses language not familiar to most nurses</li> </ul>

Canadian Council on Health Services Accreditation (CCHSA)	Achieving Improved Measurement (AIM)	Five descriptors of the worklife dimension	<ul style="list-style-type: none"> <li>- descriptors are not well developed or based on research</li> <li>- model is evolving</li> </ul>
Canadian Nurses Association (CNA) (2001)	Quality Professional Practice Environments - CNA Framework for Action	Six key indicators and 25 criteria	<ul style="list-style-type: none"> <li>- a Canadian model</li> <li>- indicators reviewed and ranked by nurses and their organizations across Canada</li> <li>- a work in progress and not all indicators are equally significant or a priority for action</li> </ul>
College of Nurses of Ontario (CNO)	Quality Practice Setting Attributes Model	Seven key system attributes and 37 elements	<ul style="list-style-type: none"> <li>- tested for validity and reliability</li> <li>- focussed on systems and CQI</li> <li>- RNABC has license to use the tool in ACP, but there are copyright restrictions</li> </ul>
International Organization for Standardization (ISO) (2001)	Quality Management Systems - Guidelines for process improvements in health services organizations	Eight quality management systems guidelines with process linkages	<ul style="list-style-type: none"> <li>- language not familiar</li> <li>- orientated to the American health care system and big business</li> <li>- only parts of the model are applicable</li> </ul>
O'Brien-Pallas & Baumann (1992)	Quality of Nursing Worklife Issues	Four internal dimensions, three external dimensions and a number of foci related to each dimension	<ul style="list-style-type: none"> <li>- based on an analysis of the theoretical literature</li> <li>- ten years old</li> <li>- Nursing Effectiveness, Utilization and Outcomes Research Units at McMaster University and University of Toronto have refined and extended this model</li> </ul>
Registered Nurses Association of British Columbia (RNABC)	Agency Consultation Program (ACP)	Ten support system descriptors and 66 questions (indicators)	<ul style="list-style-type: none"> <li>- a useful tool in practice</li> <li>- familiar to RNABC</li> <li>- not tested for validity and reliability</li> <li>- focused on systems and CQI</li> </ul>

An RNABC staff focus group eliminated five of these frameworks through a process of analysis and discussion. The frameworks were eliminated because they were not based on substantive and current evidence or they were not relevant to the Canadian health care system and all practice settings. Three frameworks were determined to have the potential

to provide a foundation for the development of evidence-based guidelines for a quality practice environment in the BC context. They were:

- the College of Nurses of Ontario's (CNO) Quality Practice Setting Attributes Model;
- Kristensen's model in the *Commitment and Care* policy synthesis; and
- CNA's Framework for Action.

RNABC is using CNO's model and its associated evidence-based tool for its Agency Consultation Program. The tool could fairly readily be converted into guidelines and indicators. The language is clear, concise and familiar to nurses and it is applicable across all practice settings. However, because of concerns related to copyright, the CNO model was eliminated from further consideration. The two remaining frameworks were taken to the focus groups to contrast, compare and consider.

### **Healthcare Literature**

There is burgeoning literature both in Canada and internationally on the topic of quality practice environments and their relationship to nurse recruitment and retention and improved client outcomes. There is also extensive literature on the work environment and its relationship to outcomes in industries outside healthcare. This section is divided into two parts. The first part focuses on the healthcare literature and the second on the general business literature

Much of the early literature on quality practice environments for nurses was based on the magnet hospital research that originated in the early 1980s in the United States. Research

shows that the magnet hospital designation is a valid marker of quality nursing care. The Magnet Hospital Program began in 1980 when the American Academy of Nurses undertook a study to identify “magnet” hospitals, that is, those that attract and retain registered nurses, and to identify the factors associated with this success. For the last two decades research on magnet hospitals has identified hospitals that are successful in creating environments in which excellent nursing care is provided. The literature describes the features those hospitals have in common that might account for their success in recruiting and retaining nurses. Outcomes in magnet hospitals include higher patient satisfaction, lower mortality rates, lower rates of nurse burnout and lower rates of needle stick injury. The nurses in magnet hospitals were less likely to feel emotionally drained or frustrated by work and were more satisfied with their job. They rated quality of care in their hospital higher. Although there were higher nurse to patient ratios, the higher cost was more than significantly offset by the shorter length of stay and lower utilization of intensive care unit days (Scott, Sochalski, & Aiken, 1999). The magnet hospital literature continues to identify organizational attributes that attract and retain nurses and shows they are consistently and significantly associated with better patient outcomes. Nurses working in magnet hospitals have higher job satisfaction and lower rates of work-related burnout (Aiken, Havens, & Sloane, 2000; Havens & Aiken, 1999; Laschinger, Shamian, & Thomson, 2001).

More recently the findings of a study of 43,000 nurses in five countries linking registered nurse staffing, working conditions and client outcomes was reported (Aiken et al., 2001) Of the 17,000 Canadian nurses in the study almost half said the quality of care in their

workplaces had deteriorated in the past year and as many said they left work undone at the end of their shift. The majority reported regular verbal abuse. Nearly three quarters reported doing non-nursing jobs. The study identified core problems in workforce design and management that, when coupled with a growing nurse shortage, contributed to adverse patient outcomes and high levels of nurse burnout and job dissatisfaction.

Similarly, in a retrospective study of 46,941 patients discharged from 75 acute care hospitals, Tourangeau, Giovannetti, Tu, & Wood (Tourangeau et al., 2002) found three predictors of a lower 30 day mortality rate: a richer registered nurse skill mix, more years of experience on a clinical unit, and a larger number of shifts missed. They concluded that if mortality rates are an important indicator of quality care in hospitals, then the number of experienced registered nurses is important. The significance of the larger number of shifts missed is not clear, but it may be that when nurses cope with workplace pressures by taking unscheduled time off, they may be able to rest and regain their capacity to work effectively again.

Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky (Needleman et al., 2002a) reported on a controlled study of 799 American hospitals from diverse states which supports the premise of Tourangeau et al. (Tourangeau et al., 2002), one also long held by nurses. They found “consistent evidence of an association between higher levels of staffing by registered nurses and lower rates of adverse outcomes” (p.1720).

A number of other Canadian studies come to similar conclusions. A key component of a quality practice environment is sufficient registered nurses to provide safe, competent and

ethical care. Nurses in Canada report that their work environments are not conducive to satisfaction, recruitment and retention or good health. Shamian, Kerr, Laschinger, & Thomson (Shamian, Kerr, Laschinger, & Thomson, 2002) studied the relationship between the work environment and the health and well being of 6,609 registered nurses in 160 acute care hospitals in Ontario. The results indicated, “full-time work was associated with burnout, poor general health, and loss of control over practice” (p. 47). Like Baumann et al. (Baumann et al., 2001), Shamian et al. recommended accreditation standards should have indicators for measuring both the quality of the work place and the quality of patient care. As noted in the previous section, work has begun in this area between CNA and CCHSA.

Zboril-Benson (Zboril-Benson, 2002) in a quantitative, non-experimental study of absenteeism amongst 2000 nurses in Saskatchewan, reported a major cause of absenteeism was fatigue related to work overload. She noted restructuring and health care cuts reduced the work force without reducing the workload. Those nurses who remained in the work force reported working harder while the quality of care deteriorated. She concluded long-term strategies are needed to recruit and retain registered nurses and foster the conditions necessary to ensure quality patient care.

Estabrooks et al. (Estabrooks et al., 2002) sought to identify the characteristics of a quality practice environment for nurses. They defined a quality practice environment as “a set of workplace features that, when present, enable nurses to demonstrate professional practice characterized by decision-making autonomy, clarity of mission, and organizational responsiveness” (p.265). They studied 17,965 registered nurses working in

acute care hospitals in three Canadian provinces. They identified attributes that best capture the essence of quality practice environments including:

- supervisory staff that is supportive of nurses;
- opportunities for staff nurses to participate in policy decisions;
- support for new and innovative ideas about patient care;
- freedom to make important patient care and work decisions;
- praise and recognition for a job well done;
- clear philosophy of nursing pervades the patient care environment; and
- administration listens and responds to employee concerns.

A number of Canadian reports have focused on nurses' working environments and made extensive and consistent recommendations. A 2001 report, *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System* (Baumann et al., 2001) is based on a wide-ranging literature review, interviews and focus groups. It investigates the impact of the work environment on the health of the nursing work force and hence, potentially, on patient outcomes. It includes more than four dozen recommendations to improve the worklife of nurses. The recommendations focus on addressing staffing issues, supporting nursing leadership and professional development, dealing with abusive or violent behaviour, promoting workplace safety and health and promoting recruitment and retention, among others.

Similarly, the Canadian Nursing Advisory Committee (CNAC) was established in 2001 by the federal/provincial/ territorial Advisory Committee on the Health Human Resources

(ACHHR) to formulate recommendations for policy direction that would improve the quality of nursing worklife. The report *Our Health, Our Future* (Health Canada Advisory Committee on Human Health Resources, 2002) calculates Canadian RNs work almost a quarter of a million hours of overtime every week, the equivalent of 7,000 full-time jobs per year. In addition, over the course of a year more than 16 million hours are lost to RN injury and illness – the equivalent of almost 9,000 full time nursing positions.

The cost of overtime, absentee wages and replacement for RN absentees is estimated to be between \$962 million and \$1.5 billion annually. Costs for licensed practical nurses and registered psychiatric nurse are on top of this amount. The report made 51 recommendations that can be grouped into three broad categories:

- those designed to put in place conditions to resolve operational workforce management issues and to maximize the use of available resources;
- those designed to create professional practice environments that will attract and retain a healthy, committed workforce for the 21st century; and
- those designed to monitor activities and generate and disseminate information to support a responsive, educated and committed nursing workforce (p.2).

The report concludes, “Only urgent action will improve the situation” (p.46).

At the provincial level, Manitoba’s Minister of Health established the Worklife Task Force to examine issues that affect nurses’ working conditions and their workplace environment. The report of the task force (Manitoba Association of Registered Nurses, 2000) identified 25 issues under five broad categories: staffing, working conditions, education, community health and valuing. The issues were not prioritized as priorities

varied nurse-to-nurse, site-to-site and region-to-region. Far ranging recommendations were made to address each issue. Many recommendations had potentially significant and immediate costs associated with them, such as revising staffing guidelines and adjusting budgets to reflect changes in acuity of clients and intensity of care in acute and long-term care facilities and in the community. Some recommendations were low cost, such as those reflecting the need to listen to and communicate with nurses.

The Academy of Canadian Executive Nurses (ACEN), in a 2002 draft document *Nursing Executive Leadership* (Academy of Canadian Executive Nurses, 2002), explored the leadership structures and behaviours required for nursing in an academic health sciences centre. It describes nurse leaders as key to supporting nurses practising in what can become a “morally and ethically distressing work environment” (p. 7). It affirmed, “we need to restore humanism to the work environments to help nurses feel safe, respected and valued” (p. 10). The paper concludes with recommendations about what action ACEN should take that will enable nurse leaders, in collaboration with others, to create a “new vision of the professional practice of nursing with a reconfigured work design and work environment compatible with the new economy, workplace and workforce” (p.13).

In the United States, the American Joint Commission on Accreditation of Health Care Organizations released a report *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis* (Joint Commission on Accreditation of Healthcare Organizations, 2002). This report addressed factors underlying the nurse shortage and identified the need to transform the workplace to give nurses the independence and

support they need to do their work well, thereby creating a culture of professional satisfaction and encouraging retention. They noted in particular the need for appropriate staffing levels and zero-tolerance policies for abusive behaviour by physicians and other health care practitioners.

In 2002 The American Association of Colleges of Nurses published a white paper *Hallmarks of the Professional Nursing Practice Environment* (American Association of Colleges of Nursing, 2002a). This paper identified eight environmental characteristics that support and optimize professional nursing practice and could be considered guidelines. The characteristics describe the philosophy of care, valuing nurses and their expertise, executive leadership, decision-making, clinical advancement, professional development, collaboration and the use of technology. Each characteristic has three to eight components that describe it further and could be considered indicators.

*Creating High-Quality Health Care Workplaces* (Koehoorn, Lowe, Rondeau, Schellenberg, & Wagar, 2002) broadens the discussion of quality practice environments beyond nurses. It reported health professionals are the least likely of all occupations to rate their work environment as healthy. It said most employers do not place human resources at the centre of their business strategy. It recommended several strategies to recruit and retain employees including making high quality work environments central to corporate values and mission; confirming that employees are assets; and building quality work environments into business plans showing links to results. The recommendations call for a bold new vision of health human resources built around recruitment, retention,

staff development and quality of worklife. It states if progress is to occur, ministries, unions, professional associations, and leaders and managers at all levels within healthcare organizations must be committed to this vision.

Izzo and Withers (Izzo & Withers, 2002) note that in addition to a changing demographic among healthcare employees there is also a shift in their work ethic. They say, “employees today want to achieve balanced lives, partnership with their employers, experience personal and professional growth, feel they are making a worthwhile contribution in their job, and enjoy a sense of community at work” (p. 53). They note replacing an employee may cost 150 percent of the employee’s annual salary or more, so employers have a direct financial incentive to respond to these new work values.

While the healthcare literature indicates that there is a correlation between work environments, client outcomes nurse satisfaction and costs, there are some caveats about the relative strength of the associations. Further work is warranted on these relationships particularly beyond the acute care sector. Nonetheless, this body of literature not only contains an indictment of many of the existing management practices in healthcare but it also provides wide-ranging solutions and outlines the associated benefits. There are major implications for nurses, their employers and governments who are concerned about quality.

### **Management Literature**

It is not only the healthcare literature that addresses the work environment. Over the past 40 years the general management literature has described the practices and attitudes that

make a good employer and identified the benefits that accrue from being a good employer. Vroom (Vroom, 1964) identified structural, procedural and internal aspects of an organization that affect productivity. He noted that when workers had higher levels of influence in decision-making about their work, productivity was higher. Herzberg (Herzberg, 1973) challenged the notion that money is a substantial motivator. He identified that satisfaction, learning and achievement are more effective motivators. Similarly, Neuhauser (Neuhauser, 2002) states that while financial compensation contributes to overall job satisfaction, it often ranks 10<sup>th</sup> or lower on a scale of key factors. She reports that often employees are more interested in more time than more money. She claims that in the long run people choose to stay in an organization because they are respected and feel pride in their work.

A study of 2.4 million workers in 40 countries asked employees how they wanted to be treated (Lebow, 2003). The employees identified that they wanted to be involved in decisions relevant to them, they wanted to be appreciated and treated as significant to the organization and they wanted autonomy, permission to make their own decisions.

In 1996 a study by Canada's National Quality Institute showed that a focus on quality is a good investment. It demonstrated that the cost of poor quality is about 32.7% of payroll costs in small to medium sized service companies. In 1998, in collaboration with Health Canada, the Institute developed the Canadian Healthy Workplace Criteria (National Quality Institute, 1998). The criteria for successful organizational improvement are:

- leadership;

- planning;
- customer focus;
- people focus;
- process management;
- supplier focus; and
- organizational performance.

In 2001 Health Canada created an initiative called Canada's Healthy Workplace Week and established a Web site with year round resources for workplace health. The Web site provides tools and resources to help companies establish workplace health. It lists ten strategies for long-term organizational health, namely:

1. Acknowledge the value of people within your organization in your vision and/or mission statement;
2. Develop a written policy on employee well-being for your organization;
3. Determine key success factors for workplace and employee health issues and link these to your strategic direction;
4. Incorporate goals and objectives on workplace and employee health and well-being into your organization's strategic planning process;
5. Ensure that there is a mechanism in place to review relevant occupational health and safety legislation and that your organization is in compliance;
6. Ensure that a commitment to a healthy workplace environment is demonstrated to employees by the management team;

7. Work at improving the interpersonal skills and leadership abilities of management and supervisory levels to help sustain a culture that reinforces a healthy workplace;
8. Share leadership, responsibility and accountability for healthy workplace issues throughout the organization;
9. Ensure that employee health issues are considered in the management decision-making process; and
10. Keep management informed of the impact of healthy workplace issues.

(National Quality Institute, 2003)

A research report by human resource consultants Watson Wyatt Worldwide concludes that to be successful, companies need to invest in people at all levels. They state, “human capital is the only resource that can give business a sustainable competitive edge” (Watson Wyatt Worldwide, 2002a). In a further study Watson Wyatt Worldwide, clearly links superior people practices to an increased return to shareholders (Watson Wyatt Worldwide, 2002b). The report concludes, “The message is clear. The better an organisation is doing managing its human capital the better the return is to shareholders.” The report identifies the 41 people practices that play the greatest role in creating shareholder value.

In Canada Martin Shain, a Senior Scientist at the Centre for Addiction and Mental Health and Head of the Workplace Program at the Centre for Health Promotion, University of Toronto, takes the position that the work environment has a direct influence on health and productivity. (Shain & Survali, 2000) He claims the organization of work can affect

productivity directly and indirectly. “Directly, through design of work systems and efficiencies in management practices; indirectly, through organizational practices that cause anxiety, depression and other negative emotional states that are antagonistic to productivity in themselves and can also contribute to physical disease processes” (p. 5). He estimates that the cost of workplace absenteeism is approximately \$30 billion a year, two thirds of which is, productivity costs, wage replacements and disability pay-outs. Shain describes organizations that take a multi-stakeholder approach to business success. He says, “these organizations judiciously balance the needs of employees and customers – and in doing so create the conditions for truly *sustainable* high performance. Leaders in these workplaces recognize that employee and customer results are not an either/or proposition ... and that employee and customer satisfaction feed off each other. So they climb both ladders of customer delight, and employee capability/delight” (p. 6).

In the United Kingdom in 2000 the National Health Service established the Health Development Agency (HDA) to identify the evidence of what works to improve people’s health and reduce health inequalities. HDA has identified six aspects of workplace health that impact the health and well being of people including management practices, staff involvement, occupational health, staff support, absence management and a healthy lifestyle (Health Development Agency, 2003). Each of these aspects has an associated standard and a series of indicators. HDA recommends a wide organizational approach to workplace health, which means establishing an integrated, sustainable program of activities that reflect the priorities of the staff and of the organization across a range of

issues and identifies the potential business benefits of a healthy work environment including:

- improved productivity
- reduced sickness absence
- reduced staff turnover and the retention of valued staff, which means reduced recruitment, training and induction costs
- improved staff attitudes towards the organisation and higher staff morale
- a more receptive climate for - and ability to cope with - workplace changes
- a decrease in accidents
- enhanced business reputation and customer loyalty

There are significant cost benefits associated with quality work environments.

Repeatedly, research studies looking at human resource practices and their correlation with business performance show companies with high performing work practices consistently outperform others by a wide margin. Some of the ways that successful companies outperform others is by attracting and retaining high caliber employees, who in turn produce high quality products or provide high quality services. These companies encourage innovation and experience less resistance to change, all of which saves money (Levering, Katz, & Moskowitz, 1994).

The business case for investing in quality practice environments needs to be made.

McKeown's *A Four Step Guide To Building the Business Case for a Healthy Workplace*

(McKeown, 2002) provides a step-by-step process for developing a business case to influence strategic decisions as follows:

- Step One: Identify the benefits to your organization's profile.
- Step Two: Predict the cost savings from improved employee health and productivity.
- Step Three: Develop your Healthy Workplace Plan including estimated costs.

This step places organizational culture at the heart of creating a healthy workplace and consequently improving the bottom line.

- Step Four: Calculate the predicted return on investment.

Organizations with quality work environments support employees on many levels - physical, social, personal and developmental. By working to improve their employees' overall quality of life, within and outside the workplace, employers see dramatic results including improved morale, productivity and, ultimately, profitability. There are very real financial consequences for employers who do not address the quality of the work environments and the stress employees feel as they try to meet the multiple and often conflicting demands of work, family and life in general. Employers with a "people first" agenda that helps employees integrate work and family life become leaders in attracting and retaining staff. Innovative programs and approaches will follow once the operational cost/benefit reasons are apparent.

There is value to all organizations in being recognized as a socially responsible employer. A healthy workplace with motivated employees is vital for organizations that want to

create value for stakeholders. Conversely, poor work environments contribute to an overall negative impression of an organization. In building the case for a quality work environment, health care leaders need to be able to demonstrate value for public funding. Enlightened healthcare leaders recognize that quality work environments are essential to the health and productivity of all staff and to the organization's financial goals. Good health is good business.

### **Chapter 3 –Talking to Nurses**

Incorporating nurses' voices into the evidence to develop the guidelines was an important part of the process. I used an inductive, non-linear and qualitative approach to collect data to develop quality practice environment guidelines. I used four different strategies to collect data from nurses in BC. My two major strategies were to hold focus groups with nurses in all parts of the province and in all practice settings and to interview key informants. The key informants were predominantly nurse leaders as well as a small group of non-nurse health care leaders who had a special interest in or perspective on quality environments. A secondary strategy included an index card exercise that supplemented the focus groups and was used to ensure no element of a quality practice environment was overlooked. Finally, I put a draft of the guidelines on the RNABC Web Site and on the BC Nurse Leaders' Web Site to enable further input by nurses across BC.

#### **Focus Groups**

The focus group approach to collecting qualitative information is based on the assumption that people are an important source of information about themselves and the issues that affect their lives. Focus groups enable people to articulate their thoughts and feelings. They often evoke candour and spontaneity and are an effective way of collecting rich data. They can be used to gather in-depth views and opinions of homogeneous groups of people for social science research. The group interaction provides data and insights that would not be accessible without the dynamics that occur in a group (Barbour, 1999; McDaniel & Bach, 1994). For these reasons focus groups were deemed a good approach to collect information from nurses in BC about their practice environments.

An inductive approach was taken to analyze the data as it was collected. Concepts and ideas derived from one focus group were taken to subsequent focus groups for discussion. Concepts that were recurring and generally supported were taken to other focus groups to develop further. At the same time, relevant literature was reviewed. Through a process of constant comparative analysis, the data were categorized and linked and a framework evolved that provided the foundation for quality practice environment guidelines (Benton, 1996).

RNs are an important source of information about themselves and the issues that affect their lives and their practice environment. I conducted focus groups with RNs in urban, rural and remote regions of BC. RNs from all practice settings (acute care, long term care, community and home care) participated in the focus groups. Each group or individual had the opportunity to consider the ideas of the previous groups or respond to issues raised by key informants as they were being interviewed within the same timeframe. I continued with the focus groups until there was general agreement about the components of a quality practice environment and no new data were being generated. I conducted a total of 14 focus groups in 2001 and 2002.

The first five focus groups occurred in 2001. Their input was used as the foundation of the RNABC policy Nursing Practice Environments for Safe and Appropriate Care (Registered Nurses Association of British Columbia, 2002). The sixth focus group of RNABC staff reviewed the composite feedback and considered the frameworks found in

Table 2. In conjunction with key informants, two frameworks were selected for further consideration by subsequent focus groups.

Focus groups 7 and 8 had the opportunity to review both the CNA and the Kristensen frameworks. It became clear that the CNA framework held the most meaning for nurses. They found some of the language of the Kristensen model vague and non-specific with few criteria identified. On the other hand, they found the structure and the language of the CNA framework easy to understand and the indicators had significance for them. They identified some concerns that were discussed further with subsequent focus groups. In particular they were concerned that not all the major features of a quality worklife were included in the framework and there were some components included that they questioned. They recommended adapting the CNA framework by eliminating one of its key indicators (Innovation and Creativity) and re-distributing its criteria. In this way, the two frameworks for quality practice environments were narrowed to one. Through ongoing focus groups the CNA framework was adapted and refined and indicators were created in a way that had meaning for nurses in BC.

To ensure all features of a quality practice environment were considered, RNABC staff went through a process of identifying all possible indicators from the literature and the index card exercise and attaching them to a part of the CNA framework. Focus groups 9 to 13 reviewed this work and went through a process of honing in on the most significant indicators, ensuring they were all-inclusive and categorized appropriately with wording that captured the essence of what was important to nurses. In this way the focus groups

refined the guidelines and indicators. The draft document that resulted from this process was put on the RNABC and BC Nurse Leaders Web sites for review and comment. It also formed the basis for discussions with the Executive Committee of the British Columbia Nurses union and other key informants.

The final focus group was with the RNABC Professional Practice Group Council. They suggested minor modifications and supported the document in general. They agreed it was important nurses and their employers had ideals to work towards. They concluded it was “time for RNABC to be a leader” and “we need to find opportunities to work with BCNU.”

Focus group participants and key informants provided verbal consent to participate in the study and further indicate their willingness to participate by coming at the scheduled time and contributing to the discussion. Data recording was done on overheads, supplemented by written notes taken at the time of the meetings. After each focus group I analyzed the data using a process of constant comparative analysis to code, categorize and link data. For example, codes identified such as “heavy patient assignments”, “not enough nurses”, “lack of control” and “increasing acuity” reflected issues usually at the top of the agenda for nurses in each of the focus groups. When categorized together these codes came under the higher-level concept of “workload”. Some concepts were recurring in different discussions. For example, the need to be free of non-nursing tasks was a recurring theme that could ultimately have been included under “workload”, “control over practice” or “organizational support

Data collection, organization and analysis proceeded concurrently until no new information was being collected and the data were organized in a way that had meaning for RNs (Benton, 1996; Glaser & Strauss, 1967; Irurita, 1996; Glaser & Strauss, 1967; Irurita, 1996). Ultimately five higher-level concepts were identified that encompassed and categorized all the significant issues nurses raised about their practice environments. Linked together, with their descriptors and indicators, they created a framework that specifically addresses the components of a quality practice environment for RNs in BC.

The results were presented in a framework that outlined the key components of a quality practice environment for RNs in BC. The framework evolved out of the data collected from the focus groups and interviews and interwoven with concepts found in the ongoing literature review.

### **Key Informants**

Data collected from interviews with key informants, nurses who have a special interest, understanding or expertise on the topic, were used to supplement and validate the focus group data. I contacted a wide range of key informants on the topic of quality practice environments including nurses in all practice settings and in a variety of roles in BC and across Canada as well as non-nurse health care administrators. In various ways they contributed to the development and refinement of the framework, guidelines and indicators. Generally key informants agreed such guidelines would support nurses and improve their worklife in all areas of practice. They believed a simple and specific resource, based on Canadian content, would be helpful in advocating for quality practice

environments. Some had concerns about imposing an additional level of bureaucracy or creating a self-serving document that would not be enforceable. They concluded the work was important, the guidelines were generally well supported by evidence and such a document would assist in developing plans to create quality work environments. Some key informants acted as wordsmiths. For example, one key informant recommended, “flexible scheduling” instead of “self scheduling” to avoid potential issues for the nursing union. Another key informant further augmented this concept to become “flexible and innovative scheduling”. These concepts were later further endorsed by the final focus group. For the most part, the key informants did not identify any new issues beyond those identified by the focus groups, but essentially provided a refinement and a validation of the work the groups had done.

Input was also solicited, but not received despite follow-up requests, from other key informants such as the Aboriginal Nurses Association of Canada, which was working concurrently on a best practices document on work environments.

### **Index Card Exercise**

An index card exercise was undertaken in conjunction with two focus groups and with regional workshops in the Okanagan and Kootenays. In this exercise individual nurses independently wrote on index cards what they identified as the most important criterion of a quality practice environment. The cards were then passed around the room and each nurse had a chance to validate the importance of the criteria their colleagues identified by putting a check mark on the card. I used the cards as a form of validation to ensure all concepts were included within the guidelines and no ideas that might relate to a particular practice setting or position had been overlooked.

## Web Survey

Towards the end of the data collection process, the penultimate draft of the guidelines was posted on the RNABC and the BC Nurse Leaders Network Web site to give wider opportunity for input from nurses. The RNABC Web site provides an opportunity to solicit input on topical issues from members with Internet access. In this case members had the opportunity to comment on the draft quality practice environment guidelines when they were posted on the RNABC Web site from May 21 to July 15, 2002. Despite advertising the survey in the RNABC Online Newslines, there were only 15 responses to the five-question survey. Some members commented independently that there was either no time or ability to access the Internet at work and when they got home, there were many other priorities. There are undoubtedly ways to improve this approach to getting member feedback. Responses to the draft posted on the BC Nurse Leaders Web site have been included in the key informant section. A summary of the responses to closed questions on the RNABC Web site is found in Table 3.

TABLE 3 - SUMMARY OF RESPONSES TO CLOSED QUESTIONS

Question	Yes	No	N/A
Is the framework sufficiently inclusive?	14	1	0
Do the indicators fit logically under the standards <sup>1</sup> ?	15	0	0
Would you be able to use something like this in your organization?	12	2	1

There were also three open-ended questions which resulting in far-ranging comments. To the question “what is missing in the standards that must be included,” members identified personal requirements for their well-being, such as fitness equipment and discounted gym

<sup>1</sup> At this stage in the process the guidelines were being called standards”

passes, as well as professional needs such as regular performance appraisals, the appropriate forums to set standards, and time to take breaks and attend inservices. One member commented the standards are too prescriptive and should be called guidelines, saying guidelines would “offer a lobby and advocacy tool for nursing administration.”

When asked how realistic or idealistic these standards are, some members said they were very realistic while others said they were somewhat unrealistic given the current situation in their facility. They commented that while some facilities do not meet these standards, they are a goal to work towards and they would enhance an agency’s ability to attract and retain nurses. One respondent noted that nursing is under-represented while professions such as physiotherapy, pharmacy and medicine have done a better job of securing prominence and respect. Another was afraid there would be no one to blow the whistle and enforce change. One nurse said “the message needs to be out there that providing a quality practice environment isn’t a ‘nice to do’ it is a ‘need to do’ because it matters to patients.”

Some members raised questions about the meanings of terms such as “flexible scheduling” and “zero tolerance of abuse.” Other comments included:

- these standards are the ideal and reflect the Magnet Hospital literature;
- the agency belief system would need to change from the top down;
- these standards target all nurses so I believe they could be beneficial;
- opportunity to reflect on practice is unrealistic due to budgetary restraints and nursing shortage;

- this is an excellent document - the issue of quality is starting to take hold in health care in Canada; and
- WOW! I would consider staying and changing my attitude.

All comments were considered in preparing the final draft of the *Guidelines for a Quality Practice Environment for Registered Nurses in British Columbia*. Some led to altered wording; some resulted in clarification of ideas; some were set aside to consider in the implementation phase. Extensive consultation with nurses in all practice setting and in rural and remote as well as urban areas of BC ensured the voice of nurses was heard. These guidelines were created for nurses in BC by nurses in BC.

## **Chapter 4 – Findings**

At present many health care organizations are preoccupied with cost containment, reorganization and downsizing. These circumstances have not created a climate conducive to creating quality work environments for nurses who often bear the brunt of these changes. At the same time, the literature continues to provide more evidence for what nurses have always known - adequate numbers of appropriately prepared nurses with effective leaders, continuing education opportunities, organizational supports and the ability to control practice correlate with better nursing care and improved client outcomes. Indeed there is now some research-based evidence that actually predicts 30-day patient mortality rates based on RN experience and staff mix. There is far more at stake than the practice environments of individual nurses. A sustainable health care system and quality client outcomes depend on a healthy nursing work force.

### **Policy Implications**

Guidelines for a quality practice environment are central to healthy public policy. The business literature further substantiates the need for healthy work environments. It concludes that quality work environments are not simply a matter of keeping staff happy; they are also good for business. If an organization is able to attract and retain high calibre people, its growth potential is enhanced. The culture of the organization needs to recognize the employee as a whole person as it is through the professionalism and competency of individuals that the organization as a whole flourishes. In order to succeed, companies must invest in their people. Successful organizations, regardless of the industry, are focused on human capital with a goal of retaining the right workers with the right skills at the right cost. While there is compelling evidence about the impact

employee health has on the health of an organization, the reality is that it is not consistently translated into practice in healthcare as demonstrated by our focus groups, workplace statistics and the research literature.

### **RNABC Guidelines**

Like other nursing regulatory bodies and professional organizations North America, RNABC has made quality practice environments a priority in developing policies and programs over many years. Despite collective efforts and a burgeoning body of literature linking the quality of nursing practice environments to the quality of client outcomes, many nurses continue to work in difficult environments that present barriers to meeting their standards for practice. The RNABC *Guidelines for a Quality Practice Environment for Registered Nurses in British Columbia*, shown in Table 4, have been developed to support nurses and their employers. They are based on a theoretical framework and have evolved through focus groups, broad consultation with nurses and their leaders and a comprehensive literature review.

TABLE 4 - GUIDELINES FOR A QUALITY PRACTICE ENVIRONMENT FOR REGISTERED NURSES  
IN BRITISH COLUMBIA

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**Guideline 1 - Workload Management:**

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There are sufficient nurses<sup>2</sup> to provide safe, competent, ethical care.

Indicators:

1. Care delivery systems enable nurses to develop a sufficient, continuous and rewarding relationship with their clients.
2. Client admissions and services are based on nurses' ability to provide safe, competent, ethical care.
3. Sufficient time is made available to discuss and plan client care with clients and colleagues.
4. Nurses are involved in determining the staff mix and client/nurse ratios.
5. Nurses are involved in resource allocation and utilization decisions.
6. Overtime is infrequent and not mandatory.
7. Work scheduling is flexible and innovative.

**Guideline 2 - Nursing Leadership:**

There are competent and well prepared nurse leaders<sup>3</sup> at all levels in the organization.

Indicators:

1. Nurse leaders are supported in their roles as collaborators, communicators, mentors, risk takers, role models, visionaries and advocates for quality care.
  2. Nurse leaders have the authority<sup>4</sup> to support safe nursing practice.
  3. A chief executive nurse reports at the level of other executive leaders in the organization.
  4. When the primary focus of the unit or program is to provide nursing care, the first-line manager is a nurse.
  5. Nurses are supported in practice by accessible, expert and experienced nurses.
- 

<sup>2</sup> Nurses – this term includes registered nurses, licensed graduate nurses and student nurses

<sup>3</sup> Leaders are central to guiding others towards a common goal or vision. They have influence and/or power through their knowledge, experience or position. Leaders work with people to enhance their growth, potential and accomplishment.

<sup>4</sup> Authority is the right to exercise control or influence.

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### **Guideline 3 - Control over Practice:**

Nurses have authority, responsibility, and accountability for nursing practice.

Indicators:

1. Decision-making is participatory at appropriate levels regarding policies, practices and the work environment.
2. Appropriate resources are available to support evidence-based nursing care.
3. Nurses and other health professionals work cooperatively and collaborate in decision-making.
4. Nurses determine the competencies required for nursing practice in the work setting.
5. Adequate supports free nurses from doing non-nursing tasks.

### **Guideline 4 - Professional Development:**

The organization encourages a lifelong learning philosophy and promotes a learning environment.

Indicators:

1. Appropriate orientation is provided for all new positions and practice settings.
2. Preceptoring and mentoring programs are available.
3. Staff have opportunities for inservice, continuing education and professional development.
4. Staff have opportunities for debriefing and reflection on practice.
5. Performance evaluation programs are in place.

### **Guideline 5 - Organizational Support:**

The organization's mission, values, policies and practices support and value nurses and the delivery of safe and appropriate nursing care.

Indicators:

1. Appropriate forums are accessible to resolve professional practice and ethical issues.
  2. Nursing expertise is respected, excellence is recognized and nurses are valued.
  3. Creative and innovative ideas and the pursuit of nursing knowledge are encouraged.
  4. There are comprehensive health, wellness and safety programs.
  5. There are measures to prevent and combat all forms of aggression, abuse and violence.
  6. Compensation is commensurate with skill, experience and responsibility.
  7. Continuous quality improvement programs are in place.
  8. The physical facility, equipment, supplies and services meet client and staff needs.
  9. Human resource policies consider nurses' personal and family concerns.
  10. Information and communication systems are effective and integrated.
  11. Technology is used appropriately.
-

There is no conclusive evidence that these guidelines and indicators are a prerequisite to creating quality practice environments or that they will lead to quality client outcomes and a summative evaluation will be required. However, the evidence is mounting; the correlations are increasing and predictors are emerging that show the relationship between nurses' practice environments, recruitment and retention and client outcomes, particularly in acute care hospitals. While the guidelines are not prioritized, heavy workloads have been repeatedly identified as a leading concern amongst nurses both in the literature and in all practice settings across BC, therefore, "Workload Management" is the first guideline. There has been no attempt to prioritize the remaining guidelines. They are all important and inter-related features of a quality work environment. Deficiencies in any of these areas threaten nurses' abilities to provide safe client care.

Some guidelines, such as those requiring additional staffing, will require additional resources in the short-term, but may overtime, be cost-effective as overtime hours are reduced and nurse retention increases, thereby reducing the costs associated with recruitment which are estimated to be 150 percent of a worker's annual salary (Izzo & Withers, 2002). Other guidelines, such as those relating to valuing nurses and including them in decision-making, will, in some organizations, require a major cultural shift and a new style of leadership. Priorities will differ among nurses and across health care organizations over time as they collaborate with nurses to enhance their practice environments. Commitment and support from governments, employers, nursing regulatory bodies and nurses themselves are required to create quality practice environments.

It is anticipated these guidelines will provide a ready reference to enable health care organizations that are committed to quality management principles to address practice environment problems that detract from safe client care. Implementation will require a comprehensive communication plan based on an understanding of the change process and involving nursing organizations, the Ministry of Health Planning, the Ministry of Health Services and the six health authorities. Strategies to value employees and improve work environments will enhance the ability of all staff to work effectively promote nurse recruitment and retention and, most significantly, improve client outcomes.

## **Chapter 5 – Conclusions and Implications**

Chapter 5 describes the conclusions I reached about the significance of quality practice environments for nurses and for other health care workers in BC and across Canada in a time of turbulence. I describe the implications of my findings, outline strategies for implementing the guidelines for the individual nurse, the employer, the union, the regulatory body and government and propose evaluation criteria.

### **Conclusions**

Organization restructuring initiatives have had an unforeseen impact on nursing affecting leadership, roles, workload, authority and responsibility. As nurses leave organizations it drives up costs and the workload of the remaining nurses and it drives down productivity, quality and efficiency. While much of the evidence around work environments and their impact on nurses and patients has been published for more than two decades, many nurses continue to work in difficult circumstances and report they are unable to meet their practice standards because of the quality of their practice environment. The evidence from research and from nurses themselves about the link between the practice environment and nurse and patient outcomes has not been incorporated into management practice in many instances. Health care leaders with decision-making power and the ability to influence budget priorities have not made quality practice environments for nurses and indeed all staff, a priority. Despite mission and value statements that speak of valuing staff, the truth lies in where administrators actually spend their time and money. One of the health authorities in BC has a vision of being “a leader in research, professional education and knowledge development and the integration of knowledge into best practices in our health care services” and supporting “a workforce that excels at

providing needed health care.” It is the experience of many nurses that this vision is not being achieved as it relates to the staff that provide first line care and have the most continuous contact with patients. But the question of why human resource management, or in the new vernacular, human capital, is not acted on as a core value remains unanswered. Do administrators not know, not agree with or are they unable for some reason to implement quality practice environments in their organizations?

Creating quality practice environments is not a fad, nor is it a panacea. It does require a fundamental transformation and a shift in perspective and recognition of the fact that the practice environment of nurses is the healing environment of patients. A healthy practice environment for nurses is a healthy work environment for all employees. In a healthy work environment staff are more satisfied, retention and recruitment is enhanced, productivity is higher, client outcomes are better and, if the experience of the private sector can be applied to the Canadian public health care system, then there are financial benefits. In an era where we are trying to create a sustainable health care system, it seems short-sighted not to be making quality practice environments a priority in healthcare organizations across the country

A strong business case can and should be made for creating quality work environments. Getting the buy-in and ownership of senior management is critical to the successful implementation of these guidelines. Healthcare leaders need to work together to create strong direction and a vision of quality for their organizations.

## **Communication and Change Strategies**

Lomas (Lomas, 1998) describes three approaches that can be applied in making the guidelines available to the intended audience: diffusion, dissemination and implementation. Diffusion is the passive process of making the guidelines available to those who seek them; dissemination involves active distribution to a target audience that may be broad or narrow. Implementation is the persistent communication of the guidelines through numerous channels, until it is difficult to ignore them. Lomas says most organizations fail to develop an implementation strategy. They assume professionals will naturally seek out and use the information available so by default the most common approaches become diffusion and dissemination need/pressures to be accountable. RNABC has considered all three approaches in communicating the Guidelines across BC. See Appendix 1 for RNABC's draft action plan for communicating the Guidelines.

If these Guidelines are to be implemented in healthcare organizations, significant changes have to occur within the organizations. Because of the close connection between the well-being of nurses (and presumably other healthcare professionals) and the well-being of patients, there needs to be a bold new initiative that places human resources at the heart of the Health Authorities' strategic plans. Change of this significance is time consuming and complex. To be successful healthcare leaders need to take a careful look at the process they use to introduce the Guidelines. Management scientist John Kotter describes an eight-stage process to create successful social change (Kotter, 1996). Healthcare leaders in BC and beyond can apply Kotter's rules to implement the Guidelines in their organizations as outlined briefly in Table 5.

TABLE 5 – USING KOTTER’S CHANGE PROCESS TO IMPLEMENT THE GUIDELINES

<b>Stage</b>	<b>Strategy</b>
1. Establishing a sense of urgency	<p>Recognizing and communicating the reality of the current situation creates the necessary urgency. The shortage of health professionals, the difficulty recruiting and retaining staff, public expectations for quality health services, fiscal restraints and the need to create a sustainable health care system coalesce to create a high level of urgency for change to improve the existing system. The importance of the work environment can no longer be discounted in planning healthcare across Canada.</p>
2. Creating the guiding coalition	<p>Guiding coalitions should be established by employers and include key stakeholders who are knowledgeable and committed to creating quality practice environments.</p> <p>Appoint coalition members who are powerful, knowledgeable, capable, respected, trusted and team players and who have the skills to weather the forces opposing change.</p> <p>Recognize this is an opportunity to demonstrate respect for staff and nurture leadership at all levels in the organization.</p> <p>Provide the coalition with initial and ongoing top administrative support.</p>
3. Developing a vision and a strategy	<p>Each Health Authority needs to put human resources at the centre of its corporate vision and strategy if it is committed to creating a quality practice environment.</p> <p>Create ownership of the new vision by involving staff in developing the new values and attitudes.</p> <p>Develop a picture of a practice environment in the future that is clear, appealing and easy to communicate to staff and patients alike.</p>
4. Communicating the vision	<p>Respecting and valuing staff needs to underlie all communication strategies and the actions of management.</p> <p>Use multiple strategies to articulate the need for quality practice environments and emphasize the correlation with better outcomes for staff and patients and the whole organization.</p> <p>Recognize people require time to adapt to change and seek to understand the personal impact of change. Acknowledge emotions openly and sympathetically. Personalize the vision to help individuals cope.</p> <p>Lead by example, spending more time with staff, focusing on priorities, providing feedback and listening to their concerns and expectations about the work environment.</p> <p>Use both formal and informal communication channels. Avoid jargon.</p> <p>Ensure leaders are visibly in support of the change and helpful to others in seeing its tangible benefits.</p> <p>Continually communicate the planning process and changes as they occur so staff know what to expect.</p>

<p>5. Empowering broad-based action</p>	<p>Create an organizational structure that is compatible with a quality practice environment, i.e., consider managerial span of control, professional support systems, appropriate committees and policies to address professional and patient care issues, etc.</p> <p>Identify, confront and overcome major obstacles including general anxiety and resistance to change, existing system limitations, a lack of executive commitment, unrealistic expectations and a lack of cross functional teams.</p> <p>Identify and designate champions and provide time, authority and resources to implement unit-based initiatives.</p> <p>Provide continuing assistance, support and guidance to the guiding coalition.</p> <p>Provide early adaptors with recognition and the necessary support to further their quality practice environment initiatives.</p> <p>Some organizations may chose to implement all the Guidelines; others may focus on one or more of the Guidelines.</p>
<p>6. Generating short-term wins</p>	<p>Treat the history of the organization with respect. Recognize individuals need to let go of the past and deal with perceived losses.</p> <p>Establish small pilot projects with a high likelihood of success within a year and develop short-term evaluations.</p> <p>Develop measurement and feedback systems to monitor the achievement of quality practice environments and their associated benefits for staff and patients.</p> <p>Mark endings and celebrate achievements.</p> <p>Recognize early successes and celebrate the people involved to reinforce the success and build momentum.</p>
<p>7. Consolidating gains and producing more change</p>	<p>Collaborate and build bridges among work groups to ensure the change continues.</p> <p>Demonstrate flexibility to try new things and encourage creative thinking and action.</p> <p>Support leaders at lower levels in the hierarchy who demonstrate interest and initiative related to quality practice environments.</p> <p>Use the success of pilot projects at the unit level to tackle larger projects across the organization that need to come in line with the vision for the practice environment.</p> <p>Ensure people are hired, promoted and developed in line with the vision.</p>
<p>8. Anchoring change in the culture</p>	<p>Sustaining gains over the long-term requires continuing commitment by all levels in the organizations and an ongoing recognition and celebration of the benefits of the change to staff and patients.</p> <p>Recruit new generations of top leadership who actively support the vision of a quality practice environment.</p> <p>Improved work environments resulting in enhanced morale, recruitment, retention and productivity and correlating with improved patient outcomes have the potential to develop self sustaining momentum and become rooted in organizational culture.</p>

## **Evaluation**

In the current climate the quality of the practice environment should be of fundamental concern to the nursing profession. Any plan to evaluate and measure quality must consider the stakeholders' interests and concerns. Governments, employers and nurses must be regarded as major stakeholders in evaluating the practice environment and identifying opportunities for improvement.

These guidelines are intended to be a working document. They are the first such guidelines developed in Canada for nurses. As more literature related to quality practice environments emerges and as we have experience with the guidelines across the province, they will need to be evaluated and revised. Evaluation is the process of delineating and obtaining useful information for judging decision-making alternatives. There are several approaches to evaluation that I will propose, although evaluation itself is beyond the scope of this paper.

While there is good reason to believe the guidelines, if implemented, would improve nurse recruitment and retention and nurse-sensitive patient outcomes, we cannot be sure how they will actually work in practice; some form of evaluation is required. Both formative and summative evaluation approaches can be used (Gillis & Jackson, 2002). Often formative evaluation collects information that is purely for internal use by the program developer. Many of the components of a formative evaluation occurred as a part of the process to develop the guidelines. The guidelines incorporate evidence from research, other nursing organization publications and expert opinion, including nurses

from all practice settings and all domains of practice. Nurses were instrumental in developing the guidelines, either on a one-to-one basis or in the focus groups. Each successive focus group removed the weaknesses of earlier drafts, fine tuned language and contributed to a document that reviewers believed reflected a quality practice environment. The penultimate draft was posted on the RNABC web site and on the BC Nurse Leaders web site and, although the response was limited, it did provide validation of the structure, language and contents of the guidelines. The guidelines were further validated through their approval by the RNABC Board of Directors, 24 nurses and non-nurses, who are charged with governing and policy-making for the Association. Without a formative evaluation, the final product is unlikely to meet the needs of the users.

In contrast to the formative evaluation which was prospective and focused on the process of developing and refining the guidelines, summative evaluation is a method of providing evidence of the effectiveness, value or worth of a program retrospectively (Gillis & Jackson, 2002). It usually involves the preparation of a formal report detailing who participated in the program and what the outcomes were. The report may include what prerequisites or conditions are important to replicate the program, the costs and benefits of the program and the disaggregated results showing findings for smaller groups of participants. Information from the formative evaluation may be included in the summative report to demonstrate how the program is responding and adapting to achieve the intended outcomes.

I am proposing a three-phased approach to carrying out a summative evaluation of the guidelines. First, the implementation of RNABC's communication plan can be evaluated. Have stakeholders across the province been convinced that the guidelines are a useful tool and a valid representation of a quality practice environment? Are there some organizations willing to move to the next phase and become involved in a pilot study? The second phase involves identifying if those organizations that were willing to participate in the pilot study were successful in actually implementing the guidelines. The final phase is to identify if the guidelines had a positive impact on critical outcomes such as nurse recruitment and retention, patient mortality, morbidity and length of stay and organizational operating costs. A brief overview of each phase follows.

### **Phase One**

RNABC's main role is to communicate the guidelines widely and then to advocate for their implementation. It is possible to evaluate how successful RNABC has been in introducing the guidelines to members, government and health care decision makers across BC. RNABC's communication plan can be evaluated to see if it contains Lomas' three approaches: diffusion, dissemination and, most importantly, implementation. Indicators of success would include identifying what action each of the stakeholders was willing to take.

A wide variety of indicators of uptake by nurses, their employers and government are possible. Staff nurses could take guidelines to their manager for discussion at a staff meeting. First line nurse managers might propose organization wide discussion. Chief Nurse Officers might table them at their executive committee. The nurses union might

endorse the document and identify how they can use it to advance their mandate of promoting and protecting the socio-economic well being of members and their communities. The Ministry of Health might invite RNABC to make presentations to relevant committees such as the Leadership Council (whose members are the Health Authority Chief Executive Officers and the Deputy Minister of Health), the Nursing Advisory Committee, the Health Employers Association and the Health Human Resources Advisory Committee. The Ministry might also commit funding and agree to co-sponsor a conference on quality practice environments. A private or public sector employer might agree to explore the possibility of their organization becoming involved in a pilot study to implement the guidelines.

## **Phase Two**

Major change, even change that is perceived to be positive, creates anxiety and resistance within an organization. So to ensure success, it is advised that change management projects, such as implementing the guidelines, begin with pilot projects and build up to organization-wide implementation (Davenport, 1993). The advantages of a pilot project include:

- Smaller groups are easier to manage.
- Pilot projects provide an opportunity to test what approaches are/are not successful in the organization's culture.
- Modifications can be made based on the lessons learned.
- Champions for the initiative can be identified and developed.

Phase two requires an evaluation of whether participating organizations were successful in implementing the guidelines. A Quality Practice Environment Appraisal Tool that would enable this evaluation is proposed in Appendix 1.

### **Phase Three**

In the final phase it is important to identify if the guidelines achieved their ultimate goal that is, to have a positive impact on the outcomes identified in the nursing literature such as nurse recruitment, retention and productivity; patient mortality, morbidity and length of stay; and organizational operating costs. Because a host of other variables impact the outcomes, it is not possible to attribute changes over time directly to the guidelines. It would be possible, however, to compare client, nurse and cost outcomes in health care agencies that have implemented the guidelines with those agencies that have not. It would also be possible to compare outcome measures in an individual agency before and after implementation, again recognizing other variables could intervene and have a positive or negative impact on outcomes. An evaluation of this magnitude would require partnership with experienced researchers, the availability of comparable and reliable management and clinical data and a source of funding.

### **Implications**

These guidelines provide a summary of the evidence about quality practice environments for nurses. As quality practice environments have been shown to correlate with nurse recruitment and retention and patient outcomes, it is important to articulate the policy relevance of these guidelines. There are significant implications for government, employers and nursing organizations including regulatory bodies, associations and

unions. Those who recognize the need for change need to challenge those who do not. Implementation will require a comprehensive approach based on an understanding of the change process and involving RNABC, the Ministry of Health Planning, the Ministry of Health Services and the six health authorities. Strategies to value employees and improve work environments will enhance the ability of all staff to work effectively to promote nurse recruitment and retention and, most significantly, improve client outcomes. The next section outlines how each of these groups can use the guidelines to promote quality practice environments in health care organizations.

### **Implications for Government**

It is the mandate of the two Ministries of Health to provide overall leadership, direction, and financial stewardship for the BC health system. Given the evidence about the impact of the practice environments of nurses on organizational and patient outcomes, it is incumbent upon the Ministries of Health to support the implementation of the guidelines. RNABC has asked the provincial government for the authority to intervene in organizations in which nurses are unable to meet their practice standards because of the practice environment, but it is not expected that this request will be granted in the pending Health Professions Act. Nonetheless, there are other ways the Ministries of Health can support the development of quality practice environments. They can ensure the CEOs of the health authorities are aware of the guidelines. They can build a requirement for quality practice environments into their health service plans with each health authority and ensure the CEOs performance contracts include their success in achieving quality practice environments. They can provide funding for workshops for healthcare leaders to develop collaborative strategies and agency specific action plans to

create quality practice environments. They can mandate the collection of management information related to practice environments in support of the CCHSA initiatives.

### **Implications for Employers**

Employers have an ethical and a professional responsibility to implement these guidelines given the potential benefits to nurses and clients. Based on the feedback from nurses across the province, many employers need to reconsider how they value their employees, in particular registered nurses, and then set up human resource management programs that focus on attracting the best and brightest and retaining valued employees. The guidelines provide a ready reference to enable health care organizations to address practice environment problems that detract from safe client care. Employers who are committed to attracting and retaining nurses, creating a healthy and high functioning staff and improving client outcomes will use these guidelines to do so.

In addition, there is a clear need for more evaluation of the costs and benefits of creating quality practice environments in the Canadian healthcare setting. Employers, in partnership with other stakeholders and researchers, need to build an evaluation component into any new programs they develop to ensure fiscal responsibility and accountability.

### **Implications for Nursing Organizations**

RNABC is responsible for regulating nurses under RNABC's *Standards for Nursing Practice in British Columbia* (Registered Nurses Association of British Columbia, 2000).

These standards describe the minimum requirements for safe nursing practice. RNABC

has the authority to apply sanctions if they are not met. RNABC has a vision of excellence. It has influence rather than authority over practice environments. On the other hand, RNABC has no authority related to quality practice environments in agencies. But as a respected, knowledgeable and credible organization RNABC has influence and moral suasion, particularly as the guidelines link to the practice standards and public safety. Developing the guidelines for a quality practice environment and using them to support the Standards falls within RNABC's broad mandate of public protection. In addition to developing customized guidelines for a quality practice environment for nurse in BC, RNABC has a responsibility to communicate them and to advocate for their implementation with government and with employers.

Healthcare unions in general and nursing unions in particular are concerned with the work environment of their members. BCNU can use these guidelines in bargaining for improved practice environments during the collective agreement process since it is clear that what is good for nurses is also good for their clients. They can use the guidelines in management/union meetings to advocate for workplace changes and they can use them to educate stewards and members about the prerequisites for quality care and how the guidelines can be used as an advocacy tool for nurses.

Put simply in the words of one nurse "the working environment of nurses is the healing environment of patients."

## Appendix 1 - Quality Practice Environments Draft Action Plan

(January 10, 2003 draft - originally developed with Wendy Winslow as Committee Chair; Revised with Carina Herman as Chair. It is still a work in progress)

Target Group	Strategy	Responsible Staff Member	Timeline	Completed
Government	Present at Leaders Conference (ASB in attendance)	WW	Nov 30,02	Yes
	Present to Nursing Advisory Committee of BC	WW	Dec 16, 02	Yes
	Present to MOH staff	WW	Jan 15, 03	
	Mail guidelines and letter from President (see Appendix 1)	LB, BL	Jan 02	Yes
	Meet with Minister(s)/Deputy Ministers	LB, BL	Feb 03	Ongoing
	Liaise with Office of Nursing Policy, Health Canada to promote QPE Guidelines	WW	Dec 02 and ongoing follow-up	Ongoing
Employers	Mail guidelines and letter from President to Regional Board chairs & CEOs	WW, BL	Dec 02	Yes
	RNPA to provide update materials to employers on yearly basis	RNPA	Ongoing	Ongoing
	RNPA will present package of materials to newly appointed employers	RNPA	Ongoing	Ongoing
	Present guidelines to CEO Counsel and promote ACP	LB, BL	Jan 03	
	Present guidelines to individual CEOs and promote ACP	LB, BL	Mar 03	
	Present guidelines to Health Authority Recruitment and Retention Officials	LB, BL initially, follow up with RNPA	Mar 03	
	Present guidelines to HCLABC	LB, BL	Mar 03	
	Article in <i>Nursing BC</i>	WW	Dec 02	Yes
	Send letter to HR	WW	Jan 03	
	Meet with BCHRNA Council to present QPE Guidelines	CH, GB	Mar 03	
Nursing Leaders	Integrate guidelines in ongoing consultation with nurse leaders	RNPA, NPC	Ongoing	Ongoing
	Informally integrate guidelines into educational sessions	RNPA, NPC	Ongoing	Ongoing
	Develop educational sessions to promote and implement guidelines	CH, WW, GB	Mar 03	
	2 day QPE sessions in 5 Health Authorities	CH, WW, GB, NC	Apr 03	
	1 day Open Space Forum (key decision makers including COO, Nurse Executives, HR)	CH, WW, GB, NC, MM	Mar 03	
	Present to Nursing Education Counsel	LB, BL	Mar 03	
	Draft/preliminary presentation to BCNU Council	WW	Sept 3, 02	Yes
	LB, BL	Mar 03		

	Follow-up presentation with Council Letter to CRPNBC and CLPNBC Distribute guidelines to newly appointed leaders	LB RNPA, NPC	Dec 02 Ongoing	Yes
RNABC Leaders	<i>Newsline</i> article in print and on Web 2 hour presentation at Leader=s Conference Distribute guidelines WPR, SPR mailout Present and distribute guidelines to PPG Council Presentation at all staff meeting Breakfast presentation to Annual Meeting delegates Two target newsletters (print) to senior nurse leaders Present and distribute guidelines at interagency meetings	BW WW JE WW  WW, CH WW, CH, CM  LG, BW  RNPA, WW	Jan 03 Nov 02 Dec 02 Mar 03  Feb 03 Apr 03  May 03 Oct 03 Mar 03 Fall 03	Yes Yes Yes
Registered Nurses	Distribute guidelines through <i>Nursing BC</i> and Web <i>Nursing BC</i> article Promotional poster for WPR/SR  Integrate guidelines into other agency workshops (e.g., Standards) or provide informal education sessions/consultations Two CE Teleconferences  Present guidelines at Ethel Johns Research Forum	BW, WW  BW, WW BW, CH, JE, LM NPC, RNPA, GB  NC, WW, SR WW, CH	Dec 02  Dec 02 Mar 03  Jun 03 and ongoing  1 Spring 03 1 Fall 03 Feb 03	Yes  Yes
Other Health Regulatory Organizations	Mail guidelines and letter from President Present guidelines at the Health Regulatory Organizations Liaise with CCHSA regarding the QPE Guidelines Publish article in <i>Health Care Management Forum</i>	LB, BL HM  WW WW	Feb 03 Jun 03  Ongoing June 03	Ongoing

## Appendix 2 - A Quality Practice Environment Appraisal Tool

<i>Guideline</i>	<i>I. Workload Management</i>
	<i>There are sufficient nurses to provide safe, competent, ethical care.</i>

<i>EVALUATION *</i>							
<i>Indicator</i>	<i>LOW Attribute(s) of LOW Evaluation</i>						<i>HIGH Attribute(s) of HIGH Evaluation</i>
		<input type="checkbox"/>					
<i>Do care delivery systems enable nurses to develop a sufficient, continuous and rewarding relationship with their clients?</i>	<i>Care delivery systems do not provide for the right number and/or mix of nurses to develop sufficient, continuous or rewarding relationships with clients.</i>	<input type="checkbox"/>	<i>Care delivery systems ensure the right number and mix of nurses to develop sufficient, continuous and rewarding relationships with clients.</i>				
<i>Are client admissions and services based on nurses' ability to provide safe, competent, ethical care?</i>	<i>Client admissions occur regardless of nurses' ability to provide safe care.</i>	<input type="checkbox"/>	<i>The nurse in charge approves all client admissions without coercion.</i>				
<i>3. Is sufficient time made available to discuss and plan client care with clients and colleagues?</i>	<i>Care planning is not a priority and does not occur with clients or colleagues.</i>	<input type="checkbox"/>	<i>Care planning is a high priority and involves both clients and colleagues.</i>				
<i>4. Are nurses involved in determining the staff mix and client/nurse ratios?</i>	<i>Staff mix and client/nurse ratios are determined by non-nurses.</i>	<input type="checkbox"/>	<i>Nurses who understand the work of the unit determine staff mix and ratios.</i>				
<i>5. Are nurses involved in resource allocation and utilization decisions?</i>	<i>Nurses are never consulted about resource allocation and utilization decisions.</i>	<input type="checkbox"/>	<i>Nurses are always consulted about resource allocation and utilization decisions that affect them /or their practice.</i>				
<i>6. Is overtime infrequent and not mandatory?</i>	<i>Overtime occurs on a regular basis and is frequently mandatory.</i>	<input type="checkbox"/>	<i>Overtime seldom occurs and is never mandatory.</i>				
<i>7. Is work scheduling flexible and innovative?</i>	<i>Work schedules are fixed and inflexible.</i>	<input type="checkbox"/>	<i>Work schedules are innovative and nurses can rearranged them when and as required.</i>				

*Explanatory comments:*

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<i>Guideline</i>	<b>2. Nursing Leadership</b>
	<i>There are competent and well prepared nurse leaders at all levels in the organization.</i>

*EVALUATION\**

<i>Indicator</i>	<i>Attribute(s) of LOW Evaluation</i>						<i>Attribute(s) of HIGH Evaluation</i>
		<input type="checkbox"/>					
<i>Are nurse leaders supported in their roles as collaborators, communicators, mentors, risk takers, role models, visionaries and advocates for quality care?</i>	<i>Nurse leaders are unsupported in their leadership roles.</i>	<input type="checkbox"/>	<i>Nurse leaders are supported developed and mentored in their leadership roles.</i>				
<i>Do nurse leaders have the authority to support safe nursing practice?</i>	<i>Nurse leaders have responsibility but no authority over safe nursing practice.</i>	<input type="checkbox"/>	<i>Nurse leaders have all the necessary authority to carry out their responsibilities effectively.</i>				
<i>Does a chief executive nurse reports at the level of other executive leaders in the organization?</i>	<i>The chief executive nurse reports two or more levels down from the chief executive officer and does not participate in executive decision-making.</i>	<input type="checkbox"/>	<i>The chief executive nurse reports directly to the chief executive officer and participates fully in executive decision-making.</i>				
<i>Is the first-line manager a nurse when the primary focus of the unit or program is to provide nursing care?</i>	<i>The first line manager is never a nurse.</i>	<input type="checkbox"/>	<i>The first line manager is always a nurse.</i>				
<i>Are nurses supported in practice by accessible, expert and experienced nurses?</i>	<i>There are no expert and experienced nurses available to support nurses in their practice.</i>	<input type="checkbox"/>	<i>Expert and experienced nurses are available at all times to support nurses in their practice.</i>				

*Explanatory comments:*

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<i>Guideline</i>	<b>3. Control over Practice</b>
	<i>Nurses have authority, responsibility, and accountability for nursing practice.</i>

*EVALUATION\**

<i>Indicator</i>	<i>Attribute(s) of LOW Evaluation</i>						<i>Attribute(s) of HIGH Evaluation</i>
		<input type="checkbox"/>					
<i>Is decision-making participatory at appropriate levels regarding policies, practices and the work environment?</i>	<i>Nurses are never involved in making any decisions that affect their work.</i>	<input type="checkbox"/>	<i>All nurses have an opportunity to be involved in making decisions that affect their work directly or indirectly.</i>				
<i>Are appropriate resources available to support evidence-based nursing care?</i>	<i>The essential resources that enable nurses to practice safely are never available.</i>	<input type="checkbox"/>	<i>All resources that nurses need to provide evidence-based care are readily available at all times.</i>				
<i>Do nurses and other health professionals work cooperatively and collaborate in decision-making?</i>	<i>Nurses work at the bottom of a hierarchical structure and never participate in decision-making with other health professionals.</i>	<input type="checkbox"/>	<i>Nurses work as equal partners with other health professionals in collaborative, consultative and collegial partnerships.</i>				
<i>Do nurses determine the competencies required for nursing practice in the work setting?</i>	<i>Nurses are not involved in determining the competencies required for nursing practice.</i>	<input type="checkbox"/>	<i>Nurses alone determine the competencies required for nursing practice in all work settings.</i>				
<i>Are there adequate supports to free nurses from doing non-nursing tasks?</i>	<i>Nurses carry out a wide variety of non-nursing tasks on a frequent and regular basis.</i>	<input type="checkbox"/>	<i>The necessary supports are always in place to free nurses to provide nursing care.</i>				

*Explanatory comments:*

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<i>Guideline</i>	<i>4. Professional Development</i>
	<i>The organization encourages a lifelong learning philosophy and promotes a learning environment.</i>

*EVALUATION \**  
*LOW* *HIGH*

<i>Indicator</i>	<i>Attribute(s) of LOW Evaluation</i>	<input type="checkbox"/>	<i>Attribute(s) of HIGH Evaluation</i>				
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<i>Is appropriate orientation provided for all new positions and practice settings?</i>	<i>There are no orientation programs in place.</i>	<input type="checkbox"/>	<i>All nurses have a complete orientation customized to their learning needs before they begin working in a new position or practice setting.</i>				
<i>Are precepting and mentoring programs available?</i>	<i>There are no precepting or mentoring programs.</i>	<input type="checkbox"/>	<i>Precepting and mentoring programs are ongoing and available to all nurses.</i>				
<i>Do staff have opportunities for inservice, continuing education and professional development?</i>	<i>There is no inservice, continuing education or professional development.</i>	<input type="checkbox"/>	<i>Inservice, continuing education and professional development programs are available and staff are supported with time and money to attend.</i>				
<i>Do staff have opportunities for debriefing and reflection on practice?</i>	<i>There is never the time or the opportunity to debrief or reflect on practice.</i>	<input type="checkbox"/>	<i>The time and the opportunity to debrief and reflect on practice is a part of every day practice.</i>				
<i>Are performance evaluation programs in place?</i>	<i>No performance evaluations are ever provided.</i>	<input type="checkbox"/>	<i>Performance evaluation is a transparent, continual and constructive process for all staff.</i>				

*Explanatory comments:*

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<i>Guideline</i>	<b>5. Organizational Support</b>
	<i>The organization's mission, values, policies and practices support and value nurses and the delivery of safe and appropriate nursing care.</i>

*EVALUATION \**

<i>Indicator</i>	<i>LOW Attribute(s) of LOW Evaluation</i>	<input type="checkbox"/>	<i>HIGH Attribute(s) of HIGH Evaluation</i>				
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<i>Are appropriate forums accessible to resolve professional practice and ethical issues?</i>	<i>There are no forums accessible to nurses to address professional practice or ethical problems.</i>	<input type="checkbox"/>	<i>There are appropriate forums in place where nurses are welcome to address and resolve professional practice and ethical problems.</i>				
<i>Is nursing expertise respected, excellence recognized and nurses valued?</i>	<i>Nurses are not recognized, respected, or valued.</i>	<input type="checkbox"/>	<i>There is great respect for nurses, and nursing expertise and nurses are valued for their contribution to client care and outcomes.</i>				
<i>Are creative and innovative ideas and the pursuit of nursing knowledge encouraged?</i>	<i>There is no support or encouragement for creative or innovative ideas or the pursuit of nursing knowledge.</i>	<input type="checkbox"/>	<i>Nurses are supported and encouraged to contribute creative and innovative ideas and pursue nursing knowledge.</i>				
<i>Are there comprehensive health, wellness and safety programs?</i>	<i>Only minimal mandated safety programs are in place. There are no health or wellness programs.</i>	<input type="checkbox"/>	<i>There are a wide variety of programs in place to ensure safety and support the health and wellness of staff.</i>				
<i>Are there measures to prevent and combat all forms of aggression, abuse and violence?</i>	<i>There are no measures in place to protect staff from aggression, abuse and violence.</i>	<input type="checkbox"/>	<i>There are effective measures in place to ensure staff are safe and protected from all forms of aggression, abuse and violence.</i>				
<i>Is compensation commensurate with skill, experience and responsibility?</i>	<i>Compensation programs are not transparent or based on objective performance criteria.</i>	<input type="checkbox"/>	<i>Compensation programs are transparent, objectively applied and commensurate with the skill, experience and responsibility of individuals.</i>				

<i>Guideline</i>	<b>5. Organizational Support (Contd.)</b>
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*EVALUATION \**

<i>Indicator</i>	<i>LOW Attribute(s) of LOW Evaluation</i>						<i>HIGH Attribute(s) of HIGH Evaluation</i>
<i>Are continuous quality improvement programs in place?</i>	<i>There are no quality improvement programs.</i>	<input type="checkbox"/>	<i>There are appropriate and effective continuous quality improvement programs throughout the organization.</i>				
<i>Do the physical facility, equipment, supplies and services meet client and staff needs?</i>	<i>The physical facility, equipment, supplies and services are not appropriate to meet the needs of either clients or staff.</i>	<input type="checkbox"/>	<i>The physical facility, equipment, supplies and services are available, appropriate and work effectively to meet the needs of clients and staff.</i>				
<i>Are information and communication systems effective and integrated?</i>	<i>There are few and ineffective information and communication systems.</i>	<input type="checkbox"/>	<i>There are appropriate, effective and integrated information and communication systems available in a timely fashion to all who need them.</i>				
<i>Is technology used appropriately?</i>	<i>Technology is minimal and not used effectively.</i>	<input type="checkbox"/>	<i>The appropriate technology is available and used effectively.</i>				

*Explanatory comments:*

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