Karin Harrison

College of Registered Nurses of Nova Scotia

2011 Annual General Meeting Resolutions

RESOLUTION 1: 2012 Election Date

Be it resolved that the election date for the 2012 election of councillors, and the deadline by which eligible ballots must be received, be set as 1500 hrs on Thursday, April 5, 2012.

Explanatory Notes

According to College By-Law 15(2), at the annual general meeting each year, the Council shall fix an election date for the election of councillors required by the College By-Laws, and shall also set the deadline by which eligible ballots for the election must be received at the College.

Mover: Jennifer Best
Seconder: Rosalind Benoit

RESOLUTION 2: Expanded Duty to Report

Be it resolved that a member has a duty to report to the Minister of Health if the member has reasonable grounds to believe that an employer, corporation, partnership or association:

(a) has placed the nursing profession/nurses in unsafe and unethical situations that impact on the practice of nursing
(b) is practising in a manner that otherwise constitutes a danger to the public.

Be it further resolved that the College of Registered Nurses of Nova Scotia (the College) develop a position statement to guide nurses in understanding how this expanded duty to report will be discharged.

Be it further resolved that the College be informed by the member when a report is made to the Minister of Health.

Be it further resolved that the relevant sections of the *Registered Nurses Act* and *Registered Nurses Regulations* be amended appropriately.

Explanatory Notes

a. Under Section 4 "Objects" of the *Registered Nurses Act*, the Department of Health and the College has a duty to serve and protect the public interest, and to preserve the integrity of the nursing profession.
b. At the 2010 AGM, a motion was introduced about the College having a duty to report and inform RNs about when a healthcare employer acts inappropriately according to the *Registered Nurses Act* and the Canadian Nurses Association Code of Ethics.
c. This motion was approved and referred to the Council of the College for consideration and response. This response was to be reported to the membership via the newsletter.
d. Greater clarity is needed about how the College will discharge this responsibility.
e. The Association of Registered Nurses of Newfoundland and Labrador has a position statement about *Registered Nurses' Professional Duty to Address Unsafe and Unethical Situations*.
f. A clear position statement similar to that of the NL Association could be very helpful in fulfilling the motion introduced and referred at the 2010 AGM.

Mover: Karin Harrison
Seconder: Karen Ferguson

RESOLUTION 3: Complaints Committee Timeline Process

Be it resolved that a timeline be established from the date a complaint against a member is received by the College to the time that the College investigation finishes, not to exceed 90 days.

Be it further resolved that the relevant sections of the College policy manual be revised to reflect these changes and RN regulations.

Explanatory Notes

a. There are no reasonable specified timelines in the *Registered Nurses Act* or *Registered Nurses Regulations* to follow.

b. A member is affected negatively, emotionally and financially awaiting outcomes when there are no specified timelines.
c. Specified timelines would support accountability in the process.
d. There are no reasonable specified timelines in the College policy manual to follow.

Mover: Karin Harrison
Seconder: Karen Ferguson

RESOLUTION 4: Timeline for Complaints Committee Decision

Be it resolved that the Complaints Committee render a decision within two weeks of hearing a complaint.

Be it further resolved that the relevant sections of the College policy manual be revised to reflect these changes and RN regulations.

Explanatory Notes

a. There are no reasonable specified timelines in the *Registered Nurses Act* or *Registered Nurses Regulations* to follow.
b. A member is affected negatively, emotionally and financially awaiting outcomes when there are no specified timelines.
c. Specified timelines would support accountability in the process.
d. There are no reasonable specified timelines in the College policy manual to follow.

Mover: Karin Harrison
Seconder: Karen Ferguson

RESOLUTION 5: Removal of Dismissed Complaints from College Records

Be it resolved that all dismissed complaints be removed from the professional conduct history of the College.

Be it further resolved that all relevant sections of College policy manual be amended appropriately.

Explanatory Notes

a. When a complaint has been dismissed, deemed frivolous and lacking in evidence, it should be removed from the professional conduct history.
b. When dismissed complaints continue to show up on the record of a member, it could influence the outcome of a future complaint.

Mover: Karin Harrison
Seconder: Karen Ferguson

RESOLUTION 6: Investigation and Reporting Process

Be it resolved that College investigations shall include all factual and relevant information relating to nursing practice and ethics, and shall not include personal commentaries/remarks not germaine to the issue(s) being investigated nor a witness' judgment about what the College disposition should be.

Be it further resolved that the relevant sections of the College policy manual, *Registered Nurses Act* and the *Registered Nurses Regulations* be amended appropriately.

Mover: Karin Harrison
Seconder: Karen Ferguson

RESOLUTION 7: Identification of Members in Post-Complaint Period

Be it resolved that the College identify members by registration number and not name in the post-complaint period.

Be it further resolved that the relevant sections of the *Registered Nurses Act* and *Registered Nurses Regulations* be amended appropriately.

Explanatory Notes

a. The public and membership do not benefit from knowing the identity of a nurse after a complaint has been heard and disciplinary action has been taken.
b. There could be more than one member with the same name.
c. Publishing a nurse's name is a fundamental violation of personal privacy and does not complement any model or theory of rehabilitation.
d. Identifying a member by name enhances the potential for gossip and a toxic work environment.

Mover: Karin Harrison
Seconder: Karen Ferguson

RESOLUTION 8: Time Limit on the Website

Be it resolved that the College limit the publication of disciplinary decisions made by the College to six months on the website.
Be it further resolved that the relevant sections of the *Registered Nurses Act* and *Registered Nurses Regulations* be amended appropriately.

Explanatory Notes

a. The College publishes the identity of any member against whom disciplinary action has been taken.
b. There is no benefit to the public or the membership for a member's identity to remain on the website for an extended period of time.
c. There is at present no time limit for the removal of a member's identity from the website.

Mover: Karin Harrison
Seconder: Karen Ferguson

NOTE: The following resolutions were submitted and subsequently withdrawn by the mover and seconder.

RESOLUTION 9: Public School Education Cuts

Be it resolved that the College express its opposition to funding cuts to public school education, especially where they might involve the programs and services of nurses in schools.

Explanatory Notes

a. The Dexter government has asked regional school boards to engage in examining the detailed impacts of a possible 1.6% cut to school funding over three years.
b. Regional school boards have prepared reports detailing devastating impacts to schools and many of their programs and services.
c. Nurses and other healthcare professionals provide invaluable health and education services in schools that could be eliminated or reduced.
d. All bodies representing nurses should strongly express their opposition to any cuts to these nursing services.

Mover: Karin Harrison
Seconder: Karen Ferguson

Withdrawn

RESOLUTION 10: Triage Protocol for Critical Care

Be it resolved that the College request the opportunity to be consulted about a proposed triage protocol for critical care for Nova Scotia and to be represented on the Triage Protocol for Critical Care Working Group.

Explanatory Notes

a. The Department of Health and Wellness established a provincial interdisciplinary working group in May 2009 to create a protocol for critical care triage if there was a mass critical care incident and if the critical care system was overwhelmed.
b. A working draft of a District/IWK Triage Protocol for Critical Care was prepared in January 2010.
c. This working draft was circulated for wider input later in 2010 but there was apparently little response.
d. Neither the College nor the Canadian Nurses Protective Society were apparently consulted about this document or included in the Working Group.

Mover: Karin Harrison
Seconder: Karen Ferguson

Withdrawn

* Verbally wanted this to go further.

College of Registered Nurses of Nova Scotia

Practice Guideline
Registered Nurses' Duty to Report

Introduction

The College of Registered Nurses of Nova Scotia (the College) works with registered nurses (RNs) and the public to regulate the profession of nursing and promote excellence in nursing practice. As self regulating professionals, RNs in Nova Scotia are accountable and responsible to ensure clients are provided safe, competent, compassionate and ethical nursing care.

RNs have a legal and ethical obligation to report incompetent, unethical or impaired practice of an RN, or unethical conduct by any regulated health professional, to the College or appropriate regulatory body. [*Registered Nurses Act*, 2006 (RN Act); *Standards of Practice for Registered Nurses*, 2012; *Code of Ethics for Registered Nurses*, 2008].

This document is designed to help RNs understand their legal and ethical responsibilities and to offer guidance should RNs encounter these challenging situations in their practice setting.

Legal Duty

In Nova Scotia, the *Registered Nurses Act* (2006) is the legislative document that establishes the legal responsibilities for registered nurses. According to the RN Act, if a registered nurse has reasonable grounds to believe another RN or regulated health professional has:

- engaged in professional misconduct, incompetence or conduct unbecoming the profession;
- is incapacitated;
- is practicing in a manner that otherwise constitutes a danger to the public;

the informed RN is required to file a written report to the College or the health professional's appropriate regulatory body.

RNs who fail to report these situations could be subject to discipline by their employer and by the College.

Ethical Duty

The RN has the ethical responsibility, as outlined in the *Code of Ethics for Registered Nurses* (2008), to question and report, "unsafe, non-compassionate, unethical or incompetent practices or conditions that interfere with their [RN] ability to provide safe and compassionate competent ethical care" (p. 9). Nurses must be attentive to indications that a colleague is unable to provide such care regardless of the reason. In this situation, the nurse is obligated to take the steps necessary to ensure safe care is provided. Reporting a situation that may protect client safety is not defamation or whistle blowing but is an RNs professional obligation. (CNPS, 2003; ARNNL, 2008.)

Regardless of legal and ethical requirements these situations can be distressing. Nurses may feel conflicted, wanting to do the right thing to protect clients, but not wanting to lay blame on a colleague. Considering the following points may be helpful:

- Primary concern must always be for the needs and safety of the client
- Focus on safe client care, not laying blame
- Application of appropriate standards of practice to the situation
- Adherence to principles of fairness, respect, dignity and honesty (ARNNL, 2006)

What is the behaviour of concern?

It is not always easy to determine when a behaviour you have witnessed constitutes a professional practice concern in which you need to intervene. Examples of behaviours/situations that may be of concern are listed below in Table 1.

Table 1.

Examples of situation or behaviours that could negatively impact client safety or quality of care include, but are not limited to:

• Under the influence of drugs/alcohol in the workplace • Confidentiality breaches • Falsifying information • A pattern of unsafe behaviour/ practices related to medication administration, assessment, intervention, monitoring, documentation and poor judgment	• Repeated errors • Verbal, physical, mental or sexual abuse of clients • Boundary violations • Providing care outside of the scope of nursing practice • Evidence of cognitive defects/mental health issues

The following are some questions to consider when determining if you need to take action:

- Have you witnessed the health professional practicing in a manner that you consider to be incompetent or non-compassionate?
- Has the professional practiced in a manner inconsistent with their Standards of Practice, Code of Ethics, or organizational policies?
- Are clients being put at risk as a result of the actions of the professional?
- Is the professional unwilling or unable to change his/her behaviour?

If you have answered 'yes' to any of the above-mentioned questions, you must take the appropriate action.

If you have further questions about the behaviour in question you may contact a professional practice consultant at the College regarding your concerns and potential courses of action. All communications will be confidential in nature. Your manager or supervisor may be a good resource for you at this point as well.

What is the prudent course of action?

The timing of your action depends on whether the client is in immediate or potential risk of harm. If the situation shows immediate risk, you may need to intervene immediately and report your concern to the College (or other regulatory body). The College has a problem-solving, decision-making framework that has been designed to assist RNs resolve professional practice issues[1], available by accessing the following link http://crnns.ca/documents/ResolvingProfessionalPracticeIssuesToolkit.pdf.

The College also has consultants available to discuss any concerns you may have. In addition to supporting your questions concerning the practice of another health professional, if required, they will support you throughout the formal complaint process as well.

There are different courses of action you can take to address your concerns but it is important to remember to be professional, objective, factual and specific.

[1] A professional practice issue is any concern or situation that either compromises client care by placing a client at risk or affect an RN's ability to provide care consistent with the Standards and Code of Ethics.

Your options are to:

- discuss your concerns directly with the health professional,
- report to your manager,
- contact the regulatory body directly.

You may feel it is most appropriate to discuss your concerns directly with the health professional. These conversations are not always easy, but as professionals, you have a duty – and the authority - to engage in them.

If you are unable to have this conversation with your colleague, or you have and the behaviour continues, you should speak with your manager or supervisor about your concerns. You must document your concerns in writing and request a response in a reasonable time frame. Due to the health professional's right to privacy, your manager may not be able to discuss the outcomes of the meeting or action plans with you. If after contacting your manager you still have reasonable grounds to believe the behaviour is unchanged, you must to take your concerns to the College (*Code of Ethics*, 2008). Ideally, it would be best to inform your manager of the decision to involve the College as well. If at any point during the above process you believe there is an imminent risk to client safety you must contact the College immediately.

Documenting the Concern (with employer)

Each organization should have a formal process in place for reporting behaviours of concern. To assist you in reporting your concerns to your employer, you should consider the following:

- Report the situation to the appropriate manager/director using the established chain of authority in the workplace, while maintaining confidentially.
- When reporting to your manager, document your concerns in writing, including dates, times, and a description of the behaviour that was witnessed. Indicate how the behaviour violates specific standards of practice, code of ethics, or organizational policies. If the concern is brought to you by a client or family member, inform them that you are required to bring the concern forward to the appropriate individual or regulatory body. To ensure that the manager can investigate your concerns while maintaining patient confidentiality, use client initials and room numbers instead of names, for patient specific issues. It is very important that the patient can be identified for the purpose of investigation.
- Detailed documentation of the professional practice concern should not be included in the client record (only client care and client condition are documented in the record e.g. care provided, assessment and outcomes).

Making a Report to the College

When you are making a report to the College a Professional Conduct Consultant is available to answer any questions you may have and to help you determine the appropriate course of action. You must submit your concern to the College in writing and will find guidelines to assist you in documenting your concerns on the College website http://www.cnns.ca/submittingacomplaint. Please also visit http://www.cnns.ca/professionalconductprocess to help understand the process that occurs when a complaint is received.

Making a Report to other Professional Regulator

If the situation of concern involves a member of another discipline, the RN should contact the appropriate regulatory body for that profession, (e.g. College of Licensed Practical Nurses of Nova Scotia, College of Physician and Surgeons of Nova Scotia, Nova Scotia College of Pharmacy, etc.). The appropriate contact information will be found on the respective website (*RN Act*, 2006).

There may also be a legal obligation to report to an external authority such as law enforcement and/or relevant provincial or federal legislation (e.g. reporting child abuse in accordance with the Children and Family Services Act; reporting an adult in need of protection in accordance with the *Adult Protection Act*, etc.).

Understanding the Obligations of Others

Every employer or agency that procures employment for a registered nurse must notify the College if an RN has been terminated or if the RN has resigned because of allegations of professional misconduct, conduct unbecoming the profession, incompetence or incapacity. (*RN Act*, 2006).

Conclusion

As a self regulated profession RNs have both a legal and ethical duty to report to the College the practice of a colleague that is unsafe, incompetent, non-compassionate or unethical. This accountability also applies to employers when they are aware of such nursing practice or unprofessional behaviour. This practice guideline outlines the steps that RNs and employers should follow when such care is witnessed and summarizes the type of support made available by the College.

References

Association of Registered Nurses of Newfoundland. (2008). *Position Statement: Registered nurses' professional duty to address unsafe and unethical situations*. St. John's, NL: Author.

Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. Ottawa: Author.

Canadian Nurse Protective Society. (2003). Defamation. *InfoLAW*, 12(3). Ottawa: Author.

College of Registered Nurses of British Columbia. (2011). *Duty to report*, Vancouver, BC: Author

College of Registered Nurses of Nova Scotia. (2012). *Standards of practice for registered nurses*. Halifax, NS: Author.

College of Registered Nurses of Nova Scotia. (2006). *Problematic substance abuse in the workplace: A resource guide for registered nurses*. Halifax, NS: Author.

College of Registered Nurses of Nova Scotia. (2012). *Resolving professional practice issues: A toolkit for registered nurses*. Halifax, NS: Author.

College of Registered Nurses of Nova Scotia. (2011). *Professional conduct services submitting a complaint*. Retrieved from http://www.crnns.ca/submittingacomplaint.

College of Registered Nurses of Nova Scotia. (2011). *Professional conduct process*. Retrieved from http://www.crnns.ca/professionalconductprocess.

Registered Nurses Act, c.21. (2006). Statutes of Nova Scotia. Halifax, NS. Government of Nova Scotia.

National Steering Committee on Patient Safety in Canadian Health Care. (2002). *Building a safer system: A national integrated strategy for improving patient safety in Canadian health care*. Ottawa: Author. Retrieved November 1, 2007, from http://rcpsc.medical.org/publications/

Nicklin, W., Mass, H., Affonso, D.D., O'Connor, P., Ferguson-Parè, M., Jeffs, L., et al. (2004). Patient safety culture and leadership within Canada's academic health science centres: Towards the development of a collaborative position paper. *Canadian Journal of Nursing Leadership*, 17(120): 22-34.

Nova Scotia Health. (2005). *Safety Tips for Nova Scotians: Being Involved in Your Care*. Retrieved November 1, 2007, from http://www.gov.ns.ca/health/waittimes/patient-tips-06-colour-315.pdf

Reason, J. (1990). *Human error*. Cambridge, UK: Cambridge University Press.

Registered Nurses Association of Ontario. (2004). *Policy Statement on Patient Safety*. Toronto: Author. Retrieved November 1, 2007, from http://www.rnao.org/Page.asp?PageID=122&ContentID=1080&SiteNodeID=341

Royal College of Physicians and Surgeons of Canada. (2001). *Health care renewal through knowledge, collaboration, and commitment: Submission to the Commission on the Future of Health Care in Canada*. Ottawa: Author.

Wallace, G. (2006). How to apologize when disclosing adverse events to patients. *Canadian Medical Protective Association Information Sheet*, September 2006.

World Health Organization. (2005). *Patients for Patient Safety – Statement of Case*. Retrieved November 1, 2007, from http://www.who.int/patientsafety/patients_for_patient/FAQ/en/print.html

JOINT POSITION STATEMENT ON PATIENT SAFETY

College of Licensed Practical Nurses of Nova Scotia
College of Occupational Therapists of Nova Scotia
College of Physicians & Surgeons of Nova Scotia
College of Registered Nurses of Nova Scotia
Nova Scotia College of Pharmacists
Nova Scotia College of Physiotherapists

BACKGROUND

In recent years, patient safety has emerged as an important issue on health policy agendas at both the national and provincial level. At the national level, the Health Council of Canada and the Canadian Patient Safety Institute (CPSI) were established in 2003. Within Nova Scotia, a number of actions have also been taken. For example, regulatory bodies have:

- worked with CPSI's *Safer Healthcare Now!* initiative to improve healthcare delivery
- partnered with the national Institute for Safe Medication Practices (ISMP) to support safe medication practices
- collaborated with agencies and the Department of Health to present patient safety education sessions
- developed a provincial policy on the disclosure of adverse events
- initiated quality assurance programs that include documenting and reporting known, alleged and suspected medication errors as well as the necessary step required to resolve the root problems.

The growing interest in patient safety has been fuelled, in large part, by the release of reports such as the *Adverse Events Study in Canada* (Baker et al., 2004). According to Baker et al, 36.9% of adverse events in Canadian hospitals are preventable (in 2001, Leape et al. found that close to two-thirds of adverse events were preventable).

The majority of 'near misses' and adverse events, which often go unrecognized and unreported, arise from systems issues. Outcomes associated with these events, in terms of both human and financial costs, underscore the urgent need to address systems issues

The major causes of harm to patients in hospitals relate to surgical procedures, adverse medication events (including adverse drug, contrast and vaccine reactions), infections, falls and pressure ulcers. Additional threats to patient safety include: prolonged work hours; poor communications or teamwork; inadequate and/or inappropriate staffing/guidance/supervision; lack of continuity of care; punitive, silencing and oppressive (work) cultures; poorly planned changes; and a lack of resources and supports.

GLOSSARY

Adverse event: An unexpected event in healthcare delivery that results in harm and is not attributable to a recognized complication (CPSI, 2007).

Good faith: When a person has reasonable grounds to believe that an unsafe condition exists even if it is not found to exist in the end.

Healthcare professional: All healthcare professionals (members) licensed by the regulatory bodies authoring this position statement.

Near miss: An event that did not reach a patient because of timely intervention or good fortune (CPSI, 2007

Patient: Used rather than 'client' to be congruent with the terminology of the international patient safety movement. Includes individuals, groups, populations or entire communities who require health care from healthcare professionals.

Patient safety: The reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices, shown to lead to optimal patient outcomes (Davies, J.M., Hebert, P., and Hoffman, C. Cited in *Draft National Guidelines for the Disclosure of Adverse Events*, CPSI, 2007).

Although most research studies on patient safety focus on adverse events in hospitals, it is important to note, particularly with the shift toward primary health care and the delivery of care in settings other than hospitals, that adverse events can occur in any setting in which healthcare is delivered (e.g., in homes, clinics, facilities).

In fact, there is evidence that adverse events may actually increase during transitions in care (e.g., hand-off between caregivers, shift change, and following discharge). Unfortunately, there are few Canadian studies available, but primary health care systems also need to be reviewed to improve patient safety. According to the College of Registered Nurses of British Columbia (2005) significant gains in patient safety relate directly to improving the practice environment of health professionals in all practice settings. The concept of a 'just' culture (one component of a safety culture) is now being promoted by more and more healthcare agencies. Promoting just and fair reporting environments does not, however, mean that intentional violations, sabotage or willful neglect and/or negligence would be ignored. Rather it places these incidents in an appropriate context when adverse events arise through systems issues (Hoppes, 2004).

A 'just' culture fosters:

- learning versus blaming
- a culture of reporting and learning
- open discussion of adverse events
- support for a culture of safety
- fair and bias-free investigations
- fair and open feedback to staff
- accountability within the system in which the adverse event occurs
- individual accountability for one's own performance
- commitment to improving and implementing change
- organizational policies promoting patient safety (Hoppes, 2004).

In terms of the disclosure of adverse events, national guidelines were recently developed to promote more effective reporting environments. According to the CPSI (2007), healthcare systems in Canada, and indeed throughout the developed world, are supporting open and transparent disclosure of adverse events (to patients and families) through their adoption of increasingly comprehensive policies.

According to the Canadian Medical Protective Association (CMPA), the use of the word 'error' to mean an adverse event in clinical practice should be discouraged. Adverse events do not directly imply negligence. In fact, some adverse events may be unforeseeable (e.g., the first time a patient experiences an allergic reaction to a medication).

Error, on the other hand, carries with it a sense of blame and fault that may be inappropriate, especially before all the circumstances and facts about a case are known (Wallace, G., 2006). In addition, the 'blame and shame' often associated with the term 'error' leaves many healthcare professionals reluctant to participate in adverse event reporting as they believe they could be targeted for discipline or retaliation.

Further to CMPA's position not to use the term 'error' in relation to adverse events, CPSI clearly discourages the use of this term in conjunction with patient safety. Patients surveyed did not understand the difference between a 'true error' in care and an adverse event or complication of care. In addition, while they often understood the term 'medical', it is important to note that medical events and adverse events are not the same.

Although the use of the term 'error' in conjunction with patient safety is not popular, Turnbull (2000) does relate that errors are a result of complicated interactions between providers and technology, providers and the system, and/or complex dealings among the many different healthcare providers.

Given the critical nature of patient safety, the regulatory bodies authoring this joint statement agree that it must be addressed through a collaborative effort. Patient safety is a responsibility to be shared by individual healthcare professionals and their agencies/organizations, as well as by regulatory bodies and governments. This joint position statement underscores the commitment shared by the regulatory bodies to continue to make improvements in patient safety in Nova Scotia.

POSITION

In their quest to assist individuals achieve an optimum level of health, healthcare professionals also take action to prevent or minimize harm. Patient safety is a fundamental responsibility of healthcare professionals across all settings and sectors because they all share a moral and ethical imperative to provide safe, competent care.

- Improving patient safety is a responsibility shared among individual healthcare professionals and others, including interdisciplinary teams, regulatory and accrediting organizations, educational institutions, unions, healthcare organizations, and governments. It also requires involvement of the public.
- Responsibilities and accountabilities for patient safety should be clearly delineated in the governance, management, and clinical processes of an organization.
- Visionary and courageous leadership is required to create a culture of safety in which most adverse events are recognized as system issues, requiring system analysis and system solutions.
- A culture of safety should include teamwork, involvement of patients, and an ongoing commitment to review, investigate and analyze adverse events to determine improvements in systems, processes and products.
- Clear, respectful communications, and effective teamwork and collaboration among healthcare professionals, are needed to remove barriers to safe care.

- Appropriate reporting and monitoring mechanisms should be established that ensure privacy and confidentiality of personal information.
- System or other changes impacting on patient safety, including health human resource issues, must be evidence-based and addressed on a systems level.
- Efforts to analyse and reduce adverse events are most effective when these events are viewed as system failures.
- Patient safety cannot be achieved without system accountability and competence, which must include reviews of adverse events and near misses. These reviews must incorporate thorough analyses, as well as consideration of the need for policy development, resources, information technology systems, communications and education.
- Actions to improve patient safety must include adequate supports for healthcare professionals (e.g., appropriate and adequate workloads and staffing).
- Improvements in patient safety, both internally (within an organization) and externally, should be effectively communicated to all patients, staff and stakeholders.
- Data should be collected at both the provincial and national level: to support research on best practices in patient safety.
- Consumers should be included in adverse event prevention activities, to enable them to learn from the perspectives of healthcare professionals as well as from the experiences themselves. Considering consumers as true partners requires a commitment to transparency within healthcare settings and by healthcare providers.
- The implementation of clear agency policies on the reporting of adverse events and near misses should be supported, as should the disclosure of adverse events to patients and families.

ROLE OF INDIVIDUAL HEALTHCARE PROFESSIONALS

Healthcare professionals in all practice settings are:

- responsible and accountable to maintain their own competence and fitness to practise, and by taking appropriate action at the organizational or system level.
- responsible to identify and report actual or potential unsafe situations, including near misses, errors and adverse events.
- expected to support organizational efforts to fully investigate near misses and adverse events: to identify the root causes of unsafe situations, with the goal of improving the system.
- expected to assist their organizations to evaluate, select and implement products, systems and technologies that will make it easier to provide safe care.
- expected to support research on patient safety and to apply existing evidence to their practice: to reduce adverse events and improve patient outcomes.
- expected to participate in reporting programs that foster lifelong learning, the creation of a supportive environment where open communication is respected and valued, and performance that is focused on the system rather than the individual.

NOTE: The American Society of Healthcare Risk Management [2006], notes that attempts to institute 'non-punitive' policies presents significant issues for patient safety programs. Staff surveys demonstrate that promoting a 'non-punitive' approach leads employees, staff and physicians to believe there will be no punishment or discipline whatsoever as long as they report an event. In relation 'non-punitive' approaches, staff members often react inappropriately in the belief that reckless behaviour will not be dealt

with. A 'just' culture promotes fair and equitable investigation, review and/or follow-up, but clearly delineates behaviour that is acceptable and unacceptable.

ROLE OF HEALTHCARE PROFESSIONAL REGULATORS

Regulatory bodies are responsible and accountable for:

- regulating the practice of individual healthcare professionals
- establishing continuing competence programs establishing processes and taking action when the incompetent, incapacitated or unethical behaviour of any one of its members jeopardizes the provision of safe care.

In addition, regulatory bodies have a role in:

1. ***Policy Development***

   To collaborate with:

   - councils, members of multidisciplinary healthcare teams, healthcare consumers, and external partners (e.g., academic institutions, provincial governments, national and provincial accreditation bodies) to promote a culture of safety and environments that improve patient safety practices.
   - other regulatory bodies to develop policies/positions on patient safety that reflect and support the development of reporting mechanisms and disclosure of adverse events.

2. ***Promotion and Advocacy***

   To:

   - support patient safety projects/programs; as partners in the Safer Healthcare Now! CPSI initiative.
   - advocate for multidisciplinary approaches that foster a culture of teamwork and systems improvement.

3. ***Professional Development***

   To:

   - collaborate in the development of multidisciplinary educational programs on patient safety.
   - adopt professional regulation links to quality care that strengthen clinical practice and leadership, improve practice through educational sessions, and focus on quality practice environments.
   - ensure competent practice through continuing competence programs.

ROLE OF AGENCIES/ ORGANIZATIONS

Provincial health agencies/organizations have an obligation to:

- demonstrate a commitment to patient safety, by encouraging and supporting involvement by staff, at all levels of care, in patient safety initiatives.
- ensure adequate numbers of healthcare professionals with appropriate competencies (appropriate skill mix) and organizational supports to provide safe care.
- utilize a variety of strategies to integrate patient perspectives, and to encourage patients to become involved as partners in the pursuit of safety.
- develop policies that promote open and honest communications and full disclosure of near misses and adverse events to patients and others, as appropriate.
- develop reporting systems that actively promote the reporting of safety concerns in the context of a fair and just culture (to encourage healthcare professionals to identify near misses and adverse events, and to take action to minimize harm in a timely fashion).

- put in place, reliable and accurate systems to identify and track the nature and types of near misses and adverse events.
- ensure that patient safety is monitored at the highest level from a variety of perspectives by regularly reporting workforce, workflow, clinical and financial data to their boards (governing bodies).
- regularly contribute appropriate patient safety information (e.g., near misses, errors, adverse events) to provincial and national data collection, while maintaining patient confidentiality.

ROLE OF GOVERNMENTS

All levels of government (federal, provincial, municipal) have a responsibility to establish policies, programs and services to improve the safety and quality of healthcare for their citizens.

ROLE OF PATIENTS/FAMILIES

Patients and families have a responsibility to be active, involved and informed members of the healthcare team. People who are involved with their care tend to do better and stay safer (Nova Scotia Health, 2005).

REFERENCES

Academy of Canadian Executive Nurses, Association of Canadian Academic Healthcare Organizations. (2005). Patient safety culture and leadership in Canada's health sciences centre. *Healthcare Quarterly* 8(1):36-37.

Advisory Committee on Health Resources. (2002). *Our Health, Our Future. Creating Quality Workplaces for Canadian Nurses.* Final report of the Canadian Nursing Advisory Committee. Ottawa, ON: Health Canada, Nursing Strategy for Canada.
American Society of Healthcare Risk Management. (2006). *2006 Forum Newsletter* Jan-Feb.

Baker, G.R., Norton, P.G., Flintoft, V., Blais, R., Brown, A., Cox, J., et al. (2004). The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *Canadian Medical Association Journal*, 170, 1678-1686. Retrieved November 1, 2007, from http://www.cmaj.ca/cgi/content/full/170/11/1678

Canadian Association of Occupational Therapists. (2001). *Health promotion and disease prevention: A foundation for the Canadian health system.* Retrieved November 1, 2007, from http://www.caot.ca/default.asp?ChangeID=65&pageID=581

Canadian College of Health Service Executives. (2003). *Position Statement on the Health Executive's Role in Patient Safety.* Retrieved November 1, 2007, from http://cchse.org.wedodns.com/assets/patientsafety/PositionStatement-PatientSafety.pdf

Canadian Healthcare Association. (2002). *Patient Safety and Quality Care: Action Required Now to Address Adverse Events.* Retrieved November 1, 2007, from http://www.cha.ca/documents/backgrounder_nov02.pdf

Canadian Nurses Association. (2003). *Patient Safety: Position Statement.* Ottawa: Author. Retrieved November 1, 2007, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS70_Patient-Safety_en.pdf

Canadian Nurses Association, University of Toronto Faculty of Nursing. (2004). *Nurses and Patient Safety: A Discussion Paper.* Ottawa: Author. Retrieved November 1, 2007, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/patient_safety_discussion_paper_e.pdf

Canadian Nurses Association. (2005). *Patient Safety: Developing the Right Staff Mix.* Report of a Think Tank. Ottawa: Author. Retrieved November 1, 2007, from http://cna-aiic.ca/CNA/documents/pdf/publications/PatientSafety_ThinkTank_e.pdf

Canadian Nurses Association. (2005). *Patient Safety Resource Guide.* Retrieved November 1, 2007, from http://www.cna-nurses.ca/cna/practice/environment/safety/guide/default_e.aspx

Canadian Nurses Protective Society. (2005). Patient safety. *infoLAW,* 14(1)

Canadian Patient Safety Institute. (2006, June). *Patient-centred healthcare organizations support global patient safety alliance.* Edmonton: Author. Retrieved November 1, 2007, from http://www.patientsafetyinstitute.ca/index.html

Canadian Patient Safety Institute. *Draft National Guidelines for the Disclosure of Adverse Events.* (2007). Ottawa: Author.

Canadian Pharmacists Association of Canada. (2005). *CPhA Takes Action: Patient Safety.* Retrieved November 1, 2007, from http://www.pharmacists.ca/content/about_cpha/Whats_Happening/CPhA_in_Action/patient_safety.cfm

College of Registered Nurses of British Columbia. (2005). *Patient Safety. Policy Statement.* Vancouver: Author.

Davies, J.M., Herbert, P., Hoffman, C. (2003). *Canadian Patient Safety Dictionary.* Retrieved November 1, 2007, from http://rcpsc.medical.org/publications/PatientSafetyDictionary_e.pdf

Health Council of Canada. (2005). *Report to Canadians: 2005.* Retrieved November 1, 2007, from:http://hcc-ccs.com/report/Annual_Report/1x.aspx

Hoppes, M. (2004). *Just Culture Toolkit.* The Risk Management & Patient Safety Institute. Division of MHA Insurance (USA).

Institute of Safe Medication Practices – Canada. Retrieved November 1, 2007, from http://www.ismp.org/

Leape, L.L., Brennan, T.A., Laaird,N., Lawthers, A.G., Logalio, A.R., Barnes, B.A., et al. (1991). The nature of adverse events in hospitalized patients. *New England Journal of Medicine*, 324(6): 377-384.

National Steering Committee on Patient Safety in Canadian Health Care. (2002). *Building a safer system: A national integrated strategy for improving patient safety in Canadian health care*. Ottawa: Author. Retrieved November 1, 2007, from http://rcpsc.medical.org/publications/

Nicklin, W., Mass, H., Affonso, D.D., O'Connor, P., Ferguson-Parè, M., Jeffs, L., et al. (2004). Patient safety culture and leadership within Canada's academic health science centres: Towards the development of a collaborative position paper. *Canadian Journal of Nursing Leadership*, 17(120): 22-34.

Nova Scotia Health. (2005). *Safety Tips for Nova Scotians: Being Involved in Your Care*. Retrieved November 1, 2007, from http://www.gov.ns.ca/health/waittimes/patient-tips-06-colour-315.pdf

Reason, J. (1990). *Human error*. Cambridge, UK: Cambridge University Press.

Registered Nurses Association of Ontario. (2004). *Policy Statement on Patient Safety*. Toronto: Author. Retrieved November 1, 2007, from http://www.rnao.org/Page.asp?PageID=122&ContentID=1080&SiteNodeID=341

Royal College of Physicians and Surgeons of Canada. (2001). *Health care renewal through knowledge, collaboration, and commitment: Submission to the Commission on the Future of Health Care in Canada*. Ottawa: Author.

Wallace, G. (2006). How to apologize when disclosing adverse events to patients. *Canadian Medical Protective Association Information Sheet*, September 2006.

World Health Organization. (2005). *Patients for Patient Safety – Statement of Case*. Retrieved November 1, 2007, from http://www.who.int/patientsafety/patients_for_patient/FAQ/en/print.html

College of Registered Nurses of Nova Scotia

Position Statement
Quality Nursing Practice Environments

INTRODUCTION

Registered nurses play a key role in Canada's changing healthcare system. However, maintaining quality client care in our rapidly evolving healthcare system is a major challenge, and for registered nurses this often means that their health and well-being is at risk.

Research has shown that the quality of a nursing practice environment has a direct impact on job satisfaction, productivity at work, recruitment and retention and the delivery of quality care (CNA, 2006: CFNU, 2006). Because client outcomes are strongly linked to the environments in which nurses practice, the College of Registered Nurses of Nova Scotia (the College: CRNNS) supports the notion that nursing practice environments should be better designed to contribute to a safer healthcare system (Baumann, O'Brien-Pallas, 2001).

In Nova Scotia, the College's Practice Environment Collaboration Program™ acts as a catalyst for change, resulting in agencies developing sustainable quality nursing practice environments that support nurses in meeting the standards for nursing practice; resulting in the delivery of safe, ethical and quality care.

Through their participation in the PECP™, 13 healthcare agencies in Nova Scotia have found ways to improve their nurses' (RNs & LPNs) work environments. Nurses participating in the PECP™ have reported a significant positive impact for nursing, as well as for clients receiving care.

Key Concepts

Even in the midst of change and uncertainty, a healthy workplace can be a quality nursing practice environment (Shamian, 2000). A strong nursing practice environment ensures that registered nurses can practise according to standards; leading to improved client outcomes and greater job satisfaction (Broughton, 2001).

The College endorses the position taken by the Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU) that a quality nursing practice environment "maximizes outcomes for clients, nurses and the system".

The College also believes that nurses have an obligation to promote practice environments that have the organizational structures and resources necessary to promote safety, support and respect for all persons in the practice settings (CNA & CFNU, 2006).

Characteristics that reflect a quality nursing practice environment include: communication and collaboration; responsibility and accountability; realistic workloads; leadership; support for information and knowledge management; professional development; and workplace culture (CNA & CFNU, 2006).

Shared Responsibilities

The College believes that the responsibility for providing quality nursing practice environments is shared, with the following parties holding the responsibility to be proactive in establishing supportive practice environments:

Registered Nurses

Within their responsibility to help create quality nursing practice environments that promote safe and ethical care, registered nurses must:

- determine the full scope of their individual practice, and attain and maintain competency within that scope of practice (Baumann, O'Brien-Pallas, 2001; Broughton, 2001)

- demonstrate leadership qualities, communicate effectively among themselves and with other members of the healthcare team, take an active role in decision-making within their agencies, collaborate with other healthcare professionals to determine standards of care, and provide input concerning resource allocation (Broughton, 2001)
- partner with employers in developing the right model of care that best meets the health needs of their population.

Employers

It is the employers' responsibility to ensure that quality nursing practice environments exist within their agencies, such that:

- registered nurses can work to the full scope of their individual practice
- the culture supports registered nurses in redesigning and recreating nursing practice environments that can sustain change (CNA, 2001)
- nursing leadership is visible at all levels of the organization, enabling RNs to implement evidence-based decision-making as an important element of quality nursing practice (CNA, 2001)
- there is zero-tolerance of workplace violence (CNA, 2001)
- orientation, continuing education, formal education, in-service education and mentoring are supported, so registered nurses can acquire and maintain competence (CNA, 2001)
- nurse educators, preceptors and mentors are available, so the individual learning needs of the registered nurse can be met through orientations and ongoing support
- registered nurses can shape their own professional development programs and pursue career pathways, including specialization, with support (CNA, 2001)
- registered nurses have the ability to determine the level and staffing mix required to meet clients' needs, and that they have adequate support staff to complete non-nursing tasks (CNA, 2001)
- a staffing system is in place so that individual registered nurses control the ability to work overtime or extra hours; reflecting a balance of personal needs with the needs of the organization (CNA, 2001).

Governments

Governments have a responsibility to collaborate with registered nurses, and to ensure nursing leadership is visible, accessible, and credible. They must also examine emerging issues, make recommendations and provide adequate funding to meet identified needs (Office of Nursing Policy [ONP], 2001). Adequate funding should ensure that agencies can:

- staff according to the appropriate number and mix of healthcare providers required to meet client needs (CNA, 2001)
- support registered nurses as they redesign and recreate a nursing practice environment that can sustain change (CNA, 2001)
- ensure registered nurses are safe from violence in the workplace (ONP, 2001)
- access up-to-date, well-maintained equipment and enough space to meet the needs of clients (CNA, 2001).

Regulatory Bodies, Accreditation Organizations, Unions and Schools of Nursing

Regulatory bodies for registered nurses are responsible for determining standards for nursing practice and entry-level competencies for registered nurses. In addition, programs and services should be offered that encourage RNs to partner with their healthcare agency in creating change, including identifying issues, priorizing concerns and taking action for improvement.

Accreditation organizations are responsible to develop and integrate performance indicators into documents that measure the ability of healthcare organizations to provide and promote quality practice environments.

Unions representing RNs are responsible to develop collective agreements that promote the provision of quality nursing care and the health, safety, and well-being of registered nurses.

Schools of nursing are responsible for preparing new graduates with the entry-level competencies necessary to provide safe, competent, and ethical nursing care in a variety of settings, and providing opportunities for students to participate in cooperative and other learning experiences to gain valuable expertise from expert nurses (Nova Scotia Department of Health, 2001).

Conclusion

Nursing practice environments must be better designed to contribute to a safer healthcare system. Improving the safety of registered nurses by reducing the risk to their health and well-being in the workplace will improve the quality of client outcomes, interdisciplinary collaboration, and effective functioning of healthcare teams; resulting in multiple benefits for all stakeholders. Creating strong nursing practice environments is a shared responsibility and, once in place, ensures that registered nurses can practise according to professional standards and contribute to improved client outcomes.

References

Baumann, A., & O'Brien-Pallas, L.L. (2001). Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system. *Canadian Health Services Research Foundation.*

Broughton, H. (2001). Nursing leadership: Unleashing the power. *Canadian Nurses Association.*

Canadian Nurses Association. (2001). *Position statement: Quality professional practice environments for registered nurses.* Ottawa: Author.

Canadian Nurses Association & Canadian Federation of Nurses Unions. (2006). *Joint position statement: Practice environments: Maximizing client, nurse and system outcomes.* Ottawa: Author.

College of Registered Nurses of Nova Scotia. (2006). *Practice Environment Collaboration Program™ Outcomes Report.* Halifax: Author

Nova Scotia Department of Health. (2001). *Nova Scotia's Nursing Strategy.* Halifax: Author.

Shamian, J. (2000). Making the talk matter. *The Canadian Nurse*, 96(10), 16-19.

The Office of Nursing Policy. (2001). *Healthy nurses, healthy workplaces.* Proceedings of the National Stakeholder Consultation Meeting. Health Canada: Author.

NURSE STAFFING

NURSE STAFFING AND PATIENT DEATH

Source

Tourangeau, A. E., Giovannetti, P., Tu, J. V., & Wood, M. (2002). Nursing-related determinants of 30-day mortality for hospitalized patients. *Canadian Journal of Nursing Research, 33*(4), 71-88.

Objective

To understand the effect of nursing-related hospital variables on 30-day mortality rates for hospitalized patients with acute medical conditions.

Background

In the last decade cost-cutting measures were undertaken in the delivery of nursing services to decrease health care spending. Many hospitals reorganized their nursing workforce through elimination and reduction of registered nurse (RN) positions, substitution of RNs with less qualified nursing personnel, and closure of clinical units. As a result, RNs were moved from one unit to another through a process referred to as "bumping". Through this process, RNs may have been moved from a nursing unit in which they had developed clinical expertise with a particular group of patients to one where they had limited knowledge and experience.

These changes and others such as the reduction of clinical resources needed to support nurses[1] were made without understanding the effects these strategies would have on patient outcomes such as mortality. Mortality rates are important indicators of the quality of hospital care.

Methods

- A retrospective design was used to test the 30-day Mortality Model. In this model, 30-day mortality rate measures the proportion of patients admitted to hospital who die within 30 days of admission regardless of whether the death occurred in hospital or after discharge. The mortality rate is adjusted to take into account various patient risk factors such as age and pre-existing conditions.
- The model includes such variables as nurse staffing dose (total inpatient nursing worked hours divided by the Ontario case weight[2]), nursing skill mix (proportion of RN hours of care to all nursing hours of care including

[1] In this study, 'nurse' refers to registered nurses (RNs) and registered practical nurses (RPNs). The title for a practical nurse in Canada, with the exception of Ontario, is licensed practical nurse (LPN). In Ontario, the title for a practical nurse is registered practical nurse (RPN).

[2] Ontario case weight is a measure of relative total resource consumption by patients.

RNs, RPNs and unlicensed assistive personnel), availability of professional role support, years of RN experience on the clinical unit, nurse capacity to work, condition of nursing practice environment, continuity of care, physician expertise, hospital status and location.

- The sample consisted of 46,941 patients discharged from 75 acute-care teaching and community hospitals in Ontario who had a diagnosis of acute myocardial infarction, stroke, pneumonia or septicemia.
- The mortality rate for these patients was linked to nurse staffing and skill mix data and to responses from 3,998 RNs working in the 75 hospitals to the Ontario Registered Nurse Survey of Hospital Characteristics.

Principal Findings

Three predictor variables from the 30-day Mortality Model were statistically significant: nursing skill mix, years of nurse experience in the clinical unit and nurse capacity to work.

- A 10 per cent increase in the proportion of RNs in all hospital types was associated with five fewer patient deaths for every 1,000 patients who were discharged.
- Each additional mean year of RN experience on the clinical unit was associated with six fewer patient deaths for every 1,000 discharged patients in urban community hospitals and four fewer deaths for every 1,000 discharged patients in non-urban community hospitals.
- In non-urban community hospitals only, fewer patients died when RNs in these hospitals missed more shifts.[3]

What do the Study Findings Mean?

- Increasing the proportion of RNs on a unit is associated with a reduction in the number of patients who die within 30 days of admission to hospital.
- If the number of RNs on a unit is reduced or RNs are substituted with lesser qualified care providers, more patients may die.
- When experienced nurses are transferred to other nursing units because of over-supply or practices such as bumping within collective bargaining agreements, more patients may die.
- Strategies are needed to recruit and retain experienced RNs.

January 2005

RS 1-11

[3] This is an unexpected finding that is difficult to explain. Nurses in non-urban community hospitals use considerably less sick time than their urban colleagues. It may be that RNs in these hospitals are not taking adequate time to recuperate. When they return to work, their ability to detect and intervene with serious patient complications may be reduced. This may contribute to higher 30-day mortality rates.

Canadian Nurses Association
50 Driveway, Ottawa ON K2P 1E2 • Tel: (613) 237-2133 or 1-800-361-8404 • Fax: (613) 237-3520 • Web site: www.cna-aiic.ca • E-mail: info@cna-aiic.ca

NURSE STAFFING

NURSE STAFFING MODEL INFLUENCES COST OF NURSING SERVICES

Source

McGillis Hall, L., Doran, D., & Pink, G. H. (2004). Nursing staffing mix models, nursing hours and patient safety outcomes. *JONA, 34*(1), 41-45.

Objective

To evaluate the effect of different nurse[1] staffing models on costs and patient safety outcomes.

Background

There is growing evidence of the relationship between nursing staff mix models with a higher proportion of RNs and positive patient outcomes. Costs associated with different nurse staffing models and how these costs may relate to patient outcomes have seldom been studied.

Methods

- This descriptive correlational study took place in 19 urban teaching hospitals in Ontario, Canada. The sample was composed of 77 adult medical, surgical and obstetric patient care units in these hospitals.
- Nurse staffing was categorized into four models according to the mix of nursing staff employed on the unit: 1) an RN/RPN staff mix; 2) an all-RN staff mix; 3) the proportion of regulated to unregulated staff (URW); and 4) an RN/RPN/URW staff mix.
- Patient safety outcomes included the rate of medication errors, wound infections, urinary tract infections and patient falls.
- The complexity of the patient's condition and the patient's age were taken into consideration when evaluating patient outcomes.
- Costs were determined by measuring the paid hours (both worked and received through benefits) of all RNs and RPNs allocated to a specific patient.

[1] In this study, 'nurse' refers to registered nurses (RNs) and registered practical nurses (RPNs). The title for a practical nurse in Canada, with the exception of Ontario, is licensed practical nurse (LPN). In Ontario, the title for a practical nurse is registered practical nurse (RPN).

Canadian Nurses Association
50 Driveway, Ottawa ON K2P 1E2 • Tel: (613) 237-2133 or 1-800-361-8404 • Fax: (613) 237-3520 • Web site: www.cna-aiic.ca • E-mail: info@cna-aiic.ca

Principal Findings

- The lower the proportion of RNs and RPNs on medical and surgical units:
    - the higher the number of medication errors and wound infections; and
    - the more nursing hours were used.
- The less experienced the RNs and RPNs on a unit are, the higher the number of wound infections.
- Older patients and those with more complex needs used more RN and RPN hours.

What do the Study Findings Mean?

- Increasing the proportion of unregulated health care workers on medical and surgical units can:
    - influence patient safety; and
    - increase nursing costs.
- Nurse managers need to consider the complexity of patient needs, the experience level of the nurses and the mix of nursing staff when determining appropriate unit staffing.
- Less experienced RNs and RPNs need supports such as mentoring and unit-based orientation and education to improve their practice and increase patient safety.
- Strategies are needed to recruit and retain experienced nurses.

January 2005

RS 1-3

Canadian Nurses Association
50 Driveway, Ottawa ON K2P 1E2 • Tel: (613) 237-2133 or 1-800-361-8404 • Fax: (613) 237-3520 • Web site: www.cna-aiic.ca • E-mail: info@cna-aiic.ca

NURSE STAFFING

BACCALAUREATE OR HIGHER NURSE EDUCATION RELATED TO FEWER SURGICAL PATIENT DEATHS

Source

Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *JAMA, 290*(12), 1617-1623.

Objective

To examine whether hospitals with higher proportions of direct-care registered nurses (RNs) educated at the baccalaureate or graduate level in nursing have lower risk-adjusted patient mortality rates and lower rates of death in patients with serious complications.

Background

There is increasing evidence that nurse[1] staffing characteristics such the number of patients assigned to each nurse and the proportion of RNs in the nursing staff mix influence quality of care in hospitals and patient safety. Little is known about what impact other characteristics of RNs in hospitals, such as their educational level, have on patient outcomes.

Methods

- In this cross-sectional study, outcome data for 232,342 patients who had general, orthopedic or vascular surgery in 168 adult acute-care general hospitals in Pennsylvania were linked with data collected from a survey of 10,184 RNs in the state and other data related to the patients' hospitalization.
- The two patient outcomes studied were:
    - death within 30 days of hospital admission; and
    - death within 30 days of hospital admission among patients who experienced serious complications (referred to as a "failure to rescue").
- Both patient outcome measures were risk-adjusted to take into account variations such as age, sex and whether the patient was admitted on an emergency basis.

[1] In this study, 'nurse' refers to registered nurses (RNs).

Canadian Nurses Association
50 Driveway, Ottawa ON K2P 1E2 • Tel: (613) 237-2133 or 1-800-361-8404 • Fax: (613) 237-3520 • Web site: www.cna-aiic.ca • E-mail: info@cna-aiic.ca

- The survey provided information on the RN's highest educational credential attained in nursing, number of patients assigned to the nurse on the last shift worked (nursing workload), and the number of years of experience working as an RN.
- Other variables included hospital characteristics (size, teaching status, level of technology) and whether the patient's surgeon was board-certified.

Principal Findings

- For each 10% increase in the proportion of RNs in a hospital holding baccalaureate or graduate degrees, the risk of death or failure to rescue decreased by 5% when patient and hospital characteristics were similar.
- Put another way, if the proportion of RNs with baccalaureate or higher degrees in all hospitals were 60% rather than 20%, 3.6 fewer deaths per 1,000 patients and 14.2 fewer deaths per 1,000 patients with complications would be expected.
- A 20% increase in the percentage of RNs with baccalaureate degrees would have a similar effect on mortality as a reduction of two patients in the average workload of RNs.
- If the nursing workforce comprised a higher percentage of RNs with education at the baccalaureate level or above **and** if workloads were decreased, mortality and failure to rescue rates would be substantially lower.

What do the Study Findings Mean?

- Increasing the proportion of RNs with baccalaureate or graduate degrees on surgical units can be expected to improve patient outcomes.
- Employers should consider that preventable deaths could be reduced by having the majority of nurses on a unit educated at the baccalaureate level or higher and, at the same time, lowering patient-to-nurse ratios.
- Diploma-prepared RNs require support and incentives from their employers to pursue higher education and educational programs that are accessible and flexible in meeting their needs.
- Strategies are needed to recruit and retain RNs with baccalaureate and graduate degrees in hospitals.
- In national nurse human resource planning, policy-makers should consider:
    - how to obtain an adequate future supply of RNs; and
    - how the educational composition of the nursing workforce can be altered to ensure that more highly educated nurses are providing direct patient care.

January 2005
RS 1-2

Canadian Nurses Association
50 Driveway, Ottawa ON K2P 1E2 • Tel: (613) 237-2133 or 1-800-361-8404 • Fax: (613) 237-3520 • Web site: www.cna-aiic.ca • E-mail: info@cna-aiic.ca

NURSE STAFFING

HIGHER LEVELS OF RN STAFFING ARE RELATED TO BETTER PATIENT OUTCOMES

Source

Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine, 346* (22), 1715-1722.

Objective

To examine the relationship between levels of nurse[1] staffing in hospitals and the rates of adverse outcomes among patients.

Background

Registered nurses (RNs) and others are concerned that patient safety and quality of care are threatened because nurse staffing levels are inadequate to match the increasing severity of illness of hospitalized patients. Although several studies have been undertaken, no definite conclusion has been reached about the relationship between the level of nurse staffing in hospitals and patient outcomes. Limitations of many of these studies include small sample size and the use of inconsistent measures of staffing levels. The current study aimed to overcome these and other weaknesses by using administrative data from a large multi-state sample of hospitals.

Methods

- A retrospective design was used to analyze patient discharge and nurse staffing data from 1997 from 799 hospitals from 11 states in the United States. The data covered 5,075,969 discharges of medical patients and 1,104,659 discharges of surgical patients.
- Two different staffing variables were examined:
    - the proportion of hours of care provided by licensed nurses (RNs and LPNs) that were provided by RNs; and
    - the number of hours of care per day provided by RNs, LPNs and nurse aides.
- Patient variables included length of stay and the rates of adverse outcomes. For both medical and surgical patients, 11 adverse outcomes were measured, including urinary tract infection, pressure ulcers, in-hospital death and failure to rescue.[2] Three other variables were measured for surgical patients only (wound infection, pulmonary failure and metabolic disturbances).

[1] In this study, 'nurse' refers to registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (NAs). RNs and LPNs are referred to together as licensed nurses. In Ontario, the title for a practical nurse is registered practical nurse (RPN).

[2] Failure to rescue refers to the death of a patient with one of five life-threatening complications (pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis or deep vein thrombosis).

Canadian Nurses Association
50 Driveway, Ottawa ON K2P 1E2 • Tel: (613) 237-2133 or 1-800-361-8404 • Fax: (613) 237-3520 • Web site: www.cna-aiic.ca • E-mail: info@cna-aiic.ca

- These outcomes were selected for study because they have the potential to be affected by nurse staffing. For example, when nurses are able to identify complications early and initiate actions independently or with other members of the health care team, the risk of death from the complication may be reduced.
- To be able to make appropriate comparisons, differences in nursing care required by patients of each hospital, patients' risk of adverse events and factors such as age, sex and the presence or absence of 13 chronic diseases, were taken into consideration.

Principal Findings

For medical patients

- A higher proportion of RNs in the mix of licensed care providers (RNs and LPNs) and more RN hours a day were associated with:
    - shorter lengths of stay;
    - lower rates of urinary tract infections; and
    - lower rates of upper gastrointestinal bleeding.
- A higher proportion of RNs in the mix of licensed care providers was also associated with lower rates of pneumonia, shock or cardiac arrest and failure to rescue.

For surgical patients

- A higher proportion of RN hours in the mix of licensed care providers was associated with a lower rate of urinary tract infection.
- A greater number of RN hours a day was associated with a lower rate of failure to rescue.

What do the Study Findings Mean?

- Increasing the number of RNs or the proportion of RNs relative to LPNs on a hospital unit can be expected to reduce the number of negative outcomes experienced by patients.
- Hospitals require adequate RN staffing to ensure patient safety and improve quality of care.
- Strategies are needed to recruit and retain RNs in the hospital workforce.

January 2005

RS 1-5

Canadian Nurses Association
50 Driveway, Ottawa ON K2P 1E2 • Tel: (613) 237-2133 or 1-800-361-8404 • Fax: (613) 237-3520 • Web site: www.cna-aiic.ca • E-mail: info@cna-aiic.ca

Nursing Workload and Patient Care

Understanding the Value of Nurses, the Effects of Excessive Workload, and How Nurse-Patient Ratios and Dynamic Staffing Models Can Help

Dr. Lois Berry, RN, PhD
Paul Curry, PhD(c)

Nora Scotia Story
* Pg 61, 64.

CFNU
CANADIAN FEDERATION OF NURSES UNIONS

Nursing Workload and Patient Care

Understanding the Value of Nurses, the Effects of Excessive Workload, and How Nurse-Patient Ratios and Dynamic Staffing Models Can Help

Dr. Lois Berry, RN, PhD
Paul Curry, PhD(c)

CFNU
CANADIAN FEDERATION OF NURSES UNIONS

Published by
The Canadian Federation of Nurses Unions

www.cfnu.ca

2841 Riverside Drive
Ottawa, Ontario K1V 8X7

613-526-4661

The "Realities from frontline nurses" found throughout this book are based on actual experiences of nurses. However, the names and some of the details have been changed to protect the confidentiality of the nurses, patients and facilities involved.

This book was prepared by the CFNU to provide information on a particular topic or topics. The views and opinions expressed within are solely those of the individuals to whom they are attributed, and do not necessarily reflect the policies or views of the CFNU, or its member organizations.

Project manager: Linda Silas
CFNU advisory committee: Vicki McKenna, ONA; Deb Stewart, MNU; Paul Curry, NSNU; Judith Grossman, UNA; Patricia Wejr, BCNU; Murielle Tessier, FIQ.
Project team: Sean Dillon-Fordyce, Oxana Genina, Deanna MacArthur, Ismail Maniliho

First Edition, September 2012

ISBN: 978-0-9868382-3-1

Printed and bound in Canada by
Imprimerie Plantagenet Printing

Table of Contents

Realities from frontline nurses:

The phones are ringing and you do the best you can to answer inquiries for individuals you have not yet had time to assess. Admitting has called for a second, third, and fourth admission. Upon the call for the fifth admission, the nursing staff state that the situation on the floor is unstable at this point, could they hold until the admissions to the floor are caught up before sending any more? The administrator on call doesn't understand the situation or what is involved in an admission process, so is less than supportive.

In less than four hours the nursing staff have admitted five new patients while attempting to assess, medicate and settle for the night the other clients under their care. At 00:30 hrs the administrator finally contacts ER to hold admissions until we are caught up. At 01:00 ER is calling to give a report for the next admission. A long night, with no breaks, and you leave your shift exhausted — worried that you might have forgotten something.

Sherilyn (Ontario)

The Canadian Federation of Nurses Unions (CFNU)

The Canadian Federation of Nurses Unions (CFNU) represents close to 200,000 nurses and student nurses. Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

Safe Staffing = Quality Care

Message from the CFNU

Linda Silas

On July 26, 2012, Canada's Premiers' Health Care Innovation Working Group released its first report to polite applause. "Baby steps," "low-hanging fruit," "motherhood and apple pie" are all words that have been used to describe the initial efforts of the Premiers, but it is a good start for the first six months of work.

Those of us clapping loudly are trying to blow some air on this spark of pan-Canadian collaboration so that health care improvements do catch fire across the country. We are very pleased that the Premiers committed to continuing this work.

Nurses know changes are needed. Hospitals across the country are over capacity. A generally accepted standard of safe hospital occupancy is 85%, yet most hospitals are working at a 100% or higher. The results of overcrowding include compromised care, high rates of hospital-acquired infections and unnecessary rates of hospital readmission. Another result is dangerous levels of workload, and the resulting vicious circle of working short.

Nurses are nearly twice as likely to be absent due to illness or injury than the average of workers in other occupations. Public sector nurses worked the equivalent of 11,400 full-time-equivalent positions in paid and unpaid overtime in 2010. Twenty

percent of nurses in the hospital sector leave their jobs annually, with a cost to the hospital estimated by some at $25,000 and by others at over $60,000 per nurse as a result of the transition. Workload is often cited as a key factor in turnover.

Two decades of national and international research have consistently demonstrated a clear relationship between inadequate nurse staffing and poor patient outcomes, including increases in mortality rates, hospital-acquired pneumonia, urinary tract infections, sepsis, hospital-acquired infections, pressure ulcers, upper gastrointestinal bleeding, shock and cardiac arrest, medication errors, falls, failure to rescue and longer than expected length of hospital stay.

The link between nursing workloads and patient safety is as clear in long-term care as it is in acute care. The more direct nursing care the resident receives, the better the resident outcomes, including lower mortality rates, improved nutritional status, better physical and cognitive functioning, lower urinary tract infection rates, fewer incidents of pressure sores, and fewer hospital admissions.

This evidence linking working conditions to care conditions can no longer be ignored. Safe staffing must be made one of the Premiers' guiding principles for health human resources management. Sadly, the word "patient' does not appear in the health human resources section of the Innovation Working Group's first report, but it is patient safety that must drive staffing decisions.

Three decades of a "silo" approach to health human resources planning has left health care workers and health care budgets on a roller coaster. Safe staffing goes beyond scopes of practice and team-based care — although both are part of addressing dangerous workloads. The Premiers' Health Care Innovation Working Group must work with provider associations, unions and employers in the next phase of its consultation. Premier Wall, co-chair of the Working Group, has a home-grown model to share — a partnership agreement between the Saskatchewan Union of Nurses and the Government of Saskatchewan with the addition of Regional Health Authorities, aimed at achieving safe levels of staffing for patients.

Some jurisdictions, notably California and Australia, have mandated staffing ratios as a way of addressing nursing workload. Emerging research has associated mandated nurse-patient ratios with improved patient outcomes and even financial savings to the health system by decreased length of stay, adverse events and reduced turnover.

Governments should commit to achieve safe staffing across the continuum of care. Data on adverse events should be linked with data on workload and staff mix to assist decision makers to improve working and care conditions.

Nurses across this country have been loud and clear. Safe staffing must be a guiding principle and a measurable outcome in health care.

The CFNU commissioned this paper, *Nursing Workload and Patient Care,* for policy makers and decision makers in health care. Safe staffing is a first step towards health human resources planning with patients' needs as a focus.

I would like to thank Dr. Lois Berry for her excellent work researching and writing this report. I would also like to acknowledge the input and expert advice of Paul Curry (NSNU) and the CFNU Advisory Committee: Vicki McKenna and Jo Anne Shannon (Ontario Nurses' Association), Patricia Wejr (British Columbia Nurses' Union), Deborah Stewart (Manitoba Nurses Union) and Judith Grossman (United Nurses of Alberta).

We must also recognize the work and commitment of Canadian nursing researchers that participated in this project by lending us their time and expertise:

- Dr. Mélanie Lavoie-Tremblay, McGill School of Nursing
- Patty O'Connor, McGill University Health Centre
- Dr. Judith Ritchie, McGill University Health Centre
- Dr. Linda McGillis Hall, University of Toronto School of Nursing
- Dr. Ann Tourangeau, University of Toronto School of Nursing
- Dr. Gail Tomblin Murphy, Dalhousie School of Nursing
- Dr. Marlene Smadu, University of Saskatchewan College of Nursing
- Dr. Judith Shamian, Victorian Order of Nurses
- Dr. Maura MacPhee, University of British Columbia School of Nursing
- Barbara Foster, Health Canada

Together, we know we have to find ways to give the power to frontline nurses to determine when care is being compromised. We know that one solution won't fit every situation, however, we are confident that this report will assist in influencing staffing decisions for the mutual benefit of better work and care conditions.

Linda Silas, RN
President of the Canadian Federation of Nurses Unions

Realities from frontline nurses:

Shortage of nurses in long-term care

In my facility, nurses are mandated to do overtime on a daily basis and we use agency nurses who come for a two-week period and leave. We are short support staff as well. When we are unable to cope, the residents suffer: treatments are missed, no interaction with nurses, basic care not provided. We are like family to our residents but we are no longer able to give TLC. It's been so long since I have used this term. I believe it means "tender loving care."

My residents are also concerned about me as their nurse. They are aware of the days I am there in the morning and still there at night when they go to bed. They take the time to thank me for staying to care for them and tell me to get some rest. They should not have to worry about me working to excess, or if there will be a nurse on duty to care for them.

I cannot remember when I last went home after a shift and felt I had met all the needs of my residents. New nurses see this as the norm. This is what is the most unsettling.

Shannon (Manitoba)

Preface

Dr. Lois Berry, RN, PhD

This report paints a sobering picture of the state of nurses' workload and the impact this workload has on patients and their families. Despite years of research showing that optimizing nurse staffing results in improved patient safety, better health outcomes, and improved quality of care, there has been little action to ensure safe nurse staffing. This is especially disheartening in the light of the many major Canadian reports by nationally respected health care policy and research organizations that have highlighted their concerns about the state of nursing worklife in this country and its impact on nurses and patients. These studies, a number of which were commissioned by government sources, have persistently and urgently called for immediate action to address nursing workload and nursing worklife issues.

Little has changed for nurses and patients over the last twenty years. In fact, my interactions with nurses from all levels in the health care system over the last eight months have confirmed that patient acuity and complexity continue to increase at an unrelenting pace, with little accommodation in staffing. Point of care nurses, union activists, frontline managers, senior nurse administrators, nurse researchers and nurse policy makers who were consulted were unanimous in their frustration. In a

system that bills itself as being committed to evidence-based decision making, many nurses believe that policy makers have failed to act on the evidence.

Nurses are the largest health professional group in the health system. They are well-educated, highly skilled, and positively regarded by the patients and families they serve. And yet they continue to practice in systems that do not engage their expertise in making decisions about patient care, or how nurses should be assigned to provide that care. The system lacks the nimbleness to adjust available nursing hours to changes in patient acuity, and the political will to create systems that acknowledge that matching nurse staffing levels to patient needs saves lives.

In international settings, nurses have countered this inaction. In California and in Australia, they have achieved standardized nurse-patient ratios. They have given up on good faith interactions with employers to achieve safe staffing, and have succeeded in having those staffing levels mandated through legislation and collective agreements. In other areas of the US, frontline nurses have worked with employers to develop dynamic staffing models that share decision making, creating staffing processes that respond to the acuity and complexity of patients.

Standardized, legislated nurse-patient ratios and dynamic, shared decision-making models of staffing have provided nurses with something lacking in the traditional staffing processes. They have given nurses at all levels direct and autonomous input into patient care decisions. They have resulted in processes where nurses feel empowered and respected. Growing research evidence shows that these processes have resulted in safer care and improved outcomes for patients and their families.

As a nurse of 37 years, I read the research and public reports referenced in this paper with increasing alarm and dismay. My question as I read these documents was this: How is it that we have failed to act on this evidence? My frustration was further heightened as I talked with nurses from across Canada as this project unfolded. Their angst and sadness at their inability to give the care that they entered the nursing profession to provide was evident as we talked. I continue to ask: Can't we do better?

This policy paper is intended to advise policy makers, decision makers, elected officials and health care executives on the current state of evidence with respect to safe staffing and improved patient outcomes. I hope that this information can inspire a commitment on the part of decision makers to indeed do better.

Executive Summary

In an era of apparent respect for evidence-based decision making, Canadian nurses are becoming increasingly disgruntled with the failure of decision makers to act on the vast evidence that links safe levels of nurse staffing with better outcomes for patients.

Two decades of national and international research have consistently demonstrated a clear relationship between inadequate nurse staffing and poor patient outcomes, including increases in mortality rates, hospital-acquired pneumonia, urinary tract infections, sepsis, hospital-acquired infections, pressure ulcers, upper gastrointestinal bleeding, shock and cardiac arrest, medication errors, falls, failure to rescue and longer than expected length of hospital stay.

In the early days of the millennium, Canadian and international governments recognized that nursing was in crisis. An international shortage of nurses, coupled with evidence that nurses were burned out, stressed and overwhelmed by their work environments, resulted in the commissioning of ten major national reports between 2000 and 2006 directed at addressing issues for nurses in the health care system.

The findings of these reports were consistent. Using phrases like "untenable crisis," "urgent need to repair the damage," and concern for "deterioration in the

quality of the nation's health care system," these reports called for action to address nursing concerns with the ultimate goal of improving patient care.

Recommendations from these reports fell into two broad categories: improving nurses' workload and improving nurses' worklife. Most reports made recommendations with respect to appropriate staffing, matching scope of practice to patient needs, addressing the increasing pace and complexity of work, reducing absenteeism and nurse fatigue, and improving the integration of client care within health care institutions and between institutions and the community. They tackled the work environment, with recommendations aimed at creating an environment where nurses experience respect, where they are involved in decision making with respect to patient care, and where increased funds are provided for education and professional development. These reports called for programs to address and reduce abuse and violence in the workplace. They highlighted the need to increase the enrolment in nursing education programs to redress the budget-driven cuts to nursing education, made during the 1990s.

Unfortunately, with the exception of increasing nursing education seats nationally and pilots around healthy work environments, few of these study recommendations were implemented. As a result of this failure to act, the negative workload and worklife issues for nurses continue, and are in fact worsening.

Currently, overcapacity and overcrowding issues in emergency departments and throughout hospitals have further exacerbated the nursing crisis of the early 2000s. Overcapacity has resulted in "hallway nursing" — the provision of patient care in hallways, patient lounges, tub rooms, and other inappropriate, ill-equipped, exposed and unsafe locations. Overcapacity occurs most frequently as a result of lack of availability of alternate care in the community, including lack of nursing home, home care and community services. Overcapacity is associated with an increased risk of in-hospital morbidity and mortality, including increased occurrences of pneumonia, poor pain management, poor management of acute chest pain, delayed antibiotic treatment beyond recommended protocols, increased hospital readmission, and decreased patient satisfaction.

Poor work environments continue to impact nurses' ability to provide safe care. Frequent interruptions, role confusion, limited technical and human support, lack of system integration and coordination, relentlessly increasing patient acuity, and a lack of autonomous decision making and input into patient care decisions continue to negatively impact nurses and the patients and families they serve. Today's nurses continue to experience high levels of burnout, absenteeism, turnover and fatigue, and lack of job satisfaction. Studies show a direct correlation between nurse satisfaction and patient satisfaction.

Surveys of Canadian frontline nurses today show that issues of workload and safe staffing are the most significant issues they face in their work on a daily basis. Nurses report that they are losing patience with the failure to act on the evidence that exists linking safe staffing to positive patient outcomes.

Nurses want solutions to these problems. They are looking to the solutions implemented in California and some states in Australia where nurses have successfully lobbied for legislation or collective agreements mandating nurse-patient ratios. Such ratios limit the number of patients for whom one nurse can provide care. For example, in California, a 1:4 nurse-patient ratio is mandated by legislation.

In New South Wales, Australia, ratios were achieved based on a formula of minimum nursing hours per patient day (NHPPD). The NHPPD formula, although varying according to hospital classification, generally creates ratios equivalent to 1:4 on day shifts across a seven-day period. Differences in ratios are found on some nursing units of higher acuity, and mechanisms exist within the legislation to allow for improved staffing in periods of increased patient acuity. Staffing can be managed at the nursing unit level. Ratios act as a minimum to insure safe staffing, not as a maximum.

Emerging evidence has demonstrated that patient outcomes have improved subsequent to the implementation of such mandated ratios. Studies of the Australian experience showed a decreased occurrence of patient conditions that have been linked directly to nursing care (nurse-sensitive indicators), including decreased mortality, central nervous system complications, ulcers, gastritis, upper gastrointestinal bleeding, sepsis, pressure ulcers and length of hospital stay. Studies of the Californian experience reveal similar results with respect to mortality, and also demonstrate significantly improved nurse reporting of reasonable workloads and improved quality of care. These improvements in quality of care were reported by nurses in frontline and managerial positions. There was a significant increase in reported job satisfaction among frontline nurses following the implementation of mandated ratios.

An alternative to mandated ratios involves the use of a dynamic, shared decision-making model of nurse staffing that incorporates both patient factors and nurse characteristics, and employs a process where frontline nurses have direct input into staffing decisions. The American Critical Care Nurses Synergy Professional Practice Model has been adapted for use in staffing decision making beyond critical care and has been implemented in projects in British Columbia and Saskatchewan. The shared decision-making aspect has increased frontline nurse engagement in staffing decisions and has been highly regarded by those involved.

Importantly, the cost of increased nurse staffing can be largely or even entirely recuperated at the institutional level. This follows from the proven link between increased nurse staffing and length of stay, readmission, patient morbidity, medication error and nurse turnover. Looking beyond the walls of health facilities, the savings for society at large through increased productivity are much, much greater than increased staffing costs.

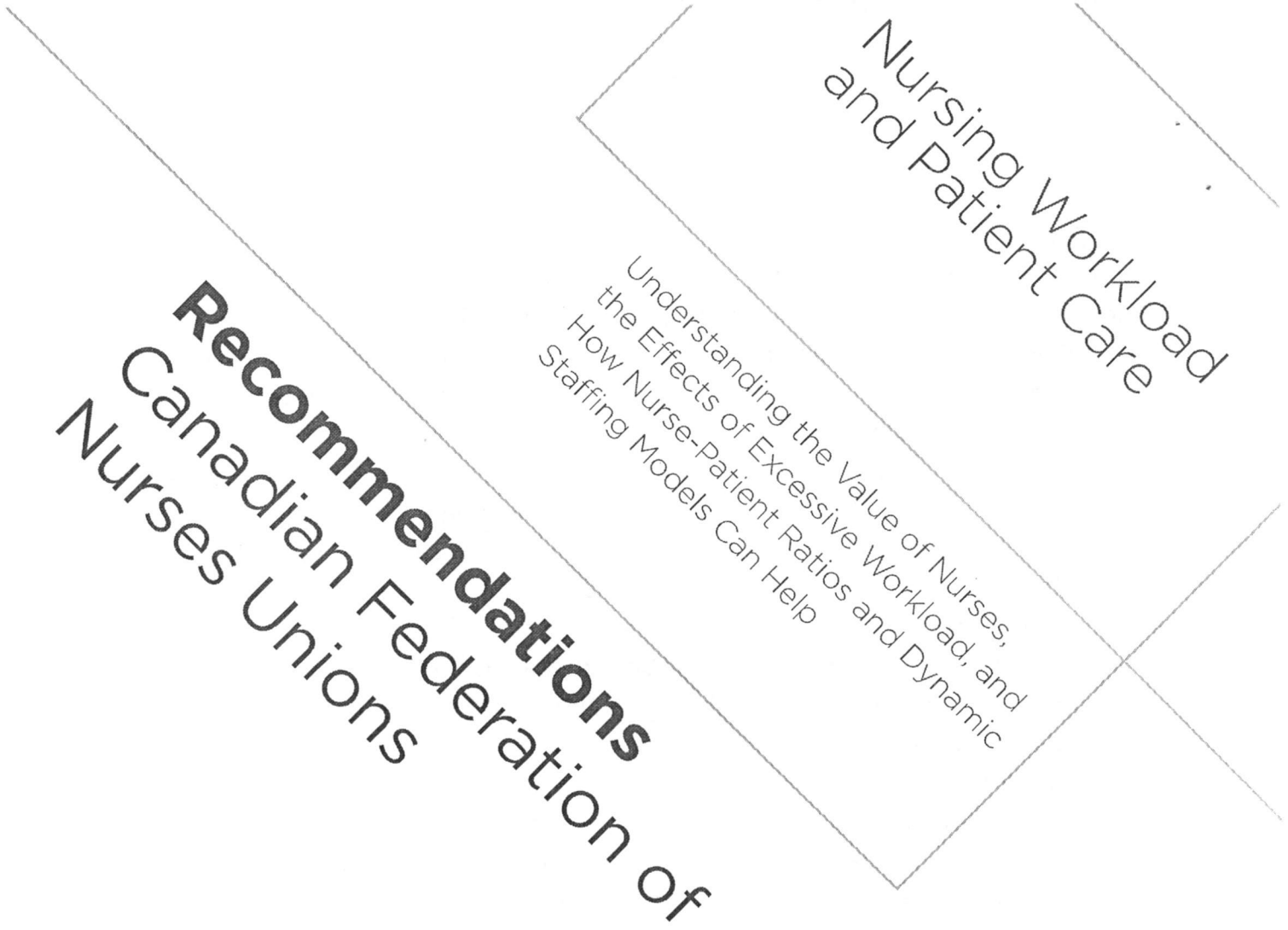
Both mandated nurse-patient ratios and dynamic shared decision-making models hold promise for frontline nurses who are losing patience with the lack of action to improve nursing workloads, worklife and the health care experience of patients and their families. Nurses want immediate action to support the implementation of safe staffing processes. They urge policy makers to implement such safe staffing mechanisms immediately, and to establish data collection processes that will capture the predicted improved outcomes for patients and their families. In addition, funding to health care institutions and programs should be tied to improvements in patient outcomes, as well as nursing workload and work environment indicators.

The Canadian reports of the last decade clearly showed that, as go nurses, so goes the health care system. At this point in time there is an urgent need to address the ongoing workload and worklife issues for nurses in order to improve the outcomes and experiences of patients and their families in the Canadian health care system.

Realities from frontline nurses:

I worked the unit for four months before quitting. Looking back, I realize I was having ethical/moral distress in not being able to provide nursing care at the level my patients deserved. I was going home feeling horrible that half of my patients didn't get bathed that day.

Sidney (Saskatchewan)



Principal recommendations

That policy makers:

1. Immediately commit to action to achieve safe staffing models across the continuum of care. Such action should include safe staffing ratios that replace like with like, ensuring that the right nurse with the right skills is matched with the patient.

2. Immediately fund implementation of a national prototype for safe staffing models, using either nurse-patient ratios or a dynamic shared decision-making model such as the Synergy Professional Practice Model.

3. Enforce health care system accountability for safe, quality patient care by moving beyond the wait-time and volume-driven, pay-for-performance benchmarks currently measured, and instead link institutional funding to improvements in patient outcomes and nursing indicators (reductions in absenteeism, burnout, turnover, etc.). Accountability mechanisms should ensure that employers and funding decision makers are held accountable for staffing decisions and their impact on patients, staff and budgets.

Supporting recommendations

That policy makers:

4. Ensure that staffing models and practices are based on evidence available in national and international research, and that they follow evidence-based guidelines such as the RNAO Best Practice Guidelines.
5. Provide targeted funding for quality nursing workplace initiatives directed at improving nursing workload and patient outcomes.
6. Standardize collection of health care data, including nursing indicators, and make it readily available to decision makers in easily understood, manageable electronic formats for use in decision making at system-wide and local levels.
7. Involve nurses at all levels in health care solutions.
8. Address governance issues in health care, starting at the front line and moving upward.
9. Clarify nursing scopes of practice and the role of unregulated workers in the system, and ensure replacement of nurses with nurses, eliminating substitution models which are unsafe and result in fragmentation of care.
10. Address overcapacity in the health care system by improving the integration of services between units, and between hospitals and their communities. This can be achieved by improving funding to home care and organizations providing alternate levels of care, and by improving access to primary care.

Realities from frontline nurses:

It's the change of shift, and nurses attempt to get their reports. They are no longer verbal; you get your report off the computer. The staffing has been reduced by two, as the CRN and the ward clerk have now left for the day. Their roles and responsibilities now become yours. The phones are ringing...

Katie (New Brunswick)

Introduction

Transformation and innovation are high on the agendas of national and provincial health care quality improvement organizations which hope to improve the health outcomes and care experience of Canadians, and control system costs. Research organizations such as the Canadian Institutes of Health Research proportion a significant amount of their annual funds to new research directed at improving the quality of health care in Canada. While this focus on new research for quality improvement is supported by Canada's nurses, there is mounting frustration among frontline nurses, nurse leaders and researchers alike at the failure of governments to act on what we *already know* about quality improvement and patient outcomes.

What do we know? We know that nurses impact patient outcomes. We know that quality nursing care reduces complications and length of stay, which ultimately reduces health care costs. We know from two decades of research that nursing workload impacts patient outcomes, and that the quality of nursing work environments impacts patient outcomes. We know that nurses are overworked and tired. They work in environments fraught with frequent interruptions, role confusion, limited technical and human support, lack of integration and

coordination, and ever-increasing patient acuity. In order to improve health outcomes and the quality of care, health care decision makers need to be challenged to act on what we already know, and to address the workloads and working environments of nurses.

How do we know that nursing workload and nursing work environments impact patient outcomes? Nurses have known this intuitively throughout their practice lives. But Canadian policy makers have been provided with what is now irrefutable evidence through two decades of national reports on the subject, supported by over 100 national and international research studies.

Between 2000 and 2006, ten major national reports were published in Canada, addressing Canada's crisis in health human resource planning, with an urgent focus on issues within the nursing workforce (Canadian Health Services Research Foundation, 2006). These reports included:

- Advisory Committee on Health Human Resources (2000). *The Nursing Strategy for Canada.* Advisory Committee on Health Human Resources.

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

- Advisory Committee on Health Human Resources (2002). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses.* Advisory Committee on Health Human Resources.

- Kerr et al. (2002). *Monitoring the Health of Nurses in Canada.* Canadian Health Services Research Foundation.

- Canadian Policy Research Networks (2004). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses. A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee.* Canadian Policy Research Networks.

- Nursing Sector Study Corporation (2005). *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada.* Nursing Sector Study Corporation.

- Advisory Committee on Health Delivery and Human Resources. (2005). *A Framework for Collaborative Pan Canadian Health Human Resource Planning.* Advisory Committee on Health Delivery and Human Resources.

- El-Jardali & Fooks (2005). *An Environmental Scan of Current Views on Health Human Resources in Canada: Identified, Proposed Solutions and Gap Analysis.* Health Council of Canada.

- Canadian Health Services Research Foundation (2006). *What's Ailing our Nurses: A Discussion of the Major Issues Affecting Nursing Human Resources in Canada.* Canadian Health Services Research Foundation.

- Ellis, Priest, MacPhee & Sanchez McCutcheon (2006). *Staffing for Safety: A Synthesis of the Evidence on Nurse Staffing and Patient Safety.* Canadian Health Services Research Foundation.

This flurry of reports was prompted by conditions in nursing at the time, but made even more urgent by the predicted massive shortage of nurses. A 1997 Canadian Nurses Association report forecast a shortage of between 59,000 and 113,000 registered nurses by 2011 if immediate action was not taken at that time (Ryten, 1997).

The findings of these reports were consistent. Using phrases like "untenable crisis," "urgent need to repair the damage," and concern for "deterioration in the quality of the nation's health care system," these reports painted an unsettling picture of a stressed and overworked nursing workforce.

Recommendations from these reports fell into two broad categories: improving nurses' workload and improving nurses' worklife. Most reports made recommendations with respect to appropriate staffing, matching scope of practice to patient needs, addressing the increasing pace and complexity of work, reducing absenteeism and nurse fatigue, and improving the integration of client care within health care institutions and between institutions and the community. They tackled nurses' worklife, with recommendations aimed at creating an environment where nurses experience respect, and where increased funds are provided for education and professional development. The reports called for programs to address and reduce abuse and violence in the workplace. They highlighted the need to increase the enrollment in nursing education programs to redress the budget-driven cuts to nursing education made during the 1990s.

All of these recommendations were backed up by Canadian and international studies on nursing workload, nursing worklife, patient outcomes and quality of care. The ensuing years have added many additional national and international research studies. In fact, research linking the impact of nurse staffing with outcomes of care has literally exploded in the last fifteen years (Clarke, 2008).

Unfortunately, little has changed. Despite all of these reports, and all of the ongoing research, we have not acted on what we know. With the exception of supporting increased enrolments in nursing education programs and quality workplace pilot projects, governments have not addressed the issues. Action lags, despite the development of patient safety and quality work environment standards for health care institution accreditation, which require institutions to monitor and improve client safety, promote a healthy and safe work environment, and promote quality worklife (Accreditation Canada, 2012). As early as the 2004 report reviewing the success in implementing the recommendations of the Canadian Nursing Advisory Committee Report of 2002, authors noted a declining interest in resolving nursing issues on the part of all governments (Maslove & Fooks, 2004).

The issues have not gone away. Canada continues to experience a nursing shortage. Following the budget-driven seat cuts to nursing education in the 1990s, the number of registered nurses did not return to the 1993 level until 2003, and because of a rising population, we still have not recovered the nurse-to-population ratio we enjoyed in the early 1990s (Canadian Institute for Health Information, 2012). If past trends continue, Canada will be 60,000 FTE RN positions short by 2022 (Tomblin Murphy et al., 2009).

The ongoing nursing shortage continues to take its toll on the workplace. A 2011 study of labour force data, commissioned by the Canadian Federation of Nurses Unions, found that public-sector nurses worked the equivalent of 11,400 full-time positions in paid and unpaid overtime in 2010, at a cost of $891,000,000 annually (Canadian Federation of Nurses Unions, 2011).

Turnover continues to plague the health care system. On average, one in five Canadian hospital nurses leaves his or her job every year, at a per capita cost to the institution of $25,000 (O'Brien-Pallas, Tomblin Murphy, Shamian, Li & Hayes, 2010). American studies cite even higher turnover costs of up to $67,000 per capita (Tschannen, Kalisch & Lee, 2010). Nurse burnout, fatigue and absenteeism as a result of excessive workload continue to impact patient care outcomes at considerable cost to the system. This cost is even higher when replacing for turnover on specialized nursing units.

This policy paper is directed at health care decision makers and provides updated research on the current state of nurses' workload and worklife issues,

and the impacts on patients and nurses. It identifies potential solutions to these long-standing issues, with a specific look at the implementation of mandated nurse-patient ratios in California and Australia. It recommends action to improve outcomes for patients and their families by aggressively and immediately addressing nurses' workload and the quality of nursing worklife.

Note: Of necessity, this document relies on RN data more heavily than data for licensed practical nurses (LPNs), registered practical nurses (in Ontario, RPNs), and registered psychiatric nurses (RPNs) simply because there is much less academic data available for the latter groups. Wherever possible, data for these groups is included. Roles and regulatory provisions for autonomous practice and self-regulation for practical and psychiatric nurses vary widely across the country. Research is needed to determine the appropriate makeup of the nursing and health care team, in particular patient care situations, to ensure that the contributions of all members are acknowledged and used appropriately.
Canadian researchers and health leaders have acknowledged that the roles of other professional health care workers and of multidisciplinary teams should also be the focus of study and recommendations (Hanson, Fahlman & Lemonde, 2007; Smadu & McMillan, 2007). Collaborative approaches should be directed at maximizing scopes of practice, determining appropriate roles, and ensuring that the proper supports, in the form of unregulated health workers and technological assistance, are in place (Canadian Health Services Research Foundation, 2010). Research and action are necessary to ensure that patients are cared for by the right provider in the right care context, with the right tools and the right amount of time to provide quality care.

Realities from frontline nurses:

Over a period of one year I gained forty pounds and started having trouble getting to work on time. On one occasion, I was reprimanded in front of other staff for being late. Some weeks later, at a time of family crisis, I called in to request a personal leave day, and I felt my integrity was being questioned by the manager. That day I submitted a request to give up my FTE and revert to a casual position.

Francis (Alberta)

Realities from frontline nurses:
In long-term care

I am a Registered Nurse working in a long-term care facility. I am responsible for three units with a total of 70 residents. I work with a team of Licensed Practical Nurses as well as Personal Care Attendants in the provision of nursing care. My day starts off normally but it quickly deteriorates. I get a call from one unit: A resident has fallen and the LPN is concerned that he has fractured his hip. I go to the unit to assess the resident. Yes, he has a broken hip. While there, I get another call that a resident on another unit has developed shortness of breath and appears to be in pain. I go back and forth between the two units, completing my assessments and interventions, and arranging transportation to hospital for both residents. On top of this, family members are waiting to talk to me, a physician has arrived to do rounds, and I have been unable to complete any of my regular duties. Several hours later I can finally take a breath, but I am very discouraged. This is wrong. Residents deserve better.

Susan (Newfoundland and Labrador)

Chapter 1

The History Behind This Project

Members and leaders of the Canadian Federation of Nurses Unions (CFNU) have become increasingly alarmed in recent months at nurses' stories of negative patient experiences resulting from inadequate nurse staffing. The anguish expressed by these frontline nurses unable to provide the care their patients require has moved the CFNU to act.

The CFNU recognized the need to clearly identify current issues related to patient care and nursing workload, and the actions needed to address these issues. The first step in the process involved a think tank of sixteen prominent Canadian nurse leaders, academics, researchers and policy makers in December 2011. These leaders provided insights on current nursing workload issues in practice and their impact on patient safety and quality of care, on the state of nursing workload research nationally and internationally, on health care finances and on action-based solutions to our current problems.

Two additional meetings of nursing and health care leaders and activists were held in January 2012 to gain further insight and feedback for this project. On January 12, the CFNU convened its provincial negotiators to meet with representatives of Californian and Australian nursing organizations to garner firsthand knowledge of

the impact of implementation of mandated nurse-patient ratios in these regions. On January 31, the CFNU representatives, with support from the Office of Nursing Policy, met with nursing, union, and health care organizational representatives, in a roundtable forum titled A Reality Check on 'Gaps' and Success Affecting Today's Health Workplaces. Input and feedback from both of these meetings played a key role in informing the direction of this policy document (See Appendices A, B and C for lists of participants).

Consultation with these nursing leaders confirmed what is echoed in this report: the failure to address patient safety and quality of care issues arising from nursing workload challenges does not occur due to a lack of evidence regarding appropriate solutions. It is also not simply a result of lack of funding. *The failure is based on a lack of political will to act on the evidence.* While further data collection is important, especially outside of acute care settings, what is necessary is action. The nurse leaders represented very diverse perspectives (unions, employers, governments, professional associations, academics, administrators, policy makers) and yet they were united in their message. They identified the importance of nurses translating their research to policy makers and the public in understandable ways. Nurses at all levels need to work together, and to work collaboratively with patients and families, to make their message powerfully obvious to political decision makers. They need to collectively explore innovative ways to act on what we know. To these nursing leaders, the evidence is clear. The time for action is now.

Realities from frontline nurses:
In long-term care

As a nurse on the evening shift I am faced with an overwhelming workload on a daily basis. With a capacity of 60 residents with various needs (diabetes, palliative, saline locks, trach care), supervising six care aides, building check (involving checking on boiler room, sprinkler room), replacing staff, one fire drill each month, I am not able to provide the quality of care that the residents deserve and pay for.

Diane (Prince Edward Island)

Nursing Overload Harms Patients

Chapter 2

The research findings are unequivocal. Nursing overload negatively affects patient outcomes. In 2002, two landmark American research studies showed an irrefutable association between nurse staffing levels and patient outcomes. Using administrative data from 799 hospitals in 11 states, Needleman et al. (2002), established clear relationships between nurse staffing and mortality rates, hospital-acquired pneumonia, urinary tract infections, sepsis, nosocomial (hospital-acquired) infections, pressure ulcers, upper gastrointestinal bleeding, shock and cardiac arrest, medication errors, falls and longer than expected length of stay (generally viewed as a measure of complications and delay of treatment) (Needleman, Buerhaus, Mattke & Stewart, 2002).

Another 2002 study of linked data from more than 10,000 nurses and more than 232,000 patients discharged from 168 Pennsylvania hospitals reported a relationship between nurse-patient ratios and preventable patient deaths. For every surgical patient added to a nurse's workload, the odds of a patient dying under the nurse's care increased by 7%. Each additional patient per nurse was associated with a 23% increase in the chance of nurse burnout and a 15% increase in the chance of job dissatisfaction (Aiken, Clarke, Sloane, Sochalski & Hiber, 2002).

But the numbers of nurses tell only part of the story. In addition to numbers of nurses, we are obliged to look at the circumstances under which nurses work. Who is on the nursing care team? What are their roles? What is the level of experience of the team members? The level of education? How many hours have they worked in a particular day? In a week? How much time off have they had? All of these factors affect patient outcomes.

What is it about nurses and their work that impacts patient outcomes?

Studies show that the makeup of the nursing team, the way in which work schedules are organized, the nature of relationships within and beyond the team, and the resources and time available to team members in planning and delivering care all impact patient outcomes. A Canadian study examined the 30-day mortality rates of medical patients discharged from medium to large Ontario acute care medical hospitals and found that lower 30-day mortality rates were associated with hospitals that had a higher percentage of RNs, a higher percentage of nurses prepared at the baccalaureate level, higher nurse-reported adequacy of staffing and resources, higher use of care maps or protocols to guide patient care, and higher nurse-reported care quality (Tourangeau, Doran, McGillis Hall, O'Brien Pallas, Pringle, Cranley & Tu, 2006).

Nurses' work schedules also influence patient outcomes. Odds of the occurrence of pneumonia deaths were 31% greater in hospitals where nurses reported schedules with long work hours, and 24% more likely to occur when nurses limited breaks between shift groupings. For patients with acute myocardial infarction, there was a 33% increase in mortality odds when the number of hours per week and days in a row worked were high. For patients with congestive heart failure, the odds of mortality increased by 39% when nurses reported working while sick (Trinkoff et al., 2011).

In a study conducted in Alberta, lower 30-day mortality rates correlated with higher RN/non RN staff mix and with a lower proportion of casual and temporary nurses in relation to permanent full-time nursing staff. In the same study, hospitals with higher scores on collaborative nurse-physician relationship scales were associated with lower rates of 30-day patient mortality (Estabrooks, Midodzi, Cummings, Ricker & Giovannetti, 2011).

Patients are also at risk when nurses are frequently interrupted during the course of their work (McGillis Hall, Pedersen & Fairley, 2010). Eighty-nine percent of the interruptions in a recent Canadian study had the potential to negatively impact patient safety. Interruptions greatly increase the risk of errors, particularly medication errors.

Interruptions come from many directions. In a Canadian study of interruptions to nurses' work, one third of all interruptions came from other members of the health team, 25% from other nurses, and 25% from patients, families and visitors.

Interruptions were largely related to communication around patient care. Twenty-five percent were related to searching for the patient or patient supplies. One third interrupted patient care assessments or procedures, one third interrupted documentation time, and 19% occurred during the preparation or administration of medications (McGillis Hall et al., 2010).

A specific look at workload, staffing and patient outcomes.

Studies continue to reinforce the findings of the early studies by Aiken et al. (2002) and Needleman et al. (2002) that nurse staffing impacts what happens to patients. In a Californian study, increases in hospital nurse staffing were associated with reductions in mortality (Harless & Mark, 2010). In a Michigan study of 13,000 hip fracture patients, the odds of in-hospital mortality decreased by 0.16 for every additional FTE RN added per patient day (Schilling & Dougherty, 2011).

In a US study of hospital administrative data, Needleman et al. (2011) looked at mortality in situations where nurse staffing was frequently eight hours or more below the recommended standard. An increased risk of death occurred in agencies that were frequently staffed below standard. A risk of increased mortality also occurred on units with high patient turnover. This may relate to the increased time demands on nurses for admission and discharge assessments, interaction with patients and families, and the need for immediate development of plans of care and discharge plans that arise when patients are admitted, discharged and new patients admitted to units over the course of a shift (Needleman, Buerhaus, Pankratz, Leibson & Stevens, 2011).

Increased nurse staffing was associated with lower hospital-related mortality in intensive care, surgical and medical units in a summary of 28 international studies. An increase by one RN per patient day was associated with decreased odds of hospital-acquired pneumonia, unplanned extubation, respiratory failure, and cardiac arrest in ICUs, and a lower risk of failure to rescue in surgical patients (Kane, Shamliyan, Mueller, Duval & Wilt, 2007). Studies in critical care units support the findings on non-critical care units. A 2010 systematic review of 26 research studies in critical care found decreased staffing in intensive care units, associated with increased adverse events in virtually all studies (Penoyer, 2010).

Studies have also addressed specific nursing outcomes, including nosocomial (hospital-acquired) infection, readmission, falls, failure to rescue, length of stay, medication errors, and patient satisfaction in relation to patient outcomes.

Nosocomial infection

Nurse staffing impacts infection rates. A recent Canadian study found that higher nursing staffing levels predicted fewer occurrences of methicillin-resistant

staphylococcus aureus (MRSA) infection (Manojlovich, Souraya, Covell & Antonakos, 2011).

Readmission

Studies continue to show that improving nursing staffing reduces the incidence of readmission. In a recent US study, researchers found an increase of 0.71 hours in RN hours per patient day (RNHPPD) was associated with 45% lower odds of an unplanned emergency room (ER) visit after discharge. In contrast, a 0.08-hour increase in registered nurse overtime was associated with a 33% increase in the odds of an unplanned patient ER visit (Bobay, Yakusheva & Weiss, 2011).

Falls

In a 2011 study of patient falls in military hospitals in the United States, a greater proportion of RNs relative to unlicensed assistive personnel was associated with fewer falls in medical-surgical and critical care units. Higher nursing care hours per patient per shift were significantly associated with a decreased likelihood of both falls and falls with injury. Increased falls were associated with increased acuity on medical-surgical units. A higher patient census was related to more falls in both step-down and medical-surgical units (Patrician, Donaldson, Loan, Bingham, McCarthy, Brosch & Fridman, 2011).

Failure to rescue

Failure to rescue is a nursing care indicator of death of a patient, usually believed to be related to a failure to observe, recognize or act on complications (Shever, 2011). Studies show that the number of times a nurse observes and assesses a patient in a day directly influences patient health outcomes. Researchers refer to these assessments and observations as nurse surveillance, defined as intentional, ongoing acquisition, interpretation, and synthesis of patient data for clinical decision making. The amount of nurse surveillance possible is, of course, clearly contingent on the level of nurse staffing. A recent US study indicated that when nursing surveillance was performed an average of 12 times a day or greater, there was a significant decrease in the odds of experiencing failure to rescue (Shever, 2011).

Length of stay

Proper nursing staffing can reduce patients' length of stay. In a systematic review of 17 studies addressing patient length of stay and hospital costs, all studies that looked at the relationship between nurse staffing and length of stay found that the

higher the number of nursing hours, the shorter the length of stay (Thungjaroenku, Cummings & Embleton, 2007). A US study found that length of stay was shortened by 24% in ICUs and by 31% in surgical patients with an increase of one RN per patient day over baseline staffing (Kane et al., 2007). Length of stay is a major factor in the cost of hospitalization. The Canadian Institute for Health Information estimated that the average hospital stay cost $6,983 in the baseline year 2004 (Canadian Institute for Health Information, 2009).

Medication errors

There is significant evidence indicating that improved nurse staffing and hours of work reduce medication errors. A 2009 US study found a higher likelihood of medication errors when nurses experienced higher patient care demands (Holden et al., 2011). A 2010 US study found that nurses who worked more than 40 hours per week were 28% more likely to report that patients occasionally/frequently received the wrong medication or dose. For every additional hour of overtime worked each week, the likelihood that a nurse reported occasional/frequent wrong medication or dose administration increased by 2% (Olds & Clarke, 2010).

Patient satisfaction/patient experience

Nurses are key players in the patient experience. A foundational study in health human resources in Canada in 2001 reported that nurses' job satisfaction was the strongest predictor of patient satisfaction (Baumann et al., 2001).

There is a clear relationship between nursing workload, quality of nursing worklife, and patient satisfaction. In a 2009 US study of 430 hospitals, the quality of the nursing work environment was positively associated with all patient satisfaction measures (Kutney-Lee et al., 2009). Another recent study involving five units at the McGill University Health Centre showed that an 8% increase in RN direct patient care correlated with a 30% improved scoring of caregiver responsiveness by patients (O'Connor, Ritchie, Droin & Covell, 2012).

The Registered Nurses Association of Ontario (RNAO) position statements on client-centered care in hospitals, long-term care facilities and home care, coupled with its *Healthy Work Environments Best Practice Guidelines, Developing and Sustaining Effective Staffing and Workload Processes,* provides evidence and guidance to inform best practices for safe staffing (Registered Nurses Association of Ontario, 2007; 2010a; 2010b). In other words, many of the tools necessary to improve the patient experience are already in our hands.

Nurse staffing is one of the few areas in health care in Canada where evidence is ignored in decision making (McGillis Hall et al., 2006).

Decision Making for Nurse Staffing: *Canadian Perspectives.* Policy, Politics & Nursing Practice, 7(4), p. 267.

Nursing Workload and Patient Care

Nursing Overload Burdens Nurses

Chapter 3

The research findings with respect to nursing workload and patient outcomes are consistent and conclusive. But so too are the findings with respect to the impact of nursing workload on nurses themselves. The negative impact of excessive workload and poor quality workplaces has been known for many years. The author of the 2002 Canadian Nursing Advisory Committee Report, Dr. Michael Decter, introduced the report with this statement:

> *There is urgent need to repair the damage done to nursing through a decade of healthcare reform and restructuring. The case for constructive change is compelling. However, simply to endeavour to return to better days will not meet the needs of Canadians for high-quality nursing services as a mainstay of our broader healthcare system. This report describes in detail why Canada needs more nurses and better working conditions for nurses. It also sets forth a plea for treating nurses with greater respect.... I hope that our report lends urgency to the recognized problems in Canadian nursing. Actions are required* (Canadian Nursing Advisory Committee, 2002, p. v).

Despite such calls for action, little has changed for nurses in the decade since this report was commissioned, a complaint that has been levelled over and over since 2002 (Shamian & El-Jardali, 2007). Some of the ongoing issues in the quality of nurses' worklife include burnout, turnover, fatigue and absenteeism.

Burnout

Nurse Alia Accad, an expert on nurse burnout, eloquently sums up the issue:

> *In 40 years specializing in stress and burnout, one thing is clear to me - burnout is the result of people working in conflict with their deepest values. Nurses have the capacity to work tirelessly and hard for years when they feel good about themselves and the value of their work. However, working for prolonged periods with no personal satisfaction from the effort is a situation ripe for burnout. While physical stress is tiring, the spiritual stress of being out of harmony with your truth and your values is devastating* (Accad, 2009).

With their current crippling work assignments, lack of input into how those assignments are determined, and lack of autonomous decision making with respect to their patients' care, nurses are experiencing burnout at unprecedented levels. They are simply not able to provide the care that they know their patients need. They are unable to meet their professional, legal and ethical obligations to patients and their families, and the angst that results takes its toll.

Burnout is an international phenomenon. In a six-country study of almost 55,000 nurses, higher levels of burnout were associated with lower ratings of quality of care, independent of the nurses' perceptions of their practice environment (Poghosyan, Clarke & Finlayson, 2010).

In a study of 546 nurses from 42 Belgian hospitals, significant associations were found between unit-level nursing practice environments and burnout, job satisfaction, intention to leave, and nurse-reported perceptions of quality of care (Van Bogaert, Clarke, Roelant, Meulemans & Van de Heyning, 2010).

Frontline nurses suffer burnout more than their colleagues. In a cross-sectional study of 95,499 US nurses, nurses in direct patient care were found to have significantly higher levels of dissatisfaction and burnout than nurses in other positions. As was found in the 2001 Canadian study (Baumann et al., 2001), patients in hospitals with high levels of nurse dissatisfaction and burnout reported lower levels of satisfaction with care (McHugh, Kutney-Lee, Cimiotti, Sloane & Aiken, 2011).

A recent Canadian study supports the international findings that burnout in nurses persists. It reveals another significant aspect about burnout in nurses in Canada — burnout is not restricted to older, shop-worn nurses. A recent study of 309 new nurses in Quebec found that 43% reported a high level of psychological distress. The same study revealed that 62% of respondents intended to quit their present jobs for other jobs in nursing, and 13% intended to leave the profession entirely (Lavoie-Tremblay, O'Brien-Pallas, Desforges & Marchionni, 2008).

Burnout is about not feeling respected. Nurses experiencing burnout no longer believe that they can make a difference. For many nurses, the work environments in which they work and the workloads they carry seriously challenge their belief that their work *has* value. Accad, in her advice to nurses about avoiding burnout, speaks of the need to regain the passion for what they do. She tells them: "You cannot burn out when your heart is aflame" (Accad, 2009). For too many nurses, that flame is flickering and dying because their worklife does not present the opportunity to provide the care they believe patients require.

Turnover

High levels of nurse turnover pose a significant problem for the health system. A recent Canadian study on turnover found that the mean turnover rate in the 41 hospitals surveyed was 19.9%. Higher turnover was associated with lower job satisfaction. High levels of role ambiguity and role conflict were associated with mental health deterioration in the nurses in these agencies. Higher turnover rates and higher role ambiguity were associated with increased risk of error. Recent studies report varying but consistently high costs for turnover: an average of $25,000 per nurse (O'Brien-Pallas et al., 2010), or ranging between $21,514 to as high as $67,100 per nurse (Tschannen, Kalisch & Lee, 2010), or even 1.3 times the salary of the departing nurse (Jones & Gates, 2007). Costs of nurse turnover include recruitment, advertising, replacement costs during vacancy (including overtime, bed closure, diversion to other institutions, etc.), hiring, orientation, decreased productivity, potential patient errors, poor work environment, loss of organizational knowledge, and additional turnover (Jones & Gates, 2007).

A cross-sectional descriptive study of 110 nursing units in 10 mid-western US hospitals found that units with higher rates of missed care and absenteeism had a higher rate of intention to leave within a year of the study. Missed care was defined as any aspect of care omitted or significantly delayed (Tschannen, Kalisch & Lee, 2010).

Fatigue

Nursing fatigue seriously affects the ability of nurses to care effectively for their patients. In a major study on nurse fatigue and patient safety, conducted in 2010, the Canadian Nurses Association (CNA) and the Registered Nurses Association of Ontario (RNAO) found that nurses reported significant levels of fatigue, defined as

> *...a subjective feeling of tiredness... that is physically and mentally penetrative. It ranges from tiredness to exhaustion, creating an unrelenting overall condition that interferes with individuals' physical and cognitive ability to function to their normal capacity. It is multidimensional in both its causes and manifestations; it is influenced by many factors: physiological (e.g., circadian rhythms), psychological (e.g., stress, alertness, sleepiness), behavioural (e.g., pattern of work, sleep habits) and environmental (e.g., work demand). Its experience involves some combination of features: physical (e.g., sleepiness) and psychological (e.g., compassion fatigue, emotional exhaustion). It may significantly interfere with functioning and may persist despite periods of rest* (Canadian Nurses Association and Registered Nurses Association of Ontario, 2010, p.1).

The 6,312 Canadian nurses surveyed in the CNA/RNAO study cited fatigue as a major negative influence on their engagement, decision making, creativity and problem-solving abilities, all essential aspects of safe patient care in today's fast paced health care system. Nurses reported that the most significant organizational reasons preventing their ability to respond to their fatigue were workload (reported by 73% of surveyed nurses), professional responsibility to be there for patients (70%), feelings of not wanting to let down their colleagues (66%) and the culture of doing more with less (60%). Nurses reported the causes of their fatigue as workload, shift work, including 12-hour shifts and working more than 12 hours in one shift, patient acuity, little time for professional development and mentoring, a decline in organizational leadership and decision-making processes, and inadequate "recovery" time during and following work shifts (Canadian Nurses Association and Registered Nurses Association of Ontario, 2010). Clearly, nurses feel a moral obligation to their patients, which prevents them from taking action to address their fatigue levels.

Absenteeism

The stress in nurses' working lives affects their ability to come to work. An analysis of Statistics Canada Labour Force data found that in 2010, an average of 19,200 Canadian nurses were absent from work every week due to illness or

disability. Nine percent of public-sector health care nurses who usually work at least 30 hours per week were absent due to illness or disability every week. This is nearly twice the rate of all other occupations, and remains higher than all other health care occupations. The annual cost of Canadian nurse absenteeism due to own illness or disability was $711 million in 2010 (Canadian Federation of Nurses Unions, 2011).

In a systematic review of online databases from 1986 to 2006, potential predictors of nurse absenteeism were examined. Findings showed that job satisfaction, organizational commitment, and work/job involvement reduced nurse absenteeism, whereas burnout and job stress increased it (Davey, Cummings, Newburn-Cook & Lo, 2009).

Issues of excessive workload and poor quality work environments are not only found in acute care settings. In a recent Canadian study, 675 RNs, LPNs and other staff from 26 long-term care facilities were surveyed about their work environment and related factors, as well as their job satisfaction and turnover intentions. Among the findings, higher job satisfaction was associated with lower emotional exhaustion, higher empowerment, better organizational support and stronger work group cohesion. Higher turnover intention was associated with lower job satisfaction, higher emotional exhaustion and weaker work-group cohesion (Tourangeau, Cranley, Laschinger & Pachis, 2010).

There is little research available regarding nursing workload issues in home care. A recent study exploring issues in home care nursing workload measurement in Canada noted that, while home care workload assessment tools exist, they have only been used in two instances in Canada. Despite the reported usefulness of such tools, their use was not sustained as the necessary personnel and financial resources to fulfill their requirements were not attainable (Mildon, 2011).

Fatigue, burnout, absenteeism and turnover are most common when nurses are not satisfied with their working conditions (O'Brien-Pallas et al., 2001; Irvine & Evans, 1995; Greco, Laschinger & Wong, 2006; Laschinger, 2004; Lasota, 2009). This dissatisfaction is often rooted in excessive workloads and insufficient staffing (Canadian Federation of Nurses Unions, 2012; Greenglass, Burke & Moore, 2003). Addressing these problems is an obvious way to improve nurses' worklife, while also improving the safety and quality of care for patients and their families.

Issues of nursing workload and worklife are not simply issues of supply and demand. They are symptoms of systemic problems within the health care system itself.

What is moral distress in nursing?

Moral or ethical distress arises when nurses are unable to fulfill their moral obligations or commitments, or fail to live up to their own expectations of ethical practice (Canadian Nurses Association, 2008). It occurs when nurses know what to do but are unable to do what is right. Storch, Rodney and Starzomski (2013) maintain that it is constraints to nurses' autonomy, and the resultant distress that threaten the well-being and safety of nurses and ultimately their patients. Moral distress has increased in nursing in recent years.

Restructuring, lack of human and structural resources, altered work environments, increased patient acuity with off-loading of care to families... have created a significant level of moral chaos in the nursing profession. The prevalence of this moral chaos within the practice of nursing has, we believe, led to a moral winter for our profession.... The metaphor of moral winter speaks to a moral landscape of nursing practice that has become frozen, lying dormant and buried beneath layers of contextual constraints. When nurses see themselves as unable to stop moral wrongdoing they themselves have become frozen, and when substandard practice becomes normalized, such that deteriorations in practice standards are not overtly challenged, a moral winter has arrived (Storch, Rodney & Starzomski, 2013, p. 190).

Nursing Workload and Patient Care

Chapter 4

Health Care Systems Issues: Trouble Starts in the Emergency Department

Overcapacity issues are a significant cause of excessive workload. Overcapacity is an issue that exists throughout health care institutions, but is perhaps most evident and more commonly identified in the emergency room (ER). Overcapacity issues in the ER provide a lens through which to view broader issues related to patient care organization, nursing workload and patient outcomes within the health care system. The ER has been described as the health care systems' "canary in the coal mine," as its functioning is reflective of the health and efficiency of the entire system (Laupacis & Born, 2011). The problems for patients and nurses that result from overcapacity in the ER are symptomatic of problems in the other units and sectors within the system.

Overcrowding in the ER emerged in the Canadian health care system, following the massive reorganization and downsizing of the system in the 1990s (Bond et al., 2007). It has resulted in the advent of institutional overcapacity protocols. These protocols are short-term strategies that move patients from the ER to nursing units, hallways, tub rooms and patient lounges, and increase the capacity of existing rooms beyond their design. Caring for patients in such temporary locations is referred to as "hallway nursing" (College of Nurses of Ontario, 2009). Hallway nursing has

significant negative impacts on the ability of nurses to provide nursing care. More importantly, it endangers patients.

Distributing the problem and hiding it in the corner: ER overcapacity and hallway nursing

Canadian media reports highlight the overcrowding of emergency rooms on an ongoing basis (CTV News, 2011; Wingrove, 2010; Yuen, 2009). ER overcrowding is defined as "a situation in which demand for service exceeds the ability to provide care within a reasonable time, causing physicians and nurses to be unable to provide quality care" (Canadian Association of Emergency Physicians & National Emergency Nurses Affiliation, 2001). In a survey of 158 Canadian emergency department directors, 62% reported overcrowding as a major problem during the preceding year (Bond et al., 2007).

Overcrowding in the ER is bad news for everyone involved

The most significant cause of ER overcrowding is compromised flow of admitted patients from the ER to hospital inpatient units (British Columbia Medical Association, 2011). In British Columbia, more than one third of patients requiring hospitalization wait more than 10 hours following the decision to admit them to hospital to access a hospital bed (British Columbia Medical Association, 2011). This lack of accessibility to timely inpatient care occurs for a variety of reasons: reduced availability of hospital beds, shortage of personnel (in particular, nurses), length of stay of hospital inpatients, complexity of patient conditions, lack of availability of appropriate community-based services, and poor integration and coordination of the hospital-to-community transition (British Columbia Medical Association, 2011; Canadian Health Services Research Foundation, 2010).

One particular concern with respect to ER nursing care is the lack of nurses with training in specialty areas like emergency care. In an attempt to help address this issue, and with the support of Nova Scotia's Registered Nurse Professional Development Centre, the Prince Edward Island Nurses' Union recently partnered with the PEI Department of Health and Wellness and the University of Prince Edward Island to implement critical care and emergency nursing programs in Prince Edward Island. Previously, nurses had to travel to Halifax for up to 15 weeks for these programs (Cotton, 2012). This kind of training is required on a larger scale and in more jurisdictions in order to have the nursing specialists in place to address shortages.

A significant cause of the access problem is the lack of appropriate resources beyond the hospital walls. Simply put, many patients end up in the ER because there is nowhere else for them to go. Up to 20% of acute care beds in British Columbia are occupied by patients requiring alternate levels of care (ALC) – that is, patients in acute care settings who could be more appropriately cared for in another setting. Often patients cannot access alternate care because of shortages in community resources such as home care, long-term care or palliative services. This situation impedes patient flow, increases wait times for acute care beds, and increases lengths of stay (British Columbia Medical Association, 2011).

The need for appropriate alternate levels of care is a national issue. In 2007-2008, ALC patients accounted for 5% of Canadian hospitalizations and 14% of hospital days in acute facilities (Canadian Institute for Health Information, 2009). Thus, on any given day, almost 5,200 beds in acute care hospitals were occupied by ALC patients. These patients come to hospital and stay. Of ALC patients admitted to acute care hospitals, 59% had stays of more than a week, 20% more than a month, and 4% of patient stays were more than 100 days (Canadian Institute for Health Information, 2009). These stays not only result in a backlog of patients in emergency rooms; they result in patients often suffering from dementia or requiring palliative care, being cared for in overcrowded chaotic ER hallways or acute care units ill-equipped for the supportive physical and emotional care they and their families require.

Contrary to popular belief, the accessing of emergency services by patients seeking primary health care for minor ailments is not the biggest barrier to timely ER care (Canadian Health Services Research Foundation, 2010; Schull, Kiss & Szalai, 2007; *University of Toronto Magazine,* 2003). Such patients tend to be dealt with quickly and do not block the system in ways that patients with complex conditions requiring admission do.

While not the biggest barrier to timely care, the use of the ER as a provider of primary care does have negative consequences. Such use diverts nursing and other staff time and attention, as well as resources, away from patients requiring the specialized services of an emergency department. Of even more significance, however, is the inadequacy and inappropriateness of the ER as a source of integrated care for patients and their families. Canada's lack of access to primary care services leaves the ER, a service set up to provide urgent and emergency care in crisis situations, completely unprepared to provide the case management and ongoing continuity required to address the complex care needs of patients and families needing ongoing care and a coordinated interprofessional team approach. Trying to provide primary care in an ER setting leaves nurses frustrated regarding their inability

to meet the ongoing health needs of clients and their families. Nurses are concerned about their inability to meet their professional standards of care, including possible loss of their licenses as a result of missed assessments and care due to the mismatch between patient care needs and available services. The episodic nature of the care provided to patients using the ER as a source of primary care, with its short term focus, lack of integration and coordination, and limited use of the interprofessional team approach leaves patients and their families at risk.

The 2002 Romanow Commission on the Future of Health Care in Canada called for a fast tracking of the implementation of an integrated primary care system based on continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to achieve transformation. It called for immediate attention to the need for alternate levels care, particularly home care. Yet now, ten years later, little has changed. Canada continues to rank behind other nations and has significant regional variability in the quality and accessibility to primary health care services (Canadian Health Services Research Foundation, 2010). The number of days of hospitalization for patients requiring alternate levels of care continues to rise, from 10% of all hospital days in 2006 to 14% in 2009 (Canadian Institute for Health Information, 2009). This is a clear signal that Canadians are often not receiving care in the most appropriate setting. Development of an integrated seamless system encompassing the continuum of care from primary and preventive care services, home care, acute, chronic and rehabilitative inpatient services, palliative care and long-term care is necessary to increase the quality of services that patients and their families receive, and that nurses and other health professionals can provide.

The negative consequences of overcrowding for patients

ER overcapacity usually results in overcrowding which is associated with an increased risk of in-hospital morbidity and mortality (Hoot & Aronsky, 2008). One study estimates the increased risk of mortality at 30% (Collis, 2010). When overcrowding exists in the ER, patients with pneumonia or acute pain experience longer wait times for treatment and a significantly higher probability of leaving the ER against medical advice or without being seen (Bernstein et al., 2009). Research shows that the frequency, timeliness and documentation of pain management were compromised during times of overcrowding (Collis, 2010).

Studies have found that prolonged patient stays in the ER for patients admitted with chest pain were associated with decreased use of guidelines and poorer patient outcomes. Patients with chest pain experience delayed treatment and delayed

transport. Antibiotic treatment for pneumonia was frequently delayed beyond recommended protocols (Collis, 2010).

Overcrowding negatively impacts the patient experience. Patients cared for in the waiting room or hallway were more likely to return for hospitalization within seven days, and left without being seen or against medical advice more often than patients cared for in acute care beds. Patients reported increased dissatisfaction with care in overcrowded situations (Pines et al., 2007).

Overcrowding and hallway nursing: What does it do to nurses?

Overcrowding in the ER has negative consequences for nurses as well as patients. In a survey of 158 Canadian emergency directors, 82% reported a perception that overcrowding was a major source of stress for nurses, and 68% noted a significant negative impact on the recruitment and retention of nurses (Bond et al., 2007).

Overcapacity issues negatively impact nurses' mental health. In a Finnish study of nurses within and outside of the ER, exposure to six months of average bed occupancy rates 10% or more above the recommended bed occupancy limit was associated with a 1.7-fold increase in new treatment for antidepressants in nurses (Virtanen et al., 2008).

A 2009 survey of over 500 Ontario nurses revealed three themes: that emergency rooms and inpatient units were under relentless and escalating pressure from overcapacity issues; that nurses were increasingly unable to uphold their professional standards as a result of this pressure, with resultant concern from both legal and moral standpoints; and that they were experiencing ever-diminishing resiliency in the face of these demands (College of Nurses of Ontario, 2009). Frequent – often daily – occurrences of overcapacity engendered feelings in the nurses of lack of control, increased risk and vulnerability. The perceived off-loading of emergency patients into areas ill-equipped to care for them produced an undercurrent of tension and conflict in many hospitals (College of Nurses of Ontario, 2009). Nurses described concern about the risks to patients from fire, the lack of time for proper assessment, delays in treatment, and caring for patients with conditions that were not part of their nursing expertise (such as adult cardiac patients being housed on pediatric units). Their frustration was summed up by one nurse who described it as the "let's distribute the problem and hide it in a corner" approach (College of Nurses of Ontario, 2009).

There were consistent messages from the Ontario nurses surveyed regarding the lack of safety for patients in these environments. The lack of appropriate equipment (oxygen, suction, infection control precautions, call bells, mechanical

lifts) endangered patients. But in addition to physical safety, the nurses reported the anguish they felt for patients experiencing lack of psychological and emotional safety due to a lack of privacy and confidentiality in exposed hallway environments. Elderly patients became increasingly confused in these environments, with the constant noise, interruptions, and continuous bright lighting. Nurses' moral distress was most evident when caring for palliative patients. Nurses found the lack of dignity afforded dying patients and their families painful to experience. Their reports of patients dying in the hallway showed anguish, sadness, anger and frustration (College of Nurses of Ontario, 2009).

The distress experienced by nurses as a result of these conditions is also consistently evidenced in reports from expert hearings that arise as a result of work situation reports filed by Canadian nurses through collective agreement processes. Nurses who are concerned about patient safety and their own ability to meet their professional standards in practice as a result of unsafe staffing have access to professional practice review processes through their collective agreements. In Ontario, for example, if nurses do not receive satisfactory responses to the filing of their work situation reports, they may call for the formation of an assessment committee to review the situation. A panel of three nurse/health care experts then reviews the practice/workload situation. Assessment committee processes nationally have identified staffing situations which endanger patients, and have made recommendations to improve patient safety through improved staffing. Unfortunately, as we have seen in other reports on this topic, the recommendations are not always implemented.

The message from nurses is clear: This is not what they signed on for. The moral distress expressed by nurses as a result of overcapacity, overcrowding, hallway nursing and excessive nursing workload in compromised surroundings ultimately affects their daily practice, their health, their ability to meet the standards of their profession, and ultimately, their desire to continue to do what they do.

It is time to address the challenges of overcrowding and hallway nursing

Health care, professional, and labour organizations have produced protocols to protect patients and health care providers in overcapacity conditions. The College of Nurses of Ontario (CNO) has made six recommendations for health care decision makers: Support the standards of professional practice; develop and support the use of evidence-informed protocols and policies; maximize the use of existing human

resources; support the use of ER performance measures; encourage the collection and reporting of additional performance data; and encourage local innovation (College of Nurses of Ontario, 2009).

The Canadian Nurses Association (CNA) position paper on overcapacity in the ER advocates increased access to community resources and alternate levels of care, more effective management of chronic disease, improved access to primary care services, improvements in the capacity for self-care, innovations in geriatric care across the health care continuum, innovations in discharge assessment, planning and follow-up, investment in health promotion and disease prevention strategies, investment in nursing retention and recruitment, maximization of care services for home care clients, and removal of legislative barriers to the participation of nurse practitioners in primary and tertiary care (Canadian Nurses Association, 2009).

The Canadian Federation of Nurses Unions has called upon federal and provincial/territorial governments to fund public home care, long-term care and hospitals to address the current realities of patients, to increase capacity for and access to primary care services, improve community-based health care services, enhance accessibility to multidisciplinary care providers, increase the efficiency of triage processes and ensure appropriate staffing levels. The CFNU recommended additional strategies to target overcrowding: improving flow of patients into and through hospitals by better integration of services between units in the hospital, and between the hospital and the community, increased availability of alternate levels of care services, and optimizing acute care lengths of stay (Canadian Federation of Nurses Unions, 2009).

Issues of integration, quality and patient safety cannot be resolved within the health care system without meaningful collaboration and coordination at all levels. Governments at all levels should clarify their roles with respect to ensuring integration and quality within in the health system for improved patient care, and nursing human resource planning, including quality nursing work environments and improved nursing workloads. However, such solutions cannot be achieved without the input of nurses at all levels within the system.

These solutions require action beyond the ER. They require serious, long-range attention to the integration of the activities of the health system, within and beyond the hospital. In the interim, we have to ensure that short-staffing does not contribute to this problem.

Realities from frontline nurses:

Understaffing in the ER

More and more patients were kept in observation because there were no beds available to admit them on units. There was space to admit four patients in observation, but there were always more admitted in other rooms not close to the nurses' station. At night staffing was reduced to two nurses and one RA...

One of the nurses went out of the trauma room and heard a strange noise, so she looked in one of the 'make-shift' rooms... She saw her patient having a seizure. How long had she been in distress?

Lynne (New Brunswick)

Nursing Workload and Patient Care

Workload Is the Top Issue for Canadian Nurses Today

Chapter 5

Canadian nurses tell us that excessive workload not only occurs in times of periodic surge capacity. It is now viewed by many frontline nurses as the norm. For example, the Newfoundland and Labrador Nurses' Union, in partnership with the Association of Registered Nurses of Newfoundland and Labrador, has felt compelled to develop a strategy document entitled *Excessive Hours of Work: Professional and Union Considerations* (Newfoundland and Labrador Nurses' Union, 2011). The document provides nurses with strategies for dealing with endemically overburdened workplaces. Polls by nurses unions from across the country, as we will soon see, testify to the rising concern over working conditions (Canadian Federation of Nurses Unions, 2012).

Nursing overload: Why does it happen?

Nursing overload arises from a variety of sources. Overcapacity of patients in relation to available bed space is a common cause. Inadequate staff availability is commonly reported, because of inadequate baseline staffing, or failure to replace staff that are away ill or on vacation. Failure to replace staff may be due to lack of

available replacement staff, or may be a cost-cutting measure. Inadequate staffing also occurs when the system is unable to adjust its staffing to address the acuity of patients, or to adjust to surges in capacity. Making up the shortfall in staffing through the use of overtime is common – public sector nurses worked over 20 million hours in overtime in 2010 (Canadian Federation of Nurses Unions, 2011). Requiring nurses to work beyond their scheduled hours has a significant impact on their quality of life and can result in fatigued nurses giving unsafe care.

Inadequate staffing may also be the result of lack of availability of the right kind of staff, including lack of the appropriate designation of nursing staff (RN, LPN) required to care for the complexity of patients, the required advanced training (critical care nursing, for example), or the appropriate supply of support staff whose absence requires nurses to assume non-nursing tasks, such as portering patients, making beds, passing trays and searching for supplies.

What do Canadian nurses say about workload?

In surveys of nursing union members in 2011 and 2012, provincial unions heard a consistent message regarding unmanageable, unsafe workloads. While in the past wages and pensions were typically the top concerns, now issues of workload, short staffing and overtime are taking precedence (Canadian Federation of Nurses Unions, 2012).

British Columbia. Of the 5,600 members of the British Columbia Nurses' Union surveyed, 81% indicated that workload was a problem; 39% indicated it as a major problem. Fifty-one percent reported that the staffing complement was insufficient to meet the workload and patient acuity requirements. Eighty percent reported that they worked short of the planned baseline staffing complement, with 35% saying they worked short-staffed most or all of the time. Reasons given for short staffing situations were positions not being filled due to budgetary constraints (32%); not backfilling for vacations and sick leave (31%); and difficulty filling vacancies (18%). Of acute care nurses surveyed, 45% said that they had cared for patients in hallways, closets or unfunded beds with no additional nurses assigned within the twelve months prior to the survey.

Alberta. Of the 1,500 members of the United Nurses of Alberta surveyed, 38% cited the shortage of nurses as the single most important issue, followed by heavy workload and burnout (21%). Two thirds of those surveyed reported being called at home repeatedly to work extra shifts or overtime at least once in an average week. This figure rose to 90% for nurses working on emergency units. Sixty-four percent

of those full-time nurses surveyed reported working above their scheduled full-time hours. The figure was 81% for part-time nurses.

Twelve percent of the Alberta nurses surveyed indicated dissatisfaction with their jobs, with 58% of these nurses indicating that their dissatisfaction was due to inadequate staffing. Only 28% of nurses surveyed reported that there was adequate staffing at their primary workplace.

Of those surveyed, 51% reported working unpaid overtime. While in 2009, 26% of nurses reporting working paid overtime said they did so due to short staffing or absenteeism, in 2011 this number had risen to 53%. Similarly, the number reporting paid overtime due to not being able to take meal and rest breaks due to emergencies and heavy workload went from 12% in 2009 to 27% in 2011.

Saskatchewan. Staffing (nurse-patient ratio) and workload were identified as the most significant bargaining issues for the 800 members of the Saskatchewan Union of Nurses surveyed, at 32% and 25% respectively. For 54%, workload was a very major concern, while 24% rated it a major concern. More than 51% claimed that nurse-to-patient ratios were a very major concern, while another 24% claimed it as a major concern.

Increasing workloads occur for a variety of reasons. Over 45% of the Saskatchewan nurses surveyed reported that the number of appropriate staff on hand had decreased over the last year. The number of patients for whom they provide care has increased over the past two to three years for 56% of those surveyed. The complexity of patient care tasks increased for 72% of those surveyed, and 67% indicated that the number of interventions for a typical patient has also increased. Over 45% indicated that the number of appropriate staff available to support care has also decreased.

Overtime is also an issue for Saskatchewan nurses. Short staffing and sick leave replacement are the greatest reasons cited for overtime. Nurses who report doing overtime hours average at least one hour of overtime per week.

Workload and working conditions play a significant role with respect to retirement. Of the Saskatchewan nurses surveyed, 32% were eligible to retire by the end of 2012. Working conditions were cited as the most important factor for determining whether to retire or remain working, with 63% saying they were a very important consideration, and 22.5% saying that they were important to decision making.

Manitoba. Of the 1,200 members of the Manitoba Nurses Union surveyed, 35% identified the shortage of nurses as the most important issue facing nurses in Manitoba. The only other issue noted by a significant number of nurses was "heavy

workload/long hours/burnout," which was identified as the main issue by 23% of nurses.

Ontario. In a survey of 58,000 members of the Ontario Nurses' Association in 2010, issues of wages and benefits were for the first time overtaken by workload and professional issues as the top concerns facing Ontario nurses. More than 60% of those surveyed reported staffing ratios as problematic, while 34% identified a significant issue with inappropriate skill mix for the acuity of patients. Members reported that budget restraints continue to trigger workload and professional issues. Rising paid and unpaid overtime continued to be significant issues, with resultant rising injuries and burnout amongst Ontario nurses.

New Brunswick. Of the 1,500 members of the New Brunswick Nurses Union surveyed, 26% stated that better working conditions are a priority, including better work-life balance. Twenty-seven percent would like to do less overtime and 27% stated that they work short-staffed at least twice a week due to vacancies and absenteeism.

Of the nurses working in long-term care facilities, 61% of nurses polled cited the need for better working conditions, 67% claimed there is a staff shortage, and 62% claimed they are not always able to deliver the care that residents require. Forty-two percent of the long-term care nurses surveyed felt that adequate staffing levels would most improve working conditions.

Nova Scotia. Of the 600 members of the Nova Scotia Nurses' Union surveyed, 43% claimed their workplace usually or always works below core staffing, with another 36% indicating that they sometimes work below core staffing. When asked why, 36% claimed the employer did not fill vacancies, while 64% claimed the employer was unable to fill vacancies. Fifty-two percent believed that core staffing was inadequate at their workplace.

Sixty-three percent of nurses reported a decline in the quality of patient care. Forty-eight percent of nurses who responded thus attributed this primarily to increased workload, while 25% attributed it to having fewer nurses on staff. When asked what would most improve the quality of care in their workplace, 80% of nurses reported additional nursing staff. When asked which factors contribute most to workplace dissatisfaction, 66% of nurses claimed workload and 59% claimed insufficient staffing, while only 33% claimed it was wages.

These surveys provide a snapshot of nurses' current views with respect to workload, data not readily available from other sources. The messages from these data are consistent with the published research findings. Nurses are working short

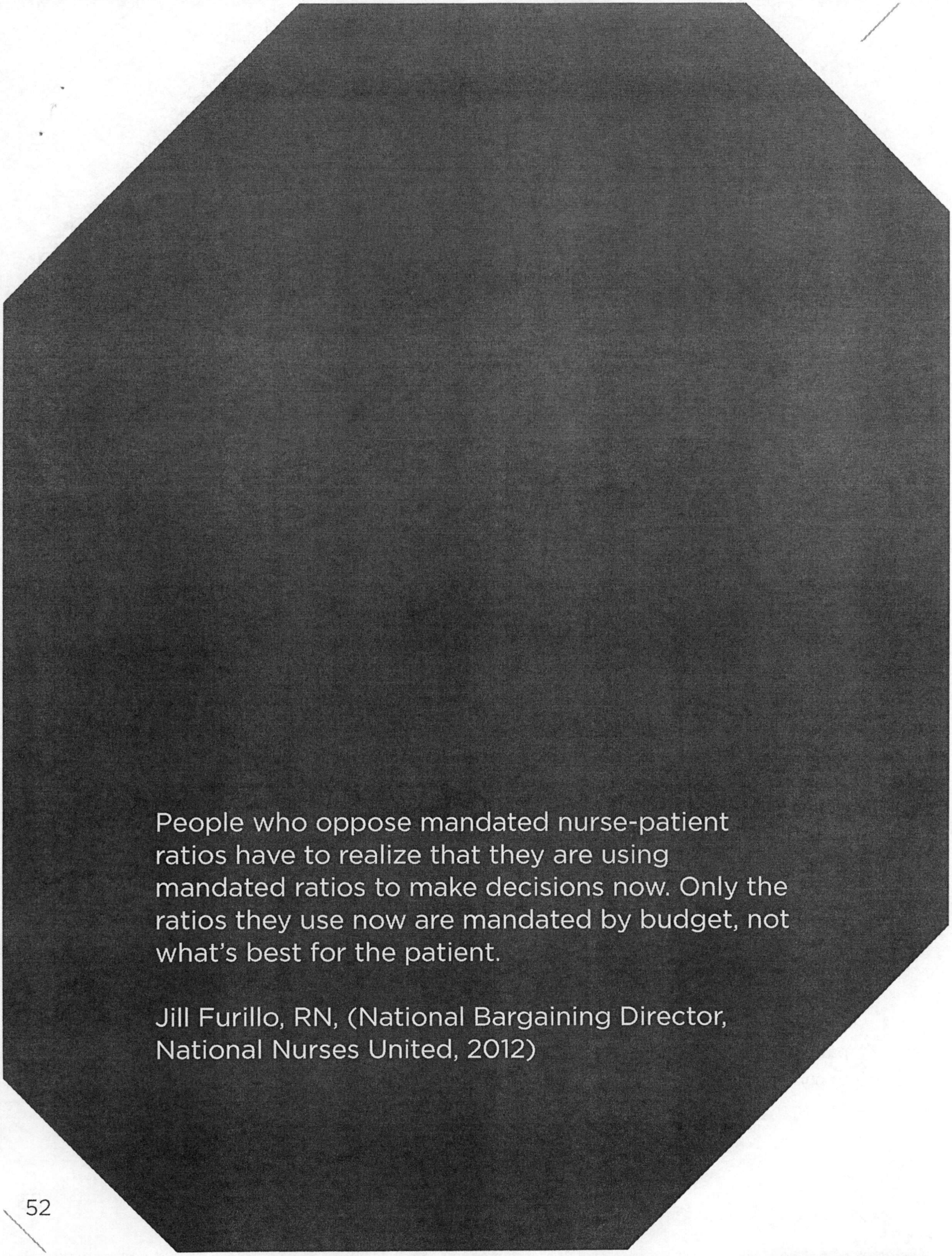
and are increasingly unable to meet the intensifying needs of their patients. They are doing their own work and the work of others who are no longer in the system. They are working paid and unpaid overtime in increasing amounts. They often do not plan to take holidays, knowing that their colleagues and their patients will likely be left without nursing support if they do. As staffing patterns change, they are unclear of their roles in relation to other providers in the system. As they come closer to retirement, the physical, mental, and emotional demands of the stretched workplace play a significant role in their decisions regarding leaving the workplace and the profession.

Realities from frontline nurses:

Another day, another impossible choice

We are working 14-16 hours, occasionally more, on a regular basis. When nurses have attempted to refuse this overtime, we have been told this would be considered 'patient abandonment.' Nurses are not willing to abandon our patients. This OT is resulting in burnout and increased sick time, and extreme fatigue at the end of a very long shift. To make things worse, the same thing could happen again tomorrow. These exhausted nurses are also to stay late again on tomorrow's shift, 'if required.'

Barb (Ontario)



People who oppose mandated nurse-patient ratios have to realize that they are using mandated ratios to make decisions now. Only the ratios they use now are mandated by budget, not what's best for the patient.

Jill Furillo, RN, (National Bargaining Director, National Nurses United, 2012)

Managing Nursing Workload for Safer, Better Care

Chapter 6

As previously noted, countless international and Canadian research studies and commissioned reports have proposed solutions to nursing workload and worklife issues over the last 20 years. Repeated calls have been made for transforming the relationship between the hospital and community, addressing the issues of alternative levels of care services, improving primary care services, improving the flow of patients through hospitals, and transforming nurse staffing decision-making processes. Many studies have demonstrated the positive relationship between increased nurse staffing and improved patient outcomes. Yet all sources of data tell us that nurses' workloads and the quality of their worklife are not improving, with corresponding harmful results for patients and their families. In many instances, things are getting worse.

Why is it that we have not solved the issues of nurse staffing in relation to patient needs? For many, the answer lies in the mechanisms we use to assign nurses to care for clients.

Successful nursing workload measurement systems: Why we aren't there yet

There is a lack of consensus among Canadian nurse leaders and researchers regarding the effectiveness of current nurse staffing models. Broad, principle-based decision-making frameworks often prove useful in theory, but the problems of applying them in practice are challenging (McGillis Hall et al., 2006). Many different workload measurement systems exist, but their applicability beyond the setting in which they were developed is often questionable. It is difficult to ensure that these systems capture aspects of workload in a broad range of facilities with many different patient groupings, unique geographies and different staffing availability. These systems may not be sensitive enough to account for varying patient care needs or unique staffing variables at a specific unit level (Registered Nurses Association of Ontario, 2007). This has resulted in the development or alteration of tools for individual unit and agency purposes. While this makes these systems more relevant in the specific situation, such individualization limits useful comparison for research and policy development purposes. Nursing work and workload concepts are often articulated and measured in a variety of ways that make them difficult to compare (Morris, MacNeela, Scott, Treacy & Hyde, 2006).

Ongoing staff shortages, inadequate staff orientation as to the purpose and processes of the rubrics developed, and cumbersome or non-existent technological processes for data collection result in inaccurate and incomplete data input at the unit level. Even when data is available, it is often not used in making staffing decisions. In some cases, the nurses who need this data to make decisions do not know how to access and interpret it (McGillis Hall et al., 2006). While there are numerous workload measurement systems in place, they are often not used for staffing decisions because they do not account for the fluctuations in staffing needs (McGillis Hall et al., 2006). Many rely on individual nurse perceptions, and so lack validity and reliability.

There is an urgent need for data that is easily collectible, reportable and comparable across sectors and jurisdictions. Standardized patient information systems, patient acuity systems and workforce data collection systems allow for integrated workforce planning and system-wide analysis of nursing workload and patient outcomes. The implementation of electronic health records (EHRs) has the potential to improve access to data for tracking and decision making. However, implementation of the EHR should be based on principles of improving the ability to deliver patient-centered care, and not simply on the need for fiscal cost accounting and decision making.

Another significant issue reported by frontline nurses is their lack of authority and autonomy in being able to implement the necessary measures to staff their units to the level indicated by the workload measurement tools. A recent Canadian survey of health care decision makers and stakeholders revealed that workload management systems were often not used because they showed need for more staff than organizations were able or willing to provide. When they were used, they were often unidirectional - when the workload measurement process showed a surplus of nurses on the unit, they were sent off to float to other units. When the process revealed a need for more nurses, rarely were any provided (McGillis Hall et al., 2006).

Nurses not only lack input into decision making at the individual patient level, they lack collective input into the way in which the health care system is run. The CNAC report of 2002 suggested the development of provincial nursing councils and other mechanisms to advise provincial, territorial and federal governments and recommend solutions to nursing, patient care, and health system issues. While many of these councils were formed, they were rarely provided with the resources they needed to explore issues, and they are now non-existent, or where still functioning, suffer from declining interest on the part of governments to address nursing issues. True nursing representation in the process would require the development and funding of action-oriented bodies representing frontline nurses, nurse leaders, nurse researchers, employers and funders to actively address issues of nursing work environments and workload (Advisory Committee on Health Delivery and Human Resources, 2005; Canadian Nursing Advisory Committee, 2002).

Initiatives to improve patient care require representation from nurses at all levels within the system, including frontline nurses. Most provinces have attempted to implement nursing advisory committees, but many of these have not produced results. Manitoba has implemented the Manitoba Nursing Advisory Committee. Representatives from unions, employers, educators and government meet on a quarterly basis. The Manitoba Nurses Union also participates in the Joint Nursing Council wherein they meet with the Ministry of Health on a quarterly basis. Unfortunately, to date, these joint committees have produced little in the eyes of the Union, and what has been productive has been done through the collective bargaining process. Similarly, since the early 1990s, la Fédération interprofessionnelle de la santé du Québec, a federation of 60 unions which includes most nurses in Quebec, has partnered with employers to established Committees on Care which have the express goal of studying complaints about workload and helping to ensure satisfactory working conditions. While this is an important tool, it has not been a systematic solution as workload continues to be major issue for Quebec nurses.

Some partnerships and initiatives work better than others. The partnership between the Saskatchewan Union of Nurses and the Government of Saskatchewan, with the addition of the regional health authorities, began in 2008 and was renewed in 2012. It is an example of collaboration that allows frank and open dialogue between political decision makers, public servants and representatives of frontline nurses directed at rebuilding the nursing profession and building a patient- and family-centered health care system in the province (Saskatchewan Union of Nurses, 2012).

In Ontario, the Joint Provincial Nursing Committee, co-chaired by the provincial Chief Nursing Officer and the President of the Ontario Nurses' Association, has initiated several projects aimed at workplace quality improvement and nurse retention and recruitment. This committee is made up of nurse stakeholders, including professional associations, deans of nursing, researchers, regulatory bodies, unions, employers, etc., and is intended to contribute to health policy from a nursing perspective.

There are glimmers of hope. Across the country, frontline nurses and nursing administrators are adopting evidence-based nursing research such as the Registered Nurses Association of Ontario's *Best Practice Guidelines* to improve the clinical aspects of nursing. Some positive work has been done on nurse recruitment and retention, including Ontario's late career initiatives (Ontario Ministry of Health and Long-Term Care, 2012), Alberta's supernumerary program for new graduates (Weidner, Graham, Smith, Aitken & Odell, 2012), and Manitoba's new legislation on bullying (Government of Manitoba, 2011).

Despite these important, if modest, efforts, nurses are beginning to become impatient. Principle-based staffing frameworks and workload measurement systems have failed to truly impact the system. Frontline nurses still lack the authority and autonomy to operationalize the staffing indicated by such measurement systems in timely ways, and there is little nursing input at the system level. These problems persist despite the overwhelming evidence that points to the need for adequate staffing to provide safe, high-quality care. What action can be taken at the front line to address their concerns, and ultimately improve the quality of care? The answer lies in staffing approaches that are transparent, responsive, and implementable at the unit level and that result in the right staffing for safe, quality patient care. Two major approaches to staffing may provide these answers: mandated standardized nurse-patient ratios, and staffing through dynamic, collaborative shared decision making.

Mandated standardized nurse-patient ratios: What's the story?

Mandated standardized nurse-patient ratios have emerged in California and Australia. Standardized nurse-patient ratios were legislated in California in 1999, following aggressive lobbying of politicians by nursing organizations. In 2004, following research to determine the most appropriate ratios for each clinical specialty area, input from stakeholders, and considerable debate and negotiation, standardized nurse-patient ratios were mandated for all state hospitals (Aiken, 2010; DeVandry & Cooper, 2009). Implementation began in 2002, with completion mandated by 2006. Ratios were mandated by specialty area. See Table 1.

Table 1
Legal nurse-patient ratios in California

Unit Type	Nurse-Patient Workload
Medical/surgical	1:5
Paediatric	1:4
Intensive care	1:2
Oncology	1:5
Psychiatric	1:6
Labour/delivery	1:3

(Table data from Aiken et al., 2010)

Nurse-patient ratios have been implemented in Australia in two separate states: Victoria (2001) and New South Wales (2011). The implementation of nurse-patient ratios occurred in Victoria at the directive of the Australian Industrial Relations Commission, following a series of cutbacks in funding during the 1990s which left nursing services in disarray. The initial 1:4 ratio evolved into the 5:20 (five nurses for twenty patients) ward-level ratio in 2004 (Gerdtz & Nelson, 2007). The 5:20 ratio was seen as an advantage over the 1:4 ratio in that it allowed for flexibility at the unit level and placed the unit nursing leader back in the staffing process, allowing for unit-based decision making (Gerdtz & Nelson, 2007). Rather than requiring every nurse to care for a maximum of four patients, the 5:20 models allows for some nurses on the unit to have more than four patients when appropriate, in order that other nurses can have fewer, sicker patients requiring more attention. These decisions can be made in real time at the level of the unit, allowing for flexible consideration of unique patient needs and nurse capabilities.

In New South Wales a nursing hours per patient day (NHPPD) formula produced the ratio as it is currently used. The NHPPD classified hospitals into one of seven categories using patient characteristics such as patient complexity, intervention levels, presence of high-dependency beds, emergency/elective patient mix, and patient turnover. Once hospitals were allocated to a classification, NHPPD were allocated to each unit. The ratios can be managed over a seven-day period, allowing for variations in capacity and patient acuity. Unit nurses have the right to request a spot check of the unit staffing plans over a one-month period if they believe that the ratios are not being applied appropriately. It is important to note that the ratios in these models denote *minimum* staffing requirements. Both the Californian and Australian models contain patient acuity processes which allow for increased staffing when units are experiencing levels of unanticipated high patient acuity.

Mandated nurse-patient ratios: Are they the way to go?

Standardized, legislated nurse-patient ratios are supported by many nurses who believe that they will improve the nursing work environment, increase nurse retention and recruitment, improve patient outcomes and increase both patient and nurse satisfaction (Ross, 2010).

The nursing research and leadership community has been split on the potential impact of mandated nurse-patient ratios. In a 2008 commentary, prominent nursing human resources researcher Peter Buerhaus argued that mandated nurse-patient ratios were counterproductive and would produce negative consequences for the profession (Buerhaus, 2009). He believed that mandated ratios removed the necessary flexibility that hospitals require to adjust staffing levels. He expressed concern that locked-in nurse-patient ratios would not let hospitals adjust for improvements in patient outcomes that originated in other departments, such as pharmacy. For example, care improvements generated in other departments could result in a decreased need for nurses. Hospitals would not be able to respond because they are locked in to mandated ratios. Greater efficiency and productivity could therefore not be achieved with mandated ratios, according to Buerhaus (2009). Others supported Buerhaus, expressing concern regarding the rigour of the science surrounding the determination of ratios (Hackenschmidt, 2004).

A further concern of nurse-patient ratio skeptics is that hospitals could meet the legislated requirement for more RNs by increasing the number of RNs but reducing the number of licensed practical nurses and unregulated workers, resulting in a net reduction in overall surveillance of patients, and more non-nursing tasks being done by RNs (Coffman, Seago & Spetz, 2002; Ross, 2010).

Some nurses expressed concern about the "at all times" requirement of nurse-patient legislation, indicating that it was a challenge to ensure that ratios are upheld while nurses are on breaks (Hackenschmidt, 2004). Skeptics predicted an increase in overtime and use of temporary agency nurses to meet the requirements of the legislation (Ross, 2010).

Others were concerned about the possible reduction in hospital services (Ross, 2010). Some feared that rural hospitals would be unable to meet the mandated ratios due to lack of available nurses, and would be forced to close, thus reducing accessibility to health care for the affected rural population (DeVandry & Cooper, 2009). Another concern expressed early in the implementation period was the fear that wait times would increase (Hackenschmidt, 2004). Early research appeared to lend some legitimacy to the concerns that nurse-patient ratios may not result in the intended changes for which they were implemented. A number of studies supported the original concerns about nurse-patient ratios, citing concerns regarding the cost of implementation (Coffman, Seago & Spetz, 2002). While one study reported a significant increase in job satisfaction for nurses in California between 2004 and 2006, such increases were also seen in other jurisdictions where ratios had not been implemented (Spetz, 2008).

Two early studies done in California, comparing pre-implementation data (2002), initial implementation data (2004) and final phase implementation data (2006), reported mixed outcomes for nurse-patient ratios (Burnes Bolton et al., 2007; Donaldson et al., 2005). The use of RN staffing did in fact increase during the implementation period. Hours of RN care per patient day increased by 0.5 hours on medical surgical units by 2004, and an additional one hour by 2006, for a total increase from 2002 to 2006 of 1.5 hours of RN care per day per patient. These numbers appeared to be largely temporary agency and traveller nurses. There was a decline in the percentage of LPNs (8% to 6%) and unlicensed personnel (33% to 24%) used in medical-surgical units (Burnes Bolton et al., 2007; see also Aiken et al., 2010). Most significantly, there was no evidence in these studies at that time that patient falls or occurrence of pressure ulcers decreased (Burnes Bolton et al., 2007; Donaldson et al., 2005). While these studies did not show an impact on patient outcomes following increased RN staffing, one study noted that the impact of simultaneous significant increases in patient acuity in hospitals during this time may have played a significant role in this outcome (Donaldson & Shapiro, 2010).

One recent study found that hospitals in California have reduced the amount of uncompensated care provided since the advent of mandated ratios (Reiter, Harless, Pink, Spetz & Mark, 2011). This is care provided for which the hospital was not

Realities from frontline nurses:

A day in the community

As part of my influenza assignment, I was assigned to do all outreach influenza vaccination for the entire county. Travel time ate away at my FTE. Then, I was also assigned to run the Health For Two program. The Health For Two program mushroomed with many young, complex and high needs clients. I requested to be assigned to fewer clinics to enable me to give the Home Visitation the agreed time. In addition to having no time allotted for actually running the programs, there was no central location for organizing the resources. What a system!

Joyce (Alberta)

Realities from frontline nurses:

Need more staff!

We had seven patients each at the beginning of the shift, and eight each halfway through. No one could take a break. This is an in-patient medical unit where we're supposed to have four patients each! Thirty-two acute patients for three RNs and one LPN is way too much. Not only that, the nurse-to-patient ratios have to be updated because patient acuity is far beyond what it was.

I filled out a workload situation report. Where it asks what we could have done differently on this shift, I can only say: we need MORE STAFF! As an RN I felt very unsafe and challenged. I was unable to provide full care. I can just imagine how my patients felt.

Eileen (Nova Scotia)

reimbursed, including free or reduced rate care to low-income clients. The authors speculated that hospitals opted to limit the provision of uncompensated care due to the financial pressures of increased nurse staffing.

In spite of these many critiques, recent studies have furnished strong evidence in favour of nurse-patient ratios.

Mandated nurse-patient ratios: The supporting evidence

Even some nurses who were concerned about the issues surrounding implementation of ratios believed that they were a good first step in addressing nursing workload and patient outcomes (Hackenschmidt, 2004). A 2006 study of Canadian nursing stakeholders and decision makers found that the attitude of some of those interviewed about standardized ratios appeared to be changing. While initially negative about ratios, viewing them as simplistic and unable to respond to variability, some decision makers interviewed at the time of the study expressed support for ratios as a way of making nursing contribution to patient care more evident and measurable (McGillis Hall et al., 2006). While supportive of ratios, some of those interviewed suggested that ratios must be constantly adapted in accordance with the reality of nurse workload, the changing practice environment, and patient care needs (Gordon, Buchanan & Bretherton, 2008).

There is important emerging research indicating that nurse-patient ratios do have a positive impact on nurses' workload and on patient outcomes. A 2011 study addressed the concern that mandated ratios would be met by replacing RNs with LPNs. The study found that registered nurse staffing – calculated as hours per adjusted patient day – was higher in California hospitals than in matched hospitals in other states following California's implementation of the mandated ratios. The increase in registered nurse hours per patient day was two times higher in California than in Texas, and five times that of New York. The study showed one half hour more RN hours per adjusted patient day than would have been expected without the mandated policy (McHugh, Kelly, Sloane & Aiken, 2011). Contrary to prediction by some, RNs have not been replaced by other nursing groups to meet the ratio requirements.

A 2011 Australian study, using data from 236,454 patient records and 150,925 nurse staffing unit records, found a significant decrease in nine nurse-sensitive outcomes following the introduction of the nursing hour per patient day (NHPPD) formula (Twigg, Duffield, Bremner, Rapley & Finn, 2011). For all medical surgical patients, the death rate decreased by 25% after the introduction of NHPPD staffing.

Surgical patients experienced a 54% drop in central nervous system complications, and a 37% decrease in ulcers, gastritis and upper gastrointestinal bleeding rates. The rate of gastrointestinal bleeding decreased in all surgical patients, and medical patients experienced a decreased death rate from shock and cardiac arrest. Sepsis rates decreased for all patients. Medical patients had lower rates of pressure ulcers, sepsis and mortality, and length of stay decreased by an average of 0.67 days. Surgical patients had lower rates of deep vein thrombosis. This study supported increasing overall nursing hours through a mandated staffing process as a way of improving patient safety (Twigg et al., 2011).

The most compelling evidence to date in support of nurse-patient ratios is offered by a 2010 study led by Linda Aiken, a prominent and prolific researcher on nurse workload and worklife and their impact on patient safety and quality care. The study focussed on whether, following the implementation of mandated nurse-patient ratios, nurse staffing in California differed from two states without such legislation, and whether the differences were associated with nurse and patient outcomes. The study included nurse survey data of 80,000 nurses in California, New Jersey and Pennsylvania, and secondary data on patient outcomes from state data sets.

The study found that there was a significant difference in staffing levels among the states. California nurses cared for two fewer medical surgical patients than nurses in the other states. Whereas 88% of California medical-surgical nurses cared for numbers of patients at or below the mandated number (5), only 19% and 33% of the nurses in New Jersey and Pennsylvania cared for numbers of patients at or below California benchmarks.

When nurses' workloads in the comparator states were in line with California ratios, nurses' burnout was lower, job satisfaction higher, and nurses reported consistently better quality of care. Higher percentages of nurses in California indicated that their workloads were reasonable, that they received significant support to do their jobs, that there were enough nurses to complete the nursing workload and give high-quality care, and that they regularly took their scheduled breaks.

Frontline and managerial nurses alike reported that the mandated ratios had produced their intended results. Quality of care had improved in California since the implementation of ratios according to 74% of staff nurses, 68% of managers, and 62% of mid- or executive-level managers. All nurse groups surveyed felt that ratios had improved nurse retention. A significantly lower proportion of California nurses experienced burnout as compared with New Jersey and Pennsylvania (29%, 34% and 36%). Nurses in California reported less dissatisfaction with their jobs than those in New Jersey and Pennsylvania (20%, 26% and 29%).

Higher nurse-patient ratios resulted in statistically significant lower mortality rates (Aiken et al., 2010). When comparing deaths using nurse-patient ratios in California to Pennsylvania and New Jersey, the research showed that surgical deaths would have been 13.9% lower in New Jersey and 10.6% lower in Pennsylvania if these states had similar nurse-patient ratios as in California. Aiken et al. estimated that 486 lives might have been saved in Pennsylvania and New Jersey over a two-year period if staffing levels were at the level mandated in California.

Other than the reported decrease in available unlicensed clinical support personnel, Aiken et al. concluded that there was no evidence of the unintended consequences of mandated ratios predicted by critics. Despite the reduction in support personnel, there was no reported evidence to suggest that this had a negative impact on patient outcomes. This study, with its large sample and sophisticated study design, rebuts the misconceptions about the unintended consequences of mandated nurse-patient ratios.

Realities from frontline nurses:

Unsafe by the numbers

We had three RNs and a patient census of 28 — that's over nine patients for each RN. We also had an LPN, but she was fresh out of school and required orientation. This was an unfair situation for her. I explained to the manager that the staff did not feel safe on this shift. I called the ER administrator to ask them to hold patients longer before admitting them to us but, of course, the ER was also understaffed! This workload is unsafe.

Janice (Nova Scotia)

Dynamic Shared Decision-Making Staffing Models: What, Why and How?

Chapter 7

One of the most common criticisms of staffing by mandated nurse-patient ratio is that the process is a blunt instrument – it does not account for variations in patient acuity, nor does it address the characteristics of the nurses available with respect to scope of practice, experience and education/certification. Critics of mandated standardized nurse-patient ratios advocate for systems with more flexibility and responsiveness (although this critique is mitigated if we shift from a 1:4 ratio to a 5:20 model as has evolved in New South Wales). The Synergy Professional Practice Model attempts to address the perceived weaknesses of standardized ratios and capture the dynamic nature of patient care.

Synergy in nursing practice

The Synergy Model was developed by the American Association of Critical-Care Nurses (AACN) in the 1990s as a nursing model of patient care. The Model aims to achieve a synergistic relationship between nurses and patients such that at any given time a patient has the most appropriate caregiver, and a nurse has the most appropriate complement of patients. When patient characteristics and nurse competencies are in synergy, optimal patient outcomes can occur (Curley, 2007).

The Model describes nursing practice based on eight patient characteristics spanning the health-illness continuum: resiliency, vulnerability, stability, complexity, resource availability, participation in care, participation in decision making, and predictability (Kaplow & Reed, 2008). Each of the patient characteristics is evaluated on a scale of one to five, with one being minimal and five being high, with the higher score indicating a more capable and higher functioning patient.

The Synergy Model also addresses eight nurse competencies: clinical judgement, advocacy and moral agency, caring practices, collaboration, systems thinking, response to diversity, facilitation of learning, and clinical inquiry (Kaplow & Reed, 2008). Each of the nurse characteristics is evaluated on a scale of one to five, where one is competent and five is expert. The nurse side of the model ensures that nursing competence matches patient needs.

Inherent in the use of the Model for staffing is a shared decision-making process, where frontline nurses and unit managers collaborate daily using a jointly developed process to assess patients and assign scores. Nurse characteristics are determined on an individual nurse basis and reviewed at predetermined intervals as part of an ongoing professional development process.

Shared decision making is a key component of effective nursing workplaces, significantly influencing job satisfaction. Structural power – access to information, resources, supports and opportunities through formal or informal lines of communication – predicts nurses' job satisfaction, decision involvement, and their trust and respect for management (MacPhee, Wardrop & Campbell, 2010). The Synergy Model advantage over other commonly used workload measurement systems is that it is dynamic – responding to changes in both patient condition and available nursing competence – and requires a shared decision-making approach between frontline nurses and unit nursing leadership. It does not only provide the frontline nurse with power in decision making, it provides for autonomy in nursing practice thereby allowing the opportunity to reduce the moral distress experienced by individual nurses when they are unable to make the contributions to patient care expected of them by their professional standards and their personal ethics of care (Storch, Rodney & Starzomski, 2013).

The Synergy Model provides a common language by which staff can communicate the needs of their patients and clarify professional roles. In a 2009 Saskatchewan demonstration project implemented as part of the Canadian Federation of Nurses Unions' national Research to Action project, the Synergy Model was used to score patient characteristics to inform staffing decisions (Rozdilsky & Alecxe, 2012). The project and its tools were modelled after a project conducted

in British Columbia from 2006-2010 (MacPhee, Jewell, Wardrop, Ahmed & Mildon, 2010). Due to unit overcapacity, ongoing human resource issues and timelines, the project did not use the nurse characteristics portion of the model, but used licensure status (RN/LPN), years of service on the unit and special training as a proxy measure (Rozdilsky & Alecxe, 2012). Implementation of the model resulted in a process where the frontline nurse, in consultation with management, could adjust day-to-day staffing in response to the number and acuity of patients.

The project report noted important outcomes in collaboration and improved communication among staff and unit and institutional leaders because of the shared decision-making processes used in making patient assignments on an ongoing basis (Rozdilsky & Alecxe, 2012; Stamler, Berry & Alecxe, 2011). This project demonstrated the importance of engaging frontline staff in the day-to-day decision making with respect to patient assignments. The positive results of empowering frontline staff to demonstrate and fully utilize their leadership skills, decision-making abilities and their professional competencies and judgement were clearly evident in the project results (Rozdilsky & Alecxe, 2012). These findings were similar to those found by MacPhee et al. (2010) in the British Columbia project, and are supported by the work of Canadian researcher Heather Spence Laschinger which links empowerment of frontline nurses with improved patient care (Laschinger, 2008).

Supporters of dynamic shared decision-making staffing models such as the Synergy Model cite as a strength the ability to account for variations in both nurse and patient characteristics when making staffing decisions. They also support the shared decision-making aspect as a means of nurse empowerment. Critics of the Synergy Model and other multi-faceted staffing models find them too complex, time-consuming and difficult to administer for the benefits achieved. Computer-based mechanisms of documentation and calculation could make the process more streamlined and efficient. Dashboard projects such as the pilot project that occurred in Hamilton, ON, as part of the Canadian Federation of Nurses Unions' Research to Action project could help in the development of simple and efficient electronic mechanisms that facilitate staffing decisions in the Synergy Model (Fram & Morgan, 2012).

Regardless of whether mandated ratio or a dynamic, shared decision-making processes are used, frontline nurses and their employers need real-time, responsive, transparent 24-hour mechanisms that give nurses the autonomy and authority to ensure nurse-patient ratios that allow for the delivery of safe, quality patient care.

Realities from frontline nurses:

Looking for a new job

Working in a specialty care unit, the nursing needs are complex and often rely on monitors and other fairly high-tech equipment. Imagine my shock when I received report from the day shift charge nurse that she was the only unit-oriented staff that worked for the whole 12-hour shift.

The charge nurse worked her tush off as she was the only one familiar with the three long-term patients that had particular needs. Plus she needed to provide a cursory orientation to two nurses who really only wanted to work their shifts in their own units. (Who could blame them!)

The charge nurse's perception is that the management has abandoned all hope and expects the frontline staff to deal with their co-workers' absences (peer pressure) to "fix" the problem.

I'm looking for a new job.

Jennifer (Manitoba)

Chapter 8

The Financial Benefits of Improved Nurse Staffing: Let's Look at the Big Picture

Whether improved staffing is achieved through mandated ratios, dynamic shared decision-making models or other mechanisms, there is solid research evidence to support its financial benefits. A 2011 US study reported that at times when unit RN hours per patient day (RNHPPD) were higher, the likelihood of a post-discharge ER visit was lower. At times when RN overtime (RNOT) was lower, the likelihood of a post-discharge ER visit was lower. When RN vacancies were higher, there was an increased potential for post-discharge ER visits. Researchers hypothesized that higher RN hours allowed for better discharge planning and teaching, and that lower RN overtime hours reduced fatigue and improved the care given by the nursing staff. With respect to cost, the additional RN staffing costs were offset by the reduced costs of ER visits (Bobay et al., 2011).

Costs in health care cannot be looked at in isolation. They must be viewed in relation to overall societal costs beyond the health care system. A 2009 simulation exercise to determine whether there were cost savings through increasing nurse staffing found societal savings from avoided deaths and patient adverse events.

Increasing RN staffing by one RN FTE/patient day was associated with a positive cost-saving ratio in various clinical settings. The financial benefit of saved lives per 1,000 hospitalized patients was 2.5 times higher than the increased cost of one additional RN FTE/patient day in ICUs, 1.8 times higher in surgical units, and 1.3 times higher in medical units. The researchers estimated that an increase by one RN FTE in ICUs in the US would save 327,390 years of life in men and 320,988 in women with a productivity benefit (present value of future earnings) of $4 billion to $5 billion. The productivity benefit from increased nurse staffing in surgical patients was estimated to be larger: $8 billion to $10 billion (Shamliyan, Kane, Mueller, Duvall & Wilt, 2009).

In a 2006 study, Needleman found that raising the proportion of RN nursing hours without raising overall nursing hours resulted in net savings to the hospital. In addition, increasing nursing hours, with or without increasing RN hours, reduced length of stay, adverse outcomes, and patient deaths at a net overall cost increase of 1.5% or less. There was no modeling of potential associated savings at a societal level, such as a potential decrease in need for home care or increased productivity with earlier return to work for patients involved. These would constitute economic and societal savings, but would not be reflected in the hospital's financial outcomes (Needleman, 2006).

In the aforementioned simulation study, the overall cost to the individual hospital of the increased nurse staffing was larger than the saving from the decreased length of stay (Shamliyan et al., 2009). Additional costs were estimated at $1,748 per patient, while savings from length of stay were estimated at 94% of this – $1,640 per patient. A 2006 study by Needleman similarly found slight increases in hospital costs, but noted that in estimating the benefits of increased nurse staffing, many economic and non-economic factors were not considered, including: the value to patients and families of reduced morbidity, the economic value to hospitals of lower liability and improved reputation, the reduction in many nurse-sensitive adverse events (falls, medication errors, blood-borne infections, etc.), patient education and decreased nurse turnover (Needleman, Buerhaus, Stewart, Zelevinsky, Mattke, 2006). If all of these factors were considered, the economic balance might very well tip in favor of increased nurse staffing. Turnover alone, as previously noted, has been estimated to cost anywhere from $25,000 per nurse (O'Brien Pallas et al., 2010) to as much as $67,000 US per RN (Jones & Gates, 2007), and short-staffing, excessive workloads and low job satisfaction are all clear predictors of nurse turnover (Aiken et al., 2002; Greco et al., 2006; Laschinger, 2004; O`Brien Pallas et al., 2001). In short, increased staffing is likely cost-effective even at the institutional level, but this remains difficult to determine unless all factors are considered (Goryakin, Griffiths & Maben, 2011).

Regardless, as a collective we should look beyond the institutional case to the clear and compelling case at the societal level (Leatherman et al., 2003; Needleman, 2008). While American studies provide us with some solid hypotheses with respect to the financial benefits of improved nurse staffing, comparisons of savings can be difficult. However, in the light of our highly integrated health and social safety net in Canada, it is clear that there are massive potential savings at the societal level. Unfortunately, today's short budget cycles, siloed approaches to budgeting, and politically motivated decision making do not allow for this big picture view.

Realities from frontline nurses:

A day in a rural long-term care home

My manager left the building saying "do your best." The shift was a nightmare. A man with dementia became violent and I had to call the RCMP. A woman was dying in pain without the needed doctor's orders for more medication. In addition to this I still had to complete my regular responsibilities including approximately 400 medications, 5 dressings, phone answering, dealing with other families and supervision of SCAs. This was my worst day as a nurse. I went home and cried. I was also 7 1/2 months pregnant that day.

Linda (Saskatchewan)

Realities from frontline nurses:

No break, no lunch, no hope

It was late afternoon before I realized I had missed break and lunch and that the physician on call had not even made rounds yet! No sooner had that crossed my mind, then in walked the doc. Needless to say, I was almost 45 minutes late leaving work, totally exhausted, frustrated and discouraged with the poor staffing and heavy workload.

I felt I did not provide the best care to my clients that I normally do and am capable of. I return for another 12-hour shift tomorrow...

Alyson (Prince Edward Island)

Patients Need Safe, Quality Care. Nurses Need Solutions.

Chapter 9

Why do decision makers fail to act on such powerful evidence? Much of this failure can be attributed to the short-term financial management strategies of the health care system, which require solutions to immediate fiscal demands at an institutional level, thereby restricting our ability to move forward in a manner that is driven by vision and strategy. As a publicly funded and administered system, the Canadian health care system requires true integration to create seamless movement of patients through the system. Fiscal planning and administration must be done with long-term, big-picture goals in mind. Staffing decisions should be made considering long-term financial gains from improved patient outcomes. This long view will prevent administrators from balancing health care budgets through short-sighted cuts to nurse staffing.

Nurses know what the evidence says about their workload and the health outcomes for their patients. They know it from reading research findings such as those found here, and they know it from their day-to-day interactions with patients. They are frustrated. Working daily in an environment that cloaks itself in the mantle

of evidence-based practice, they do not understand why twenty years of evidence on nursing workload and its impact on patients is ignored.

The 2004 Canadian Policy Research Network study, which reviewed the success in implementing the 2002 Canadian Nursing Advisory Committee (CNAC) Report, made the following statement: "The goodwill displayed by nursing stakeholders is not endless and ultimately, success can only be measured by whether nurses perceive that their jobs are changing for the better" (Maslove & Fooks, 2004). The ten Canadian reports on nursing and health human resources between 2000 and 2006 called for immediate action. Research in the ensuing years has only served to reinforce this call. Action is now long overdue.

In his introduction to the Canadian Nurses Advisory Committee report in 2002, Michael Decter commented: "Simply put, as nursing goes, so goes the rest of the system" (Canadian Nursing Advisory Committee, 2002). Creating mechanisms for nurses to have autonomous, meaningful input into the care they give their patients, and the time and tools to give that care will go a long way to making a more effective, sustainable, cost-effective system that better meets the needs of the patients and families it serves.

Realities from frontline nurses:

In the OR

Today I went home discouraged and exhausted with a headache and a sore back which may be because I have not eaten all day and I am so tired. I wonder if I missed anything and I keep thinking about whether I could have done anything to prevent the death of the young woman. I can't get the images of her family out of my mind. I question whether I want to continue working like this and wonder if tomorrow will be the same type of day. I don't think I can take two days like this in a row.

Ken (Newfoundland and Labrador)

Principal recommendations

That policy makers:

1. Immediately commit to action to achieve safe staffing models across the continuum of care. Such action should include safe staffing ratios that replace like with like, ensuring that the right nurse with the right skills is matched with the patient.

2. Immediately fund implementation of a national prototype for safe staffing models, using either nurse-patient ratios or a dynamic shared decision-making model such as the Synergy Professional Practice Model. pg 65

3. Enforce health care system accountability for safe, quality patient care by moving beyond the wait-time and volume-driven, pay-for-performance benchmarks currently measured, and instead link institutional funding to improvements in patient outcomes and nursing indicators (reductions in

absenteeism, burnout, turnover, etc.). Accountability mechanisms should ensure that employers and funding decision makers are held accountable for staffing decisions and their impact on patients, staff and budgets.

Realities from frontline nurses:

New Year's

Over New Year's Eve week-end, the nurse's working day began at 06:45 hours on December 31st.

There was no nurse available for the night shift so I worked until midnight and then slept on the cot in the staff room until 05:00. On January 1st when I began a new shift, there was still no nurse for that night so, guess what... I remained at work until 23:00 hours that night.

Candice

Supporting recommendations

That policy makers:

4. Ensure that staffing models and practices are based on evidence available in national and international research, and that they follow evidence-based guidelines such as the RNAO Best Practice Guidelines.
5. Provide targeted funding for quality nursing workplace initiatives directed at improving nursing workload and patient outcomes.
6. Standardize collection of health care data, including nursing indicators, and make it readily available to decision makers in easily understood, manageable electronic formats for use in decision making at system-wide and local levels.
7. Involve nurses at all levels in health care solutions.
8. Address governance issues in health care, starting at the front line and moving upward.
9. Clarify nursing scopes of practice and the role of unregulated workers in the system, and ensure replacement of nurses with nurses, eliminating substitution models which are unsafe and result in fragmentation of care.
10. Address overcapacity in the health care system by improving the integration of services between units, and between hospitals and their communities. This can be achieved by improving funding to home care and organizations providing alternate levels of care, and by improving access to primary care.

References

Accad, A. (2009). Job Stress. *Stress Out: Show Stress Who's the Boss!* Davenport, Sumner (ed.) Thousand Oaks, California, USA: Self Investment Publishing.

Accreditation Canada. (2012). *Accreditation Canada Qmentum Program Standards: Leadership.* Ottawa, ON, Canada.

Advisory Committee on Health Delivery and Human Resources. (2005). *A Framework for Collaborative Pan Canadian Health Human Resource Planning.* Ottawa, ON, Canada. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-frame-cadre/2007-frame-cadre-eng.pdf

Advisory Committee on Health Human Resources. (2000). *The Nursing Strategy for Canada.* Ottawa, ON, Canada. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2000-nurs-infirm-strateg/2000-nurs-infirm-strateg-eng.pdf

Advisory Committee on Health Human Resources. (2002). *Our Health, Our Future, Quality Workplaces for Canadian Nurses: the Final Report of the Canadian Nursing Advisory Committee.* Ottawa, ON, Canada.

Aiken, L. (2010). Safety in numbers. *Nursing Standard, 24*(44), 62-63.

Aiken, L., Clarke, S., Sloane, D., Sochalski, J. & Hiber, J. (2002). Hospital nurse staffing, patient mortality, nurse burnout, and job satisfaction. *Journal of the American Medical Association, 288*(16), 1087-1993.

Aiken, L., Sloane, D., Comiotti, J., Clarke, S., Flynn, L., Seago, J., Spetz, J. & Smith, H. (2010). Implications of the California nurse staffing mandate for other states. *Health Services Research, 45*(4), 904-921.

Baumann, A., O'Brien Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Doran, D., Kerr, M., McGillis Hall, L., Vézina, M., Butt, M. & Ryan, L. (2001). *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, their Patients and the System.* Ottawa, ON, Canada. http://www.chsrf.ca/Migrated/PDF/pscomcare_e.pdf

Bernstein, S., Aronsky, D., Epstein, S., Handel, D., Hwan, U. & McCarthy, M. (2009). The effect of emergency department crowding on clinically oriented outcomes. *Academic Emergency Medicine, 16,* 1-10.

Bobay, K., Yakusheva, O. & Weiss, M. (2011). Outcomes and cost analysis of the impact of unit-level nurse staffing on post-discharge utilization. *Nursing Economic$, 29*(2), 69-87.

Bond, K., Ospina, M., Blitz, S., Afilalo, M., Campbell, S., Bullard, M., Innes, G., Holroyd, B., Curry, G., Schull, M. & Rowe, B. (2007). Frequency, determinants and impact of overcrowding. *Healthcare Quarterly, 10*(4), 32-40.

British Columbia Medical Association. (2011). *Emergency Department Overcrowding.* Vancouver, British Columbia, Canada. https://www.bcma.org/files/WEB%20Emergency%20Dept%20Overcrowding.pdf

Buerhaus, P. (2009). Avoiding mandatory hospital nurse staffing ratios: An economic commentary. *Nursing Outlook, 57,* 107-112.

Burnes Bolton, L., Aydin, C., Donaldson, N., Storer Brown, D., Sandhu, M., Fridman, M. & Udin Aronow, H. (2007). Mandated nurse staffing ratios in California: A comparison of staffing and nursing-sensitive outcomes pre- and post regulation. *Policy, Politics & Nursing Practice, 8,* 238-250.

Canadian Association of Emergency Physicians & National Emergency Nurses Affiliation. (2001). Joint position statement on emergency department overcrowding. *Canadian Journal of Emergency Medicine, 3*(2), 82-84.

Canadian Federation of Nurses Unions. (2009). *A Position Statement on Hallway Nursing.* Ottawa, ON, Canada. http://www.nursesunions.ca/sites/default/files/Hallway_Nursing_Position_Statement.pdf

Canadian Federation of Nurses Unions. (2011). *Trends In Own Illness or Disability-Related Absenteeism and Overtime Among Publicly-Employed Registered Nurses: Quick Facts.* Prepared by Informetrica Limited. Ottawa, ON, Canada. http://www.nursesunions.ca/report-study/trends-in-own-illness-or-disability-related-absenteeism-and-overtime-among-publicly-emp

Canadian Federation of Nurses Unions. (2012). *Long-Term Health Care Workforce Planning Built on Partnership, Expertise and Safe Staffing: A Practical Imperative* (Submission to the House of Commons Standing Committee on Human Resources, Skills and Social Development). Ottawa, ON, Canada.

Canadian Federation of Nurses Unions. (2012). *Provincial Union Surveys of Frontline Nurses* Unpublished.

Canadian Health Services Research Foundation. (2006). *What's Ailing Our Nurses? A Discussion of the Major Issues Affecting Nursing Human Resources in Canada.* Ottawa, ON, Canada. http://www.chsrf.ca/Migrated/PDF/What_sailingourNurses-e.pdf

Canadian Health Services Research Foundation. (2010). Myth: Emergency room overcrowding is caused by non-urgent cases. *Journal of Health Research & Policy, 15*(3), 188-189.

Canadian Health Services Research Foundation. (2010). *Picking Up the Pace: How to Accelerate Change in Primary Healthcare.* Ottawa, ON, Canada. http://www.chsrf.ca/Libraries/Picking_up_the_pace_files/2011_CHSRF_PUP_Conference_Report_ENG_FINAL.sflb.ashx

Canadian Institute for Health Information. (2009). *Alternate Level of Care in Canada.* Ottawa, ON, Canada. http://secure.cihi.ca/cihiweb/products/ALC_AIB_FINAL.pdf

Canadian Institute for Health Information. (2012). *Regulated Nurses: Trends 2006 — 2010.* Ottawa, ON, Canada. http://secure.cihi.ca/cihiweb/products/RegulatedNursesCanadianTrends2006-2010_EN.pdf

Canadian Nurses Association. (2008). *Canadian Nurses Association Code of Ethics for Registered Nurses.* Ottawa, ON, Canada. http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf

Canadian Nurses Association. (2009). *Position Statement: Overcapacity Protocols and Canada's Health Care System.* Ottawa, ON, Canada. http://www.cna-aiic.ca/cna/documents/pdf/publications/PS101_Overcapacity_e.pdf

Canadian Nurses Association. (2009). *Tested Solutions for Eliminating Canada's Registered Nurse Shortage.* Ottawa, ON, Canada. http://www2.cna-aiic.ca/cna/documents/pdf/publications/RN_Highlights_e.pdf

Canadian Nurses Association and Registered Nurses Association of Ontario. (2010). *Nurse Fatigue and Patient Safety: Research Report.* Ottawa, ON, Canada. http://www.cna-aiic.ca/cna/practice/safety/default_e.aspx

Canadian Nursing Advisory Committee. (2002). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses.* Ottawa, ON, Canada. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-cnac-cccsi-final/2002-cnac-cccsi-final-eng.pdf

Chapman, S., Spetz, J., Seago, J., Kaiser, J., Dower, C. & Herrera, C. (2009). How have mandated nurse staffing ratios affected hospitals? Perspectives from California hospital leaders. *Journal of Healthcare Management, 54*(5), 321-335.

Clarke, S. (2008). Nurse staffing and patient outcomes: Getting to the heart of the matter in research, practice and policy. *Pennsylvania Nurse, 63*(4), 8-9.

Coffman, J., Seago, J. & Spetz, J. (2002). Minimum nurse-to-patient ratios in acute care hospitals in California. *Health Affairs, 21,* 53-64.

College of Nurses of Ontario. (2009). *Nursing in Temporary Locations: Listening to Ontario's Nurses.* Toronto, ON, Canada. http://www.cno.org/Global/docs/policy/NursingInTheHallsAugust2009.pdf

Collis, J. (2010). Adverse effects of overcrowding on patient experience and care. *Emergency Nurse, 18*(8), 34-39.

Cotton, J. (2012). Building Capacity - The implementation of a critical care/emergency program. *Canadian Journal of Nursing Leadership(Sp),* 80-88.

CTV News. (2011, December 29). Montreal ERs over capacity. Montreal, QC, Canada. http://montreal.ctv.ca/servlet/an/local/CTVNews/20111229/mtl_ERs_111229?hub=MontrealHome

Curley, M. (2007). The Synergy Model: From theory to practice. M. Curley, *Synergy: The unique relationship between nurses and patients,* 1-23. Indianapolis, IN, USA: Sigma Theta Tau International.

Davey, M., Cummings, G., Newburn-Cook, C. & Lo, E. (2009). Predictors of nurse absenteeism in hospitals: a systematic review. *Journal of Nursing Management, 17,* 312-330.

DeVandry, S. & Cooper, J. (2009). Mandating nurse staffing in Pennsylvania. *Journal of Nursing Administration, 39*(11), 470-478.

Donaldson, N. & Shapiro, S. (2010). Impact of California mandated acute care hospital nurse staffing ratios: A literature synthesis. *Policy, Politics & Nursing Practice, 11*(3), 184-201.

Donaldson, N., Burnes Bolton, L., Aydin, C., Brown, D., Elashoff, J. & Sandu, M. (2005). Impact of California's licensed nurse-patient ratios on unit-level nurse staffing and patient outcomes. *Policy, Politics & Nursing Practice, 6,* 198-210.

Duffield, C., Diers, D., O'Brien Pallas, L., Aisbett, C., Roche, M., King, M. & Aisbett, K. (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research, 24,* 244-255.

El-Jardali, F. & Fooks, C. (2005). *An Environmental Scan of Current Views on Health Human Resources in Canada: Identified Problems, Proposed Solutions and Gap Analysis.* Toronto, ON, Canada: Health Council of Canada. http://ahhri.nan.on.ca/upload/documents/environscan_current-views_hhr-in-canada_healthcouncilcan.pdf

Ellis, J., Priest, A., MacPhee, M. & Sanchez McCutcheon, A. (2006). *Staffing for Safety: A Synthesis of the Evidence on Nurses Staffing and Patient Safety.* Ottawa, ON, Canada. http://www.chsrf.ca/PublicationsAndResources/ResearchReports/CommissionedResearch/06-09-01/e1b9468c-dafe-4ccf-b4f3-3f29ee0cb7e6.aspx

Estabrooks, C., Midodzi, W., Cummings, G., Ricker, K. & Giovannetti, P. (2011). The impact of hospital nursing characteristics on 30-day mortality. *Journal of Nursing Administration, 41*(7/8), S58 — S68.

Fram, N. & Morgan, B. (2012). Linking nursing outcomes, workload and staffing decisions in the workplace: The Dashboard project. *Canadian Journal of Nursing Leadership(Sp),* 114-125.

Franche, R.-L., Murray, E., Ostry, A., Ratner, P., Wagner, S. & Harder, H. (2010). Work disability prevention in rural areas: A focus on health care workers. *The International Electronic Journal of Rural and Remote Health, Education, Practice and Policy,* 1-24.

Gerdtz, M. & Nelson, S. (2007). 5-20: A model of minimum nurse-to-patient ratios in Victoria, Australia. *Journal of Nursing Management, 15,* 64-71.

Gordon, S., Buchanan, J. & Bretherton, T. (2008). *Safety in Numbers: Nurse-to-Patient Ratios and the Future of Health Care.* Ithaca, NY, USA: Cornell University Press.

Goryakin, Y., Griffiths, P. & Maben, J. (2011). Economic evaluation of nurse staffing and nurse substitution in health care: A scoping review. *International Journal of Nursing Studies, 48,* 501-512.

Greco, P., Laschinger, H. & Wong, C. (2006). Leader empowering behaviours, staff nurse empowerment and work engagement/burnout. *Canadian Journal of Nursing Leadership 19*(4), 41-56.

Greenglass, E., Burke, R. & Moore, K. (2003). Reactions to increased workload: Effects on professional efficacy of nurses. *Applied Psychology: An International Review, 52*(4), 580–597.

Hackenschmidt, A. (2004). Living with nurse staffing ratios: Early experiences. *Journal of Emergency Nursing, 30*(4), 377-379.

Hanson, G. P., Fahlman, J. and Lemonde, M. (2007). *Quality Worklife — Quality Healthcare Collaborative (QWQHC) Environmental Scan, Final Report.* Ottawa, ON, Canada: QWQHC, with the Canadian Health Services Research Foundation. http://www.chsrf.ca/Migrated/PDF/ResearchReports/CommissionedResearch/QWQHC_Environmental_Scan_e.pdf

Harless, D. & Mark, B. (2010). Nurse staffing and quality of care with direct measurement of inpatient staffing. *Medical Care, 48,* 659-663.

Harrington, C., O'Meara, J., Collier, E. & Schnelle, J. (2003). Nursing indicators of quality in nursing homes. *Journal of Gerontological Nursing,* October, 5-11.

Holden, R., Scanlon, M., Patel, N., Kaushal, R., Hamilton Escoto, K., Brown, R., Alper, S., Arnold, J., Shalaby, T., Murkowski, K. & Karsh, B. (2011). A human factors framework and study of the effect of nursing workload on patient safety and employee quality of working life. *British Journal of Medicine Quality & Safety, 20,* 15-24.

Hoot, N. & Aronsky, D. (2008). Systematic review of emergency department crowding: Causes, effects and solutions. *Annals of Emergency Medicine, 52*(2), 126-136.

Irvine, D., & Evans, M. (1995). Job satisfaction and turnover between nurses: Integrating research findings across studies. *Nursing Research, 44*(4), 246-253.

Jones, C. & Gates, M. (2007). The costs and benefits of nurse turnover: A business case for nurse retention. *The Online Journal of Issues in Nursing, 12*(3), manuscript 4.

Kane, R., Shamliyan, T., Mueller, C., Duval, S. & Wilt, T. (2007). The Association of Registered Nurse staffing levels and patient outcomes. *Medical Care, 45*(12), 1195-1204.

Kaplow, R. & Reed, K. (2008). The AACN model for patient care: A nursing model as a force of magnetism. *Nursing Economic$, 26*(1), 17-25.

Kerr, M., Laschinger, H., Severin, C., Almost, J., Thomson, D., O`Brien Pallas, L., Shamian, J., McPherson, D., Koehoorn, M., LeClair, S. (2002). *Monitoring the Health of Nurses in Canada.* Ottawa, ON, Canada: Canadian Health Services Research Foundation. http://www.chsrf.ca/Migrated/PDF/ResearchReports/OGC/kerr_final.pdf

Kozier, B. J., Erb, G., Berman, A., Snyder, S., Raffin Bouchal, D., Hirst, S., Yiu, L., Stamler, L., Buck, M. (2010). *Fundamentals of Canadian Nursing: Concepts, Process, and Practice.* (2nd ed.) Toronto, ON, Canada: Rearson Education Canada.

Kutney-Lee, A., McHugh, M., Sloane, D., Cimiotti, J., Flynn, L., Felber Neff, D. & Aiken, L. (2009). Nursing: A key to patient satisfaction. *Health Affairs, 28*(4), 669-677.

Laschinger, H. (2008). Effects of empowerment on professional practice environments, work satisfaction, and patient care quality. *Journal of Nursing Care Quality, 23*(4), 322-330.

Laschinger, H. (2004). Hospital nurses' perceptions of respect and organizational justice. *Journal of Nursing Administration,* 34, 354-364.

Lasota, M. (2009). *Trends in own illness or disability-related absenteeism and overtime among publicly-employed registered nurses: Summary of key findings.* Prepared by Informetrica Ltd for the Canadian Federation of Nurses Unions. Ottawa, ON, Canada.

Laupacis, A. & Born, K. (2011). *The Risk of Emergency Department Overcrowding.* http://healthydebate.ca/2011/07/topic/politics-of-health-care/ed-wait-times

Lavoie-Tremblay, M., O'Brien-Pallas, L., C., G., Desforges, N. & Marchionni, C. (2008). Addressing the turnover issue among new nurses from a generational viewpoint. *Journal of Nursing Management, 16*(6), 724-733.

Leatherman, S., Berwick, D., Iles, D., Lewin, L., Davidoff, F., T, N. & Bisognano, M. (2003). The business case for quality: Case studies and an analysis. *Health Affairs, 22*(2), 18-30.

MacPhee, M., Jewell, K., Wardrop, A., Ahmed, A. & Mildon, B. (2010). British Columbia's nursing workload project: Evidence to empowerment. *Canadian Journal of Nursing Leadership, 23*(1), 54-63.

MacPhee, M., Wardrop, A. & Campbell, C. (2010). Transforming work place relationships through shared decision making. *Journal of Nursing Management, 18,* 1016-1026.

Manitoba Government. (2011). *Workplace Safety and Health Regulation 107/2011,* Amendment to the *The Workplace Safety and Health Act* (C.C.S.M. c. W210).

Manojlovich, M., Souraya, S., Covell, C. & Antonakos, C. (2011). Nurse dose: Linking staffing variables to adverse patient outcomes. *Nursing Research, 60*(4), 214-220.

Maslove, L. & Fooks, C. (2004). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses.* A Progress Report on Implementing the Final Report of the Canadian Nursing Advisory Committee. (Canadian Policy Research Networks, Ed.) Ottawa, ON, Canada. http://www.cprn.org/documents/30762_en.pdf

McGillis Hall, L. , Pink, L., Lalonde, M., Tomblin Murphy, G., O'Brien Pallas, L., Laschinger, H., Tourangeau, A., Besner, J., White, D., Tregunno, D., Thomson, D., Peterson, J., Seto, L., Akeroyd, J. (2006). Decision making for nurse staffing: Canadian perspectives. *Policy, Politics & Nursing Practice, 7*(4), 261-269.

McGillis Hall, L., Pedersen, C. & Fairley, L. (2010). Losing the moment: understanding interruptions to nurses' work. *Journal of Nursing Administration, 40*(4), 169-176.

McHugh, M., Kelly, L., Sloane, D. & Aiken, L. (2011). Contradicting fears, California's nurse-to-patient mandate did not reduce the skill level of the nursing workforce in hospitals. *Health Affairs, 30*(7), 1299-1306.

McHugh, M., Kutney-Lee, A., Cimiotti, J., Sloane, D. & Aiken, L. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs, 30*(2), 202-210.

Mildon, B. (2011). *The Concept of Home Care Nursing Workload.* Unpublished doctoral dissertation, University of Toronto. https://tspace.library.utoronto.ca/bitstream/1807/29508/1/Mildon_Barbara_L_201106_PhD_thesis.pdf

Morris, R., MacNeela, P., Scott, A., Treacy, P. & Hyde, A. (2006). Reconsidering the conceptualization of nursing workload: Literature review. *Journal of Advanced Nursing, 57*(5), 463-471.

Moskop, J., Sklar, D., Gudeman, J., Schears, R. & Bookman, K. (2009). Emergency department crowding, Part 1 — Concept, causes, and moral consequences. *Annals of Emergency Medicine, 53*(5), 605-611.

Needleman, J. (2003). Nurse staffing and patient safety: Current knowledge and implications for action. *International Journal for Quality in Health Care, 15*(4), 275-277.

Needleman, J. (2008). Is what's good for the patient good for the hospital? *Policy, Politics & Nursing practice, 9*(2), 80-87.

Needleman, J., Buerhaus, P., Mattke, S. & Stewart, M. (2002). Nurse staffing levels and the quality of care in hospitals. *New England Journal of Medicine, 346*(22), 1715-1722.

Needleman, J., Buerhaus, P., Maureen, S., Zelevinsky, K. & Mattke, S. (2006). Nurse staffing in hospitals: Is there a business case for quality? *Health Affairs, 25*(1), 204-211.

Needleman, J., Buerhaus, P., Pankratz, S., Leibson, C. & Stevens, S. (2011). Nurse staffing and inpatient hospital mortality. *New England Journal of Medicine, 364*(11), 1037-1045.

Newfoundland and Labrador Nurses' Union. (2011). *Excessive Hours of Work: Professional and Union Considerations.* St John's: Newfoundland and Labrador Nurses' Union. http://www.nlnu.ca/uploads/file/Excessive%2520Hours%2520of%2520Work_final.pdf

Nursing Sector Study Corporation. (2006). *Building the Future: An Integrated Strategy for Nursing Human Resources in Canada.* Ottawa, ON, Canada. http://www.cha.ca/documents/pa/NSSII.pdf

O'Brien-Pallas, L., Baumann, A., Donner, G., Tomblin Murphy, G., Lochhaas-Gerlach, J. & Luba, M. (2001). Forecasting models for human resources in health care. *Journal of Advanced Nursing 33*(1), 120-9.

O'Brien-Pallas, L., Tomblin Murphy, G., Shamian, J., Li, X. & Hayes, L. (2010). Impact and determinants of nurse turnover, a pan-Canadian study. *Journal of Nursing Management, 18,* 1073-1086.

O'Connor, P., Ritchie, J., Drouin, S. & Covell, C. (2012). Redesigning the workplace for 21st century healthcare. *Healthcare Quarterly, 15*(Sp), 30-35.

Olds, D. & Clarke, S. (2010). The effect of work hours on adverse events and errors in health care. *Journal of Safety Research, 41,* 153-162.

Ontario Ministry of Health and Long-Term Care. Nursing Secretariat. (2012). 2012/2013 Late Career Nurse Initiative. *Health Bulletins.* Toronto, ON, Canada.

Patrician, P., Donaldson, N., Loan, L., Bingham, M., McCarthy, M., Brosch, L. & Fridman, M. (2011). The association of Shift-Level nurse staffing with adverse patient events. *Journal of Nursing Administration, 41*(2), 64-70.

Penoyer, D. (2010). Nurse staffing and patient outcomes in critical care: A concise review. *Critical Care Medicine, 38*(7), 1521-1528.

Pines, J.M., Garson, C., Baxt, W.G., Rhodes, K.V., Shofer, F.S. & Hollander, J.E. (2007). ED crowding is associated with variable perceptions of care compromise. *Academic Emergency Medicine, 14*(12), 176-81.

Plecash, C. (2012, February 6). Accountability issues dominate talk on the future of Canada's health care system. *Hill Times Online.* http://www.hilltimes.com/policy-briefing/2012/02/06/accountability-issues-dominate-talk-on-the-future-of-canada%E2%80%99s-health-care/29452

Poghosyan, L., Clarke, S. & Finlayson, M. A. (2010). Nurse burn-out and quality of care: Cross-national investigation in six countries. *Research in Nursing & Health, 33,* 288-298.

Recent News.ca. (2012, June 20). *Investigative Panel Supports RN Concerns about Staffing Levels, Patient Safety, at SAH's Emergency Department.* Sault Ste. Marie, ON, Canada. http://www.recentnews.ca/investigative-panel-supports-rn-concerns-about-staffing-levels-patient-safety-at-sahs-emergency-department/

Registered Nurses Association of Ontario. (2007). *Healthy Work Environments Best Practice Guidelines: Developing and Sustaining Effective Staffing and Workload Practices.* Toronto, ON, Canada. http://www.rnao.org/Storage/35/2935_BPG_Staffing_Workload.pdf

Registered Nurses Association of Ontario. (2010). *Position Statement: Strengthening Client Centered Care in Hospitals.* Toronto, ON, Canada. http://rnao.ca/policy/position-statements/strengthening-client-centered-care-hospitals

Reiter, K., Harless, D., Pink, G., Spetz, J. & Mark, B. (2011). The effect of minimum nurse staffing legislation on uncompensated care provided by California hospitals. *Medical Care Research and Review, 68*(3), 332-351.

Ross, J. (2010). Legislating nurse staffing: Understanding the issues and reviewing the evidence. *Journal of PeriAnesthesia Nursing, 25*(5), 319-321.

Rozdilsky, J. & Alecxe, A. (2012). Improving patient, nursing and organizational outcomes utilizing formal nurse-patient ratios. *Canadian Journal of Nursing Leadership*(Sp), 103-113.

Ryten, E. (1997). *A Statistical Picture of the Past, Present and Future of Registered Nurses in Canada.* Ottawa, ON, Canada: Canadian Nurses Association.

Saskatchewan Union of Nurses. (2012). *Government/SUN/RHA Tripartite Agreement.* Regina, SK, Canada. http://sun-nurses.sk.ca/government-relations/government-sun-rha-agreement

Schilling, P. & Dougherty, P. (2011). Do higher hospital-wide nurse staffing levels reduce in-hospital mortality in elderly patients with hip fractures? *Clinical Orthopedics and Related Research, 469*(10), 2932–2940.

Schull, M., Kiss, A. & Szalai, J. (2007). The effect of low-complexity. *Annals of Emergency medicine, 49,* 257-264.

Shamian, J. & El-Jardali, F. (2007). Healthy workplaces for healthcare workers in Canada: Knowledge transfer and uptake in policy and practice. *Healthcare Papers, 7*(Sp), 6-25.

Shamliyan, T., Kane, R., Mueller, C., Duvall, S. & Wilt, T. (2009). Cost savings associated with increased RN staffing in acute care hospitals: A simulation exercise. *Nursing Economic$, 27*(5), 302-331.

Shever, L. (2011). The impact of nursing surveillance on failure to rescue. *Research and Theory for Nursing Practice: An International Journal, 25*(2), 107-126.

Smadu, M. & McMillan, C. (2007). Time to move from paper to practice. Commentary. *HealthcarePapers, 7*(Sp), 64-66.

Spetz, J. (2004). California's minimum nurse-to-patient ratios. *Journal of Nursing Administration, 34,* 571-578.

Spetz, J. (2008). Nurse satisfaction and the implementation of minimum nurse staffing regulations. *Policy, Politics & Nursing Practice, 9,* 15-21.

Stamler, L. L., Berry, L. & Alecxe, A. (2011). Improving Patient, Nursing and Organizational Outcomes Utilizing Formal Nurse-Patient Ratios. Part of final report for the Research To Action Project. Ottawa, ON, Canada: Canadian Federation of Nurses Unions.

Storch, J., Rodney, P. & Starzomski, R. (2013). *Toward a New Horizon: Nursing Ethics for Leadership and Practice* (2nd ed.). Don Mills (ed.). Toronto, ON, Canada: Pearson Canada.

Thungjaroenku, P., Cummings, G. & Embleton, A. (2007). The impact of nurse staffing on hospital costs and length of stay: A systematic review. *Nursing Economic$, 25*(5).

Tomblin Murphy, G., Birch, S., Alder, R., Mackenzie, A., Lethbridge, L., Little, L. & Cook, A. (2009). *Tested Solutions for Eliminating Canada's Registered Nurse Shortage.* Ottawa, ON, Canada: Canadian Nurses Association. http://www2.cna-aiic.ca/cna/documents/pdf/publications/RN_Highlights_e.pdf

Tourangeau, A., Cranley, L., Laschinger, H. & Pachis, J. (2010). Relationships among leadership practices, work environments, staff communication and outcomes in long-term care. *Journal of Nursing Management, 18,* 1060-1072.

Tourangeau, A., Doran, D., McGillis Hall, L., O'Brien Pallas, L., Pringle, D., Cranley, L. & Tu, J. (2006). Impact of hospital nursing care on 30-day mortality for acute medical patients. *Journal of Advanced Nursing, 57*(1), 32-44.

Trinkoff, A., Johantgen, M., Storr, C., Gurses, A., Liang, Y. & Han, K. (2011). Nurses' work schedule characteristics, nurse staffing, and patient mortality. *Nursing Research, 60,* 1-8.

Tschannen, D., Kalisch, B. & Lee, K. H. (2010). Missing nursing care: The impact on intention to leave and turnover. *Canadian Journal of Nursing Research, 42*(4), 22-39.

Twigg, D., Duffield, C., Bremner, A., Rapley, P. & Finn, J. (2011). The impact of nursing hours per patient day (NHPPD) staffing method on patient outcomes: A retrospective analysis of patient and staffing data. *International Journal of Nursing Studies, 48,* 540-548.

*University of Toronto Magazine. (*2003, summer). Study measures overcrowding in hospital emergency rooms. Toronto, ON, Canada. http://www.magazine.utoronto.ca/leading-edge/canada-emergency-room-overcrowding-study-michael-schull/

Van Bogaert, P., Clarke, S., Roelant, E., Meulemans, H. & Van de Heyning, P. (2010). Impact of unit-level nurse practice environment and burnout on nurse-reported outcomes: a multilevel modelling approach. *Journal of Clinical Nursing, 19,* 1664-1674.

Virtanen, M., Pentti, J., Vahtera, J., Ferrie, J., Stansfeld, S., Helenius, H., Elovainio, M., Honkonen, T., Terho, K., Oksanen, T. & Kivimäki, M. (2008). Overcrowding in hospital wards as a predictor of antidepressant treatment among hospital staff. *American Journal of Psychiatry, 165*(11), 1482-1486.

Weidner, A., Graham, C., Smith, J., Aitken, J. & Odell, J. (2012). Evaluation of nursing retention and recrutiment programs in Alberta. *Canadian Journal of Nursing Leadership*(Sp), 130-147.

Wingrove, J. (2010, November 19). Emergency room overcrowding putting patients at risk. *Globe & Mail.* Toronto, ON, Canada. http://www.theglobeandmail.com/news/national/prairies/emergency-room-overcrowding-putting-patients-at-risk/article1807108/

Yuen, J. (2009, May 3). Halls of shame: Ontario's push to shorten ER wait times means patients are languishing in hallways, nursing groups charge. *Toronto Sun.* Toronto, ON, Canada. http://www.torontosun.com/news/canada/2009/05/03/9330606-sun.html

Appendix A

Canadian Federation of Nurses Unions — Workload Project Think Tank

Toronto,

December 5-6, 2011

Participant	Position	Organization
Linda Silas	President	Canadian Federation of Nurses Unions
Barbara Foster	A/Executive Director	Office of Nursing Policy, Health Canada
Dr. Judith Shamian	President and CEO	Victorian Order of Nurses
Dr. Gail Tomblin Murphy	Professor & Associate Director	Dalhousie School of Nursing
Dr. Mélanie Lavoie-Tremblay	Assistant Professor	McGill School of Nursing
Patricia O'Connor	Director of Nursing	McGill University Health Centre
Dr. Judith Ritchie	Associate Director of Nursing for Research	McGill University Health Centre
Dr. Linda McGillis Hall	Professor, Associate Dean of Research & External Relations	University of Toronto School of Nursing
Dr. Ann Tourangeau	Associate Professor	University of Toronto School of Nursing
Dr. Marlene Smadu	Associate Dean	University of Saskatchewan College of Nursing
Dr. Maura MacPhee	Associate Professor	University of British Columbia School of Nursing
Murielle Tessier Dufour	Conseillère syndicale Secteur Organisation du travail	Fédération interprofessionnelle de la santé du Québec
Jo Anne Shannon	Professional Practice Specialist	Ontario Nurses' Association
Deborah Stewart	Professional Practice and Education Officer	Manitoba Nurses Union
Judith Grossman	Policy and Research Officer	United Nurses of Alberta
Patricia Wejr	Senior Policy Analyst	British Columbia Nurses' Union
Arlene Wortsman	Consultant	Arlene Wortsman and Associates
Dr. Lois Berry	Consultant	University of Saskatchewan College of Nursing
Paul Curry	Research Officer	Canadian Federation of Nurses Unions

Appendix B

Nurses Unions Negotiators Meeting

Vancouver,

January 12, 2012.

Participant	Position	Organization
John Vivian	Executive Director	Newfoundland and Labrador Nurses' Union
David Brown	Executive Director	New Brunswick Nurses Union
Kendra Gunn	Executive Director	Prince Edward Island Nurses' Union
Dan Anderson	Director & Chief Negotiator	Ontario Nurses' Association
Leona Barrett	Labour Relations Officer	Manitoba Nurses Union
Rosalee Longmoore	President	Saskatchewan Union of Nurses
Paul Kuling	Second Vice President	Saskatchewan Union of Nurses
Kelly Miner	Director of Labour Relations	Saskatchewan Union of Nurses
Amber Alecxe	Director Patients and Families First and Government Relations	Saskatchewan Union of Nurses
Carl Veistrup	Employment Relations Officer	Saskatchewan Union of Nurses
David Harrigan	Director of Labour Relations	United Nurses of Alberta
Gary Fane	Executive Director of Negotiations and Strategic Development	British Columbia Nurses' Union
Linda Silas	President	Canadian Federation of Nurses Unions
Dr. Lois Berry	Consultant	University of Saskatchewan College of Nursing
Brett Holmes	General Secretary	New South Wales Nurses' Association
Jill Furillo	National Bargaining Director	National Nurses United
Debra McPherson	President	British Columbia Nurses' Union
Debbie Forward	President	Newfoundland and Labrador Nurses' Union
Heather Smith	President	United Nurses of Alberta
Jeannine Arbour	Negotiator	United Nurses of Alberta
Linda Haslam-Stroud	President	Ontario Nurses' Association
Bev Mathers	Negotiator	Ontario Nurses' Association
Valerie MacDonald	Negotiator	Ontario Nurses' Association

Appendix C

Roundtable Meeting
"A Reality Check on 'Gaps' Affecting Today's Health Workplaces"

Ottawa,

January 31, 2012

Participant	Position	Organization
Lori Lamont	Vice President & Chief Nursing Officer	Winnipeg Regional Health Authority
Jane MacDonald	Vice President	Public Affairs and Community Engagement, VON
Patricia O'Connor	Director of Nursing	McGill University Health Centre
Diane Calvert-Simms	Vice President of Patient Services, Chief Nursing Officer	Cape Breton District Health Authority
Suzanne Johnston	VP, Clinical Programs & Chief Nursing Officer	Northern Health
Debbie Forward	President	Newfoundland and Labrador Nurses' Union
Michel Mailhot	6th Vice President	Fédération interprofessionnelle de la santé du Québec
Sandi Mowat	President	Manitoba Nurses Union
Rosalee Longmoore	President	Saskatchewan Union of Nurses
Patricia Wejr	Senior Policy Analyst	British Columbia Nurses' Union
Dr. Debra Bournes	Chief Nursing Officer	Ontario Ministry of Health & Long Term Care
Sylvie Hains	Directrice des soins infirmiers	Ministère de la Santé et des Services sociaux du Québec
Anita Paras	Manager, Workforce Planner	Alberta Health Services
Lynn Digney Davis	Chief Nursing Officer	Saskatchewan Health
Dorothy LaPlante	Executive Director, Officer of Nursing Services	First Nations and Inuit Health Branch
Linda Silas	President	Canadian Federation of Nurses Unions
Norma Freeman	Nurse Advisor	Canadian Nurses Association
Barb Foster	A/Executive Director	Health Canada, Office of Nursing Policy
Kate Thompson	Senior Nurse Consultant	Health Canada, Office of Nursing Policy
Jacquie Lemaire	Senior Policy Analyst	Health Canada, Office of Nursing Policy
Dr. Lois Berry	Consultant	University of Saskatchewan
Arlene Wortsman	Consultant	Arlene Wortsman and Associates
Paul Curry	Research Officer	Canadian Federation of Nurses Unions

Appendix D

Traduction du Message de la présidente de la FCSII, Linda Silas

Le 26 juillet 2012, le premier rapport communiqué par le Groupe d'innovation en matière de santé, groupe créé par les premiers ministres provinciaux et territoriaux, a été accueilli par des applaudissements polis. « Petits pas », « solutions faciles », « évident et qui va de soi » sont des expressions utilisées pour décrire les efforts initiaux des premiers ministres. C'est, toutefois, un bon début pour six mois de travail.

Si certains d'entre nous applaudissent fort c'est pour essayer d'attiser cette étincelle de collaboration pancanadienne afin que les améliorations aux soins de santé se propagent dans tout le pays. Nous sommes vraiment ravis de savoir que les premiers ministres sont déterminés à continuer ce travail.

Les infirmières et les infirmiers savent que des changements sont nécessaires. Les hôpitaux du pays fonctionnent en surcapacité. Une norme généralement acceptée, relativement au taux d'occupation des hôpitaux, est 85 %. Or, la plupart des hôpitaux ont un taux d'occupation de 100 % ou plus. Le surpeuplement compromet les soins, engendre un taux élevé d'infections d'origine hospitalière et des réadmissions non nécessaires à l'hôpital. Sans parler des charges de travail atteignant des niveaux dangereux qui amorcent le cercle vicieux du manque de personnel.

Le personnel infirmier est presque deux fois plus susceptible de s'absenter en raison d'une maladie ou blessure que la moyenne des travailleurs de toute autre profession. En 2010, les heures supplémentaires, rémunérées et non rémunérées, des infirmières et des infirmiers du secteur public correspondent à 11 400 emplois équivalents temps plein. Vingt pour cent des infirmières et des infirmiers du secteur hospitalier quittent leur emploi annuellement. Cela représente un coût, pour l'hôpital, estimé par certains à 25 000 $ et par d'autres à 60 000 $ par infirmière pour la transition. La charge de travail est souvent invoquée comme facteur clé du roulement de personnel.

Deux décennies d'études nationales et internationales ont établi, de façon constante, un lien très clair entre la dotation inadéquate en personnel infirmier et de piètres résultats des patients, y compris une augmentation du taux de mortalité, des pneumonies contractées à l'hôpital, des infections urinaires, des septicémies, des infections hospitalières, des plaies de pression, des saignements gastroduodénaux, des chocs et des arrêts cardiaques, des erreurs médicales, des échecs des secours, et des durées plus longues que prévues du séjour à l'hôpital.

Le lien entre la charge de travail du personnel infirmier et la sécurité des patients est aussi évident en soins de longue durée qu'en soins actifs. Ainsi, plus les patients reçoivent de soins directs, meilleurs sont les résultats, notamment taux inférieur de

mortalité, meilleur état nutritionnel, meilleur fonctionnement sur le plan physique et cognitif, taux inférieur d'infections urinaires, moins de plaies de pression, et moins d'admissions à l'hôpital.

Nous ne pouvons plus ignorer les données liant les conditions de travail à la qualité des soins. Un niveau sécuritaire de dotation doit être un principe directeur pour les premiers ministres lors de la gestion des ressources humaines en santé. Malheureusement, dans le premier rapport du Groupe de travail, le mot « patient » n'apparaît pas dans la section sur les ressources humaines en santé. Or, c'est la sécurité des patients qui doit être la force motrice derrière les décisions liées à la dotation en personnel.

Trois décennies d'une approche cloisonnée en matière de planification des ressources humaines en santé se sont traduites en montagnes russes pour les travailleurs de la santé et les budgets en santé. La dotation sécuritaire va au-delà des champs d'activités et des soins dispensés par des équipes, même si les deux font parties des solutions aux charges de travail dangereuses. Le Groupe de travail sur l'innovation en matière de santé doit travailler avec les associations de fournisseurs, les syndicats et les employeurs lors de la prochaine étape de la consultation. Le premier ministre Wall, co-président du Groupe de travail, a un modèle conçu dans sa province à partager, soit une entente de partenariat entre le Syndicat des infirmières et infirmiers de la Saskatchewan et le gouvernement de la Saskatchewan, ainsi que les régies régionales de la santé, visant à établir des niveaux sécuritaires de dotation pour les patients.

Certains États et pays, notamment la Californie et l'Australie, ont des niveaux de dotation prescrits par la loi, afin de régler les problèmes liés à la charge de travail. Des études récentes établissent un lien entre les ratios infirmière-patients prescrits et de meilleurs résultats des patients. À cela s'ajoutent des économies pour le système de santé en raison d'une diminution de la durée du séjour à l'hôpital, des incidents néfastes et du roulement du personnel.

Les gouvernements devraient s'engager à établir des niveaux sécuritaires de dotation en personnel dans tout le continuum de soins. Les données sur les incidents néfastes devraient être associées aux données sur la charge de travail et celles sur la composition du personnel (éventail des compétences) afin d'aider les décideurs à améliorer les conditions de travail et la qualité des soins.

La voix des infirmières et des infirmiers du pays a été forte et claire. La dotation sécuritaire doit être un principe directeur et un résultat mesurable dans le secteur de la santé.

Cet ouvrage intitulé *Améliorer les résultats des patients et la qualité des soins en ciblant la charge du travail du personnel infirmier : ratios prescrits infirmière-patients,*

et plus encore, a été commandé par la FCSII à l'intention des décideurs et des responsables des politiques dans le secteur de la santé. La dotation sécuritaire est un premier pas dans la planification des ressources humaines qui mettent l'accent sur les besoins des patients.

J'aimerais remercier Lois Berry, Ph. D., et Paul Curry (SIINÉ) pour leur excellent travail de recherche et pour la rédaction de ce rapport. J'aimerais aussi souligner la contribution, les conseils et l'expertise du comité consultatif de la FCSII : Vicki McKenna et Jo Anne Shannon (Association des infirmières et infirmiers de l'Ontario), Patricia Wejr (Syndicat des infirmières et infirmiers de la Colombie-Britannique), Deborah Stewart (Syndicat des infirmières et infirmiers du Manitoba) et Judith Grossman (Infirmières et infirmiers unis de l'Alberta).

Nous devons aussi souligner le travail et l'engagement des chercheurs canadiens du secteur des soins infirmiers qui ont participé à ce projet en nous consacrant leur temps et leur expertise :

- Dr Mélanie Lavoie-Tremblay, École des sciences infirmières de l'Université McGill
- Patty O'Connor, Centre universitaire de santé McGill
- Dr Judith Ritchie, Centre universitaire de santé McGill
- Dr Linda McGillis Hall, École des sciences infirmières de l'Université de Toronto
- Dr Ann Tourangeau, École des sciences infirmières de l'Université de Toronto
- Dr Gail Tomblin Murphy, École des sciences infirmières de l'Université Dalhousie
- Dr Marlene Smadu, Faculté des sciences infirmières de l'Université de la Saskatchewan
- Dr Judith Shamian, Infirmières de l'Ordre de Victoria
- Dr Maura MacPhee, École des sciences infirmières de l'Université de la Colombie-Britannique
- Barbara Foster, Santé Canada

Nous savons tous qu'il faut trouver des façons de permettre, aux infirmières et aux infirmiers de première ligne, d'agir lorsqu'ils jugent que les soins sont compromis. Nous savons qu'une solution ne convient pas nécessairement à toutes les situations, toutefois, nous avons l'assurance que ce rapport permettra d'influencer les décisions relatives à la dotation et se traduira en avantages mutuels en raison des meilleures conditions de travail et d'une meilleure qualité des soins.

Linda Silas, I.I.
Présidente de la Fédération canadienne des syndicats d'infirmières et infirmiers

Appendix E

Traduction du Résumé et des Recommandations

À une époque où l'on semble respecter les prises de décisions fondée sur les données probantes, le mécontentement des infirmières et des infirmiers du Canada s'accroît de plus en plus car les décideurs n'agissent pas en fonction de l'abondance de données établissant un lien entre des niveaux sécuritaires de dotation en personnel infirmier et de meilleurs résultats des patients.

Deux décennies d'études nationales et internationales ont établi, de façon constante, un lien très clair entre la dotation inadéquate en personnel infirmier et de piètres résultats des patients, y compris une augmentation du taux de mortalité, des pneumonies contractées à l'hôpital, des infections urinaires, des septicémies, des infections hospitalières, des plaies de pression, des saignements gastroduodénaux, des chocs et des arrêts cardiaques, des erreurs médicales, des échecs des secours, et des durées plus longues que prévues du séjour à l'hôpital.

Au tout début du millénaire, le gouvernement canadien, et ceux d'autres pays, ont reconnu la crise touchant le secteur des soins. En raison de la pénurie infirmière à l'échelle internationale, et des données selon lesquelles le personnel infirmier est épuisé, stressé et submergé par leur milieu de travail, dix importants rapports nationaux ont été commandés, entre 2000 et 2006, dans le but de mieux comprendre les problèmes du personnel infirmier au sein du système de soins de santé.

Les conclusions de ces rapports sont conséquentes. En utilisant des expressions ou des phrases telles « crise intenable », « besoin urgent de réparer les dommages » et inquiétude par rapport à la « détérioration de la qualité du système de soins de santé du pays », ces rapports demandent d'agir pour régler les problèmes du secteur des soins infirmiers dans le but ultime d'améliorer les soins dispensés aux patients.

Les recommandations comprises dans ces rapports se rangent dans deux grandes catégories : améliorer la charge de travail du personnel infirmier et améliorer la vie au travail du personnel infirmier. La plupart des recommandations ciblent ce qui suit : dotation pertinente, jumelage du champ d'activité aux besoins du patient, solutions à la cadence accrue et à la complexité du travail, réduction de l'absentéisme et de la fatigue chez le personnel infirmier, et meilleure intégration des soins entre les établissements de soins, et entre les établissements et la collectivité. Les rapports se sont attardés au milieu de travail en faisant des recommandations ciblant la création de milieux de travail respectueux envers le personnel infirmier grâce à la participation aux décisions relatives aux soins des patients et davantage de fonds alloués à la formation et au développement professionnel. Ces rapports préconisent les programmes visant à réduire la violence au travail. Ils soulignent l'importance

d'augmenter le nombre d'inscriptions dans les écoles de sciences infirmières afin de redresser la situation en raison des réductions, motivées par le budget dans les années 1990, et ciblant la formation infirmière.

Malheureusement, peu de ces recommandations ont été mises en œuvre, sauf une augmentation du nombre de places dans les écoles infirmières et quelques projets pilotes sur les milieux de travail sains. En raison de cette inaction, les problèmes liés à la charge de travail et à la vie au travail du personnel infirmier sont toujours présents. En fait, ils s'enveniment.

Actuellement, les problèmes de surcapacité et de surpeuplement des urgences et dans tous les hôpitaux n'ont fait qu'exacerber la crise du secteur infirmier du début des années 2000. La surcapacité a engendré les « soins infirmiers dans les couloirs », i.e. soins dispensés dans les corridors, les salons des patients, et autres lieux inappropriés, mal équipés et exposés. La surcapacité survient surtout en raison du manque d'autres niveaux de soins dans la collectivité, dont manque de foyers de soins, de services communautaires et de soins à domicile. La surcapacité est liée à une augmentation du risque de morbidité et de mortalité à l'hôpital, y compris augmentation de la fréquence des pneumonies, mauvaise gestion de la douleur, mauvaise gestion des douleurs thoraciques aigues, retard dans l'administration d'antibiotiques par rapport aux protocoles recommandés, augmentation du nombre de réadmissions à l'hôpital, et diminution du degré de satisfaction des patients.

Les milieux de travail malsains continuent de nuire à la sécurité des soins dispensés par le personnel infirmier. Les interruptions fréquentes, la confusion quant aux rôles, le soutien technique et humain limité, le manque d'intégration et de coordination au sein du système, l'augmentation continue de l'acuité des besoins des patients, l'absence de prise de décision de façon autonome et de participation aux décisions relatives aux soins des patients continuent d'avoir des répercussions négatives sur le personnel infirmier et leurs patients. De nos jours, le personnel infirmier affiche un degré élevé d'épuisement, d'absentéisme, de roulement, de fatigue et d'insatisfaction au travail. Les études établissent un lien direct entre le degré de satisfaction du personnel infirmier et celui des patients.

Selon des sondages, menés auprès du personnel infirmier de première ligne au Canada, les problèmes liés à la charge de travail et à la dotation sécuritaire sont les problèmes qui surviennent le plus souvent au travail sur une base quotidienne. Les infirmières et les infirmiers mentionnent être à bout de patience en raison de l'inaction malgré les données probantes liant la dotation sécuritaire aux résultats positifs des patients.

Les infirmières et les infirmiers veulent des solutions à ces problèmes. Ils se tournent vers les solutions mises en œuvre en Californie et dans certains États de l'Australie où le personnel infirmier a réussi à faire pression et obtenir des ratios infirmière-patients prescrits par la loi et les conventions collectives. De tels ratios

limitent le nombre de patients dont doit s'occuper l'infirmière. Par exemple, en Californie, un ratio de 1:4 est prescrit par la loi.

À New South Wales, en Australie, les ratios ont été déterminés en fonction d'une formule d'heures minimum de soins infirmiers, par patient, par jour. Cette formule peut varier selon les classifications au sein de l'hôpital mais, généralement, les ratios correspondent à 1:4 pour le quart de jour sur une période de sept jours. Les ratios peuvent varier dans certaines unités de soins dans lesquelles l'acuité des besoins est plus élevée. Des mécanismes, prescrits par la loi, permettent d'améliorer la dotation lors de périodes où l'acuité des besoins des patients augmente. La dotation en personnel peut être gérée au niveau de l'unité de soins. Les ratios correspondent à un minimum pour assurer un niveau sécuritaire de dotation, et non pas à un maximum.

De nouvelles études démontrent une amélioration des résultats des patients à la suite de la mise en place de ratios prescrits. Des études ciblant l'expérience australienne démontrent une diminution de la fréquence des incidents directement liés aux soins infirmiers (indicateurs de résultats liés aux soins infirmiers), y compris diminution du taux de mortalité, des complications du système nerveux central, des ulcères, des gastrites, des saignements duodénaux, des septicémies, des plaies de pression, et de la durée du séjour à l'hôpital. Des études ciblant l'expérience californienne révèlent des résultats similaires par rapport au taux de mortalité, et indiquent qu'un nombre significativement plus grand d'infirmières et d'infirmiers mentionnent des charges de travail raisonnables et une amélioration de la qualité des soins. Cette amélioration de la qualité des soins a été mentionnée par les infirmières et les infirmiers de première ligne et ceux occupant des postes de gestion. Après la mise en œuvre des ratios prescrits, on a aussi observé une augmentation significative du nombre d'infirmières et d'infirmiers mentionnant être satisfaits au travail.

Une alternative aux ratios prescrits est un modèle dynamique de prise de décision partagée relativement à la dotation. Ce modèle tient compte à la fois des caractéristiques des patients et du personnel infirmier, et comprend un processus grâce auquel le personnel infirmier de première ligne participe directement aux décisions relatives à la dotation. Le modèle synergique de prestation des soins de l'American Association of Critical Care Nurses a été adapté à la prise de décisions relatives aux secteurs autres que les soins intensifs, et a été mis en œuvre en Colombie-Britannique et en Saskatchewan. La prise de décision partagée a augmenté la participation des infirmières et des infirmiers aux décisions relatives à la dotation, et ils accordent une très bonne cote à ce processus.

Il est important de souligner que le coût lié à une augmentation de la dotation infirmière peut être largement, voire même entièrement, récupéré par l'établissement. Cela s'explique par le lien confirmé entre une augmentation de la dotation infirmière et la diminution de la durée du séjour, des réadmissions, de la morbidité, des erreurs médicales et du roulement du personnel infirmier. Si l'on va au-delà des

murs des établissements de santé, on observe que, pour l'ensemble de la société, les économies réalisées en raison d'une plus grande productivité sont beaucoup, beaucoup plus importantes que les coûts pour augmenter la dotation.

Les ratios infirmière-patients prescrits, et les modèles dynamiques de prise de décisions partagée, sont encourageants pour les infirmières et les infirmiers de première ligne qui sont à bout de patience en raison de l'inaction à améliorer la charge de travail et la vie au travail du personnel infirmier, ainsi que l'expérience des patients et de leur famille. Le personnel infirmier veut qu'on agisse immédiatement pour mettre en place des processus de dotation sécuritaire. Les infirmières et les infirmiers demandent, avec instance, aux décideurs de mettre en œuvre, immédiatement, de tels mécanismes ainsi que des procédures de collecte de données permettant de consigner l'amélioration prévue aux résultats des patients. De plus, le financement des établissements et des programmes de santé devrait se faire en fonction des améliorations des résultats des patients et des indicateurs de la charge et des conditions de travail du personnel infirmier.

Les rapports canadiens publiés au cours de la dernière décennie illustrent clairement jusqu'à quel point la situation infirmière est le miroir de la situation dans le système de soins de santé. En ce moment, il est impératif de régler les problèmes liés à la charge de travail et à la vie au travail du personnel infirmier si nous voulons améliorer les résultats des patients, ainsi que leur expérience et celle de leur famille dans le système canadien de soins de santé.

Principales recommandations

Que les décideurs :

1. S'engagent immédiatement à agir pour mettre en place des modèles de dotation sécuritaire dans tout le continuum de soins. Les mesures devraient comprendre des ratios sécuritaires de dotation selon lesquels les personnes sont remplacées par des personnes ayant les mêmes compétences, et selon lesquels le patient est jumelé à une infirmière ayant les compétences pertinentes.
2. Financent immédiatement la mise en œuvre d'un modèle national de dotation sécuritaire, en utilisant soit les ratios infirmière-patients ou un modèle dynamique de prise de décision partagée, par exemple le modèle synergique de prestation des soins.
3. Honorent l'obligation de rendre compte au sein du système de soins de santé afin d'assurer la sécurité et la qualité des soins aux patients en allant plus loin que les éléments actuellement mesurés (temps d'attente, paramètres liés

au volume et à la rémunération au rendement), et allouent plutôt les fonds aux établissements en fonction des améliorations par rapport aux résultats des patients et aux indicateurs relatifs au personnel infirmier (diminution de l'absentéisme, de l'épuisement, du roulement, etc.). Des mécanismes de responsabilisation devraient être en place afin que les employeurs et les décideurs chargés du financement soient tenus responsables des décisions relatives à la dotation en personnel et des répercussions sur les patients, le personnel et les budgets.

Recommandations à l'appui

Que les décideurs :

4. S'inspirent des données issues d'études nationales et internationales pour élaborer les modèles de dotation et les pratiques, et qu'ils respectent les lignes directrices fondées sur les données probantes, dont les lignes directrices de l'Association des infirmières et infirmiers autorisés de l'Ontario relatives aux pratiques exemplaires.
5. Financent, de façon ciblée, les initiatives visant une meilleure qualité du milieu de travail infirmier en améliorant la charge de travail infirmière et les résultats des patients.
6. Normalisent la collecte des données en soins de santé, y compris les indicateurs relatifs au personnel infirmier, et rendent ces données facilement accessibles aux décideurs grâce à des formats électroniques faciles à comprendre et à gérer, et pouvant être utilisés lors de la prise de décisions à l'échelle locale ou dans l'ensemble du système.
7. Fassent participer le personnel infirmier à tous les paliers par rapport à la mise en œuvre de solutions pour régler les problèmes du secteur infirmier.
8. S'occupent des problèmes liés à la gouvernance dans le secteur de la santé, en commençant aux premières lignes et en progressant vers le haut.
9. Clarifient le champ d'activité du personnel infirmier et le rôle des travailleurs non réglementés au sein du système, et assurent le remplacement des infirmières par des infirmières en éliminant les modèles de remplacement qui posent des risques et entraînent une fragmentation des soins.
10. Règlent le problème de la surcapacité au sein du système par une meilleure intégration des services entre les unités, et entre les hôpitaux et les collectivités. Cela peut se faire par un meilleur financement des soins à domiciles et des organismes dispensant d'autres niveaux de soins, et en améliorant l'accès aux soins de santé primaires.

Realities from frontline nurses:

Proud to be a nurse in spite of the conditions

My co-worker and I cried. We cried because we felt for our palliative patient but, worst of all, in my case, I did not feel that I had provided very good care to her. I felt I was the worst nurse because I didn't have time to turn her! However my co-worker and I gave each other a pat on the back that we were able to prevent the two paediatric patients from going into respiratory failure, and they survived that night.

I am thankful for being a part of the health care team and proud to be a nurse!

Jackie

Relying on the best evidence, and on the experience of frontline nurses, *Nursing Workload and Patient Care* presents a sobering look at the challenges facing our overworked nursing workforce and the ensuing effects on patients. This book reviews the now incontrovertible body of evidence linking inadequate nurse staffing with increases in mortality and other negative outcomes for patients. *Nursing Workload and Patient Care* lays bare the empty promises of countless government studies while urging policy makers to fully understand the value that a nurse's education and training bring to patient care. The report offers a clear vision of a future in which nurse staffing benefits patients and nurses while contributing to the financial viability of our health system.

ISBN: 978-0-9868382-3-1

CANADIAN FEDERATION OF NURSES UNIONS | WHERE KNOWLEDGE MEETS KNOW-HOW

PositionStatement

CANADIAN NURSES ASSOCIATION

ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

ETHICAL PRACTICE: THE *CODE OF ETHICS FOR REGISTERED NURSES*

CNA POSITION

The *Code of Ethics for Registered Nurses* (CNA, 2008) serves as a foundation for nurses' ethical practice. CNA believes that the following seven values, which are described in the code, are central to ethical nursing practice. In the code each of these values is accompanied by a number of responsibility statements, and together they outline the ethical practice that is expected of registered nurses. CNA believes that the quality of the work environment in which nurses practise is also fundamental to their ability to practise ethically.

1. **Providing safe, compassionate, competent and ethical care**
   Nurses provide safe, compassionate, competent and ethical care.

2. **Promoting health and well-being**
   Nurses work with people to enable them to attain their highest possible level of health and well-being.

3. **Promoting and respecting informed decision-making**
   Nurses recognize, respect and promote a person's right to be informed and make decisions.

4. **Preserving dignity**
   Nurses recognize and respect the intrinsic worth of each person.

5. **Maintaining privacy and confidentiality**
   Nurses recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship.

6. **Promoting justice**
   Nurses uphold principles of justice by safeguarding human rights, equity and fairness and by promoting the public good.

7. **Being accountable**
   Nurses are accountable for their actions and answerable for their practice.

Ethical nursing practice also involves endeavouring to address broad aspects of social justice that are associated with health and well-being. These aspects relate to the need for change in systems and societal structures in order to create greater equity for all. Nurses should endeavour as much as possible, individually and collectively, to advocate for and work toward eliminating social inequities. The code contains thirteen statements entitled "ethical endeavours," which are intended to guide nurses in this area. These statements address the need for awareness and action around such areas as social inequities, accessibility and comprehensiveness of health care, and major health concerns (e.g., poverty, violence, inadequate shelter) as well as broader global concerns (e.g., war, violations of human rights, world hunger).

Canadian Nurses Association, 50 Driveway, Ottawa ON K2P 1E2
Tel: 613-237-2133 or 1-800-361-8404 Fax: 613-237-3520
Website: www.cna-aiic.ca E-mail: info@cna-aiic.ca

BACKGROUND

CNA's *Code of Ethics for Registered Nurses* is a statement of the ethical values of nurses and of nurses' commitments to persons with health-care needs and persons receiving care. It is intended for nurses in all contexts and domains of nursing practice and at all levels of decision-making. It is developed by nurses for nurses. It will assist nurses in practising ethically and working through ethical challenges that arise in their practice with individuals, families, communities and public health systems. CNA revises the code every five years. A rigorous consultative process resulted in the release of a newly revised code in June 2008.

The code provides guidance for ethical relationships, responsibilities, behaviours and decision-making, and it is to be used in conjunction with the professional standards, laws and regulations that guide practice. It serves as a means of self-evaluation and self-reflection for ethical nursing practice and provides a basis for feedback and peer review. The code also serves as an ethical basis from which nurses can advocate for quality work environments that support the delivery of safe, compassionate, competent and ethical care. The code informs other health-care professionals as well as members of the public about the ethical commitments of nurses and the responsibilities nurses accept as being part of a self-regulating profession.

The code is organized in two parts. The specific values and ethical responsibilities expected of registered nurses in Canada are set out in part I. Endeavours that nurses may undertake to address social inequities as part of ethical practice are outlined in part II. A thorough discussion of all the elements of the code can be found in the *Code of Ethics for Registered Nurses* (2008).

Approved by the CNA Board of Directors

Published July 2008

References:

Canadian Nurses Association. (2008). *Code of ethics for registered nurses.* Ottawa: Author.

Also see:

CNA's website (www.cna-aiic.ca) for related learning resources, ethics position statements and the *Ethics in Practice* series.

Canadian Nurses Association. (2006). *Social justice... a means to an end, an end in itself.* Ottawa: Author.

Related International Council of Nurses publications:

The ICN Code of Ethics for Nurses (2006)

Ethical Guidelines for Nursing Research (2003)

Ethics in Nursing Practice: A Guide to Ethical Decision-Making (2002)

Replaces:

Code of Ethics for Registered Nurses [position statement] (2002)

PS-95

Canadian Nurses Association, 50 Driveway, Ottawa ON K2P 1E2
Tel: 613-237-2133 or 1-800-361-8404 Fax: 613-237-3520
Website: www.cna-aiic.ca E-mail: info@cna-aiic.ca

College of Registered Nurses of Nova Scotia

Position Statement
Professionalism and Registered Nurses in Nova Scotia

INTRODUCTION

The College of Registered Nurses of Nova Scotia (the College) recognizes that professionalism is a dynamic process that must be supported and enhanced through structures and processes in the practice environments of registered nurses.

> "Professionalism in nursing is an essential ingredient of a healthy work environment. How well nurses are able to demonstrate the attributes of professionalism is a factor of both the environment and the nurse. For some RNs, consistently demonstrating professionalism can be a challenge given the complex demands of patient care and everyday realities of the workplace" (Registered Nurse Journal, RNAO, March 2007).

Professionalism requires that registered nurses, in all roles, demonstrate professional standards and ethical behaviours. Nurses are expected to exhibit the values and attributes of professionalism when providing nursing care and when collaborating with clients, families, nurse colleagues, nursing students and other members of the healthcare team. It is imperative that registered nurses, collectively as a professional body and as individuals, continuously reflect on the values, behaviours and relationships of their profession.

Professionalism also contributes to positive work environments and should always be considered integral in the development of recruitment and retention initiatives.

Supporting Data

Over the past decade, nursing organizations across Canada have been grappling with the issue of professionalism and have acknowledged the need to address the changing image of the profession.

According to an Ipsos survey in 2007, the public ranks nursing as one of the most 'trustworthy' professions, second only to firefighters. However, the extensive scientific knowledge base and complex skills required of registered nurses are seldom acknowledged.

Opinion polls reinforce the belief that nurses are generally prized for their virtues, not their knowledge (Gordon & Nelson, 2006, p. 63). A variety of Canadian studies have illustrated a lack of respect shown toward registered nurses by members of the public and from other members of the healthcare team (CNA, 2006, p.30). Within recent years in Nova Scotia, results of surveys and focus groups held with registered nurses, other members of the healthcare team, and members of the public have supported similar findings (Retirement & Retention of Late Career Nurses in Nova Scotia – Final Report, 2006; Corporate Research Associates Inc, Omnibus Surveys, 2005 & 2006; 2006 Member Survey and Focus Groups, Omnifacts Research).

According to a member survey conducted by Omnifacts Research (Bristol Group) for the College in 2006, registered nurses believe they promote a professional image by demonstrating knowledge and expertise and collaborating with other members of the healthcare team. However,

opportunities exist for nurses to make improvements in their grooming and general appearance, their introductions to clients (i.e., introducing themselves with respect to their name, title and role), and wearing identification to help the public know that they are registered nurses (Report on 2006 Member Survey and Focus Groups, Omnifacts Research, p. 25).

These findings, combined with the longstanding acknowledgement that nurses' work is 'invisible' and often minimized, support the need for registered nurses to be more vigilant than ever about the messages they are projecting. This takes on yet more significance in light of the evolving role of registered nurses within today's interprofessional health team.

> "No one knows exactly what will happen in the future. By considering what might happen, people can more rationally decide on the sort of future that would be most desirable and then work to achieve it" (Villeneuve, M., & MacDonald, J., 2006, p.2).

With more than 230,000 registered nurses nationally, including approximately 9,500 in Nova Scotia, nurses should have a strong voice in the healthcare debate and should seize the opportunity to impact quality outcomes in the healthcare delivery system.

Key Concepts on Professionalism

Professionalism is considered a 'way of being' for registered nurses in Nova Scotia. It is an inherent component of the practice of nursing and, as a prerequisite in meeting nursing standards, encompasses:

- accountability
- continuing competence
- application of knowledge
- skills and judgment
- professional relationships and advocacy
- professional leadership
- self-regulation.

Professionalism is demonstrated by registered nurses through actions that include:

- possessing a special body of practical and theoretical knowledge
- applying that knowledge
- using theoretical and/or evidence-based rationale for practice
- synthesizing information from a variety of sources
- using multi-faceted information or evidence from nursing and other disciplines to inform practice, and
- sharing or communicating knowledge with colleagues, clients and others to continually improve care and health outcomes (RNAO, 2006).

Professionalism, in relation to the *Code of Ethics*, also includes an understanding of a special body of theoretical knowledge about ethical values, concepts and decision-making (RNAO, 2006, p. 18).

Nursing Professionalism in Nova Scotia

In promoting professional nursing practice and the image of the nursing profession, registered nurses in Nova Scotia are expected to consider the *Standards for Nursing Practice* and *Code of Ethics* as being equally important and relevant to their practice.

As professionals, registered nurses are expected to embody the competencies, relationships and attitudes mandated within the *Standards for Nursing Practice* and *Code of Ethics for Registered Nurses* and to demonstrate professionalism through these three main themes:

- **Competencies**
  Registered nurses are accountable to the public to provide safe, competent, compassionate and ethical nursing care. They are also required to attain, maintain and demonstrate competencies relevant to their own scope of practice. Throughout their nursing careers, registered nurses are expected to commit to lifelong learning.

- **Relationships**
  Registered nurses are expected to demonstrate professionalism in their regular interactions with clients, families, team members, organizations, and the healthcare system and processes.

Advocating for clients is central to the role of registered nurses. In an effort to ensure that clients receive safe, competent and ethical care, registered nurses are expected to:

- seek social justice and be culturally competent
- communicate practice-related issues
- take initiative and demonstrate leadership by identifying needs of clients within the system.

Professionalism should be effectively demonstrated while working independently and exercising decision-making within the full scope of nursing practice.

Professionalism includes developing collaborative relationships in a professional context with other nurses, the healthcare team, the organization and system, and processes including governments, other agencies, associations, unions, and facilities. These professional relationships require:

- active involvement in professional practice initiatives and activities
- acting as a mentor to nurses and colleagues, to enhance and support professional growth
- demonstrating respect and denoting recognition of interdependence among healthcare providers.

Behaviours demonstrating professionalism are outlined in the *Standards for Nursing Practice* and *Code of Ethics*. Registered nurses must be aware of the importance of a positive image for nursing and take steps to support adherence to the Standards and Code. A poor impression of registered nurses not only has a negative effect on the profession, it also impacts client outcomes and creates an environment in which colleagues and other members of the healthcare team may be unable to provide essential safe, competent and ethical care.

Impressions of registered nurses are generated through factors such as their general appearance, the language they use, and their self-identification. Professionalism also requires sensitivity, cultural competence and an awareness of the context of practice.

- **Attitudes**

The term 'attitude' relates to a way of thinking, acting, or feeling (Gage Canadian Dictionary, 1997). Registered nurses demonstrate positive attitudes by:

- displaying self-confidence
- practising with integrity
- speaking and acting respectfully
- behaving in a courteous manner
- being sensitive to cultural diversity
- demonstrating a positive 'can do' approach
- expressing empathy for others.

Registered nurses exhibit leadership and take pride in themselves and their profession, which is evidenced by their adherence to the *Standards for Nursing Practice* and *Code of Ethics*. Other characteristics that support a positive professional image or attitude include:

- supporting and participating in a culture of innovation to enhance practice outcomes
- showing initiative and being involved (i.e., taking action)
- influencing the future of nursing, delivery of health care and the healthcare system.

"Ability is what you're capable of doing ... motivation determines what you do ... attitude determines how well you do it." Lou Holtz (Internet quotable quote #26452)

Conclusion

Registered nurses play a key role in the Canadian healthcare system. The role that registered nurses will play in the future healthcare system in Nova Scotia will be greatly determined by the level of professionalism they demonstrate. Registered nurses and agencies employing them must acknowledge and support registered nurses who demonstrate professionalism by adhering to their *Standards for Nursing Practice* and *Code of Ethics*. They must appropriately address those situations in which there is a lack of adherence to professional standards.

Definitions

Client(s): the recipient(s) of nursing services: e.g., individuals (family members/guardians/ substitute caregivers), families, groups (communities groups), populations or entire communities (adapted from CNA, NNCP, 1997, p. 42).

Competence: The integrated knowledge, skills, judgment and attributes required of a registered nurse to practise safely and ethically in a designated role and setting. Attributes include, but are not limited to, attitudes, values and beliefs (CNA, 2000).

Registered nurse: refers to a registered nurse, nurse practitioner, licensed graduate nurse, registered nurse with a conditional licence, and a nursing student.

References

College of Registered Nurses of Nova Scotia. (2006). *Retirement & Retention of Late Career Nurses in Nova Scotia – Final Report.* Halifax, NS: Author.

Corporate Research Associates Inc Atlantic Quarterly. (2005). *Omnibus Surveys, College of Registered Nurses of Nova Scotia Summer 2005 Commissioned Results.* Halifax, NS: Author.

Corporate Research Associates Inc Atlantic Quarterly. (2006). *Omnibus Surveys, College of Registered Nurses of Nova Scotia Summer 2006 Commissioned Results.* Halifax, NS: Author.

Gage Educational Publishing Company. (1997). *Gage Canadian Dictionary.* Toronto, ON: Gage Educational Publishing Company, p. 94.

Gordon, S., Nelson, S. (2005). An end to the angels. *American Journal of Nursing.* 105(5), 62-69.

Holtz, Lou. Internet quotable quote #26452. Retrieved October 20, 2008, from http://www.quotationspage.com/quote/26452.html.

Ipsos-Reid (2007, January 22). *Canada Speaks survey: When it comes to professions, whom do we trust?* Retrieved May 4, 2007, from http://www.ipsos-na.com/news/pressrelease.cfm?id=3333

Omnifacts Research (Bristol Group). (2006 February). *2006 Member Survey and Focus Groups, College of Registered Nurses of Nova Scotia.* Halifax, NS: Author.

Registered Nurses Association of Ontario. (2007, March). Professionalism: Best-practice guidelines. *Registered Nurse Journal.* Toronto, ON: Author.

Villeneuve, M., MacDonald, J. (2006). *Toward 2020: Visions of Nursing.* Ottawa, ON: Canadian Nurses Association.

Standards of Practice for Registered Nurses

College of Registered Nurses
of Nova Scotia

Table of Contents

Introduction

In Nova Scotia, the professional practice of nursing[1] is defined in the *Registered Nurses Act* (RN Act, 2006) and *Regulations* (2009), and reflected in the *Standards of Practice for Registered Nurses* and the *Code of Ethics for Registered Nurses*.

Through the RN Act, the nursing profession is granted the authority to set standards for the practice and education of its members; balanced with an obligation to protect and serve the public interest.

Registered nurses are prepared to consistently practise safely, compassionately, competently and ethically in diverse practice settings, with a variety of clients at different levels throughout the continuum of health and illness.

The College of Registered Nurses of Nova Scotia (the College: CRNNS), working with registered nurses and the public, regulates the nursing profession to protect the public and promote excellence in nursing practice. This mission is achieved, in part, through the development of standards, or minimal professional practice expectations, for all registered nurses in all settings and roles.

Professional standards for the practice of registered nurses were first developed in Nova Scotia in 1983. However, with the input of registered nurses in practice settings throughout the province, the Standards have been reviewed and revised on an ongoing basis since then to ensure that they reflect trends in both nursing and health care in Nova Scotia as well as across Canada. For instance, the 2012 Standards reflect the increasing complexity of client care, new models of care delivery, new roles and expectations for nurses, and an increased emphasis on teamwork and collaboration, evidence-based practice, primary health care and labor mobility. Revisions to the RN Act (2006) and the *Code of Ethics for Registered Nurses* (CNA, 2008) are also reflected in this most recent version of the Standards.

The *Standards of Practice for Registered Nurses* apply to both novice (entry-level) and experienced registered nurses, including nurse practitioners. Entry-level registered nurses are prepared to practise in accordance with the Standards and Code, while strengthening their efficiency and ability to prioritize, organize and make decisions based on their foundational level of knowledge and practice (clinical) experiences. In conjunction with these Standards, the College has established competencies that entry-level registered nurses in Nova Scotia are expected to demonstrate upon graduation from an approved nursing education program.

In addition to meeting the *Standards of Practice for Registered Nurses*, nurse practitioners are also required to adhere to a set of standards that pertain directly to their practice (i.e., *Nurse Practitioner Standards of Practice*, 2012).

According to the RN Act (2006), the

> (ai) "practice of nursing" means the application of specialized and evidence based knowledge of nursing theory, health and human sciences, inclusive of principles of primary health care, in the provision of professional services to a broad array of clients ranging from stable or predictable to unstable or unpredictable, and includes
>
> (i) assessing the client to establish their state of health and wellness;
> (ii) identifying the nursing diagnosis based on the client assessment and analysis of all relevant data/information;
> (iii) developing and implementing the nursing component of the client's plan of care;
> (iv) coordinating client care in collaboration with other health care disciplines;
> (v) monitoring and adjusting the plan of care based on client responses;
> (vi) evaluating the client's outcomes;

[1]For the purpose of this document, the *practice of nursing* refers to all registered nurses, including nurse practitioners.

(vii) such other roles, functions and accountabilities within the scope of practice of the profession which support client safety and quality care, in order to

(A) promote, maintain or restore health;
(B) prevent illness and disease;
(C) manage acute illness;
(D) manage chronic disease;
(E) provide palliative care;
(F) provide rehabilitative care;
(G) provide guidance and counseling; and
(H) make referrals to other health care providers and community resources,

and also includes research, education, consultation, management, administration, regulation, policy or system development relevant to the above.

Nursing Standards: An Overview

'Standards for nursing practice' means the minimal professional practice expectations for any registered nurse in any setting or role, approved by Council or otherwise inherent in the nursing profession *(Registered Nurses Act,* 2006*).*

The primary reason for having standards is to promote, guide, direct and regulate professional nursing practice. Standards set out the legal and professional basis for nursing practice: describing the desirable and achievable level of performance expected of registered nurses in their practice, against which actual performance can be measured. Standards also serve as a guide to the professional knowledge, skill, and judgment needed to practise nursing safely.

The *Standards of Practice for Registered Nurses* established by the College are the benchmark for assessing the professional practice of all registered nurses in Nova Scotia, regardless of specialty or practice setting. Nurse practitioners are required to meet these Standards, as well as those set specifically for their expanded practice.

Standards range from the unwritten but inherent requirements of a profession, to these broad profession-wide standards established by the College, and onto detailed standards for client care. As standards progress from profession-wide expectations to specific levels of nursing care, the focus changes accordingly (i.e., from minimum standards the public can expect from all registered nurses, to standards developed for specialty nursing groups, onto unit or specific client care standards related to nursing functions and/or interventions needed to achieve desired client outcomes).

Figure 1 (right) illustrates the complementary relationship between the nursing standards established by the College and those set at other levels within the healthcare system. As depicted in Figure 1, the *Standards of Practice for Registered Nurses* form the foundation for all other standards pertaining to the practice of registered nurses in the delivery of quality care. Practice standards developed by and for specialized areas of nursing practice, which must reflect the *Standards of Practice for Registered Nurses*, may be adopted by district health authorities (DHAs) throughout the province, individual agencies, and/or specific nursing units.

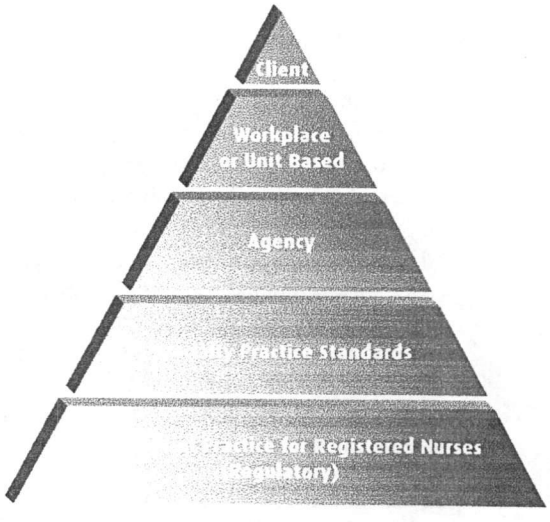


Figure 1: Pyramid of RN Practice Standards

Self-Regulation

The regulation of a profession has a primary purpose of protecting the public from harm. There are two levels of self-regulation: 1) registered nurses being accountable for their own practice, which includes being accountable and adhering to the *Standards of Practice for Registered Nurses* and *Code of Ethics* and applying them in their work, regardless of their context of practice, role or setting; and, 2) the College, as the regulatory organization, being accountable for ensuring that the nursing profession, as a whole, carries out its commitment to the public (i.e., ensuring that its members act in the public interest and fulfill the role that has been entrusted to them by society). The College is accountable for establishing and monitoring the standards of practice for registered nurses and has the statutory responsibility to take action when a registered nurse's ability to provide safe and appropriate care is questioned.

The College regulates the practice of registered nurses and nurse practitioners to serve and protect the public interest, preserve the integrity of the nursing profession and maintain public confidence in the ability of the nursing profession to regulate itself. Self-regulation reflects a continuing commitment to enable the nursing profession to practise effectively in an ever-changing healthcare industry and to sustain public confidence and trust. All College programs and services reflect and are grounded in self-regulation.

Self-regulation includes, but is not limited to:

1. promoting good nursing practice
2. preventing poor nursing practice
3. intervening when practice is unacceptable.

The College promotes good nursing practice by:

- setting standards for nursing education
- setting registration and licensure requirements
- promoting evidence-based nursing and health care
- establishing and promoting professional practice standards, competencies and an ethical code
- promoting professional quality workplace environments.

The College prevents poor practice by:

- providing registered nurses with tools and resources to maintain and enhance their competencies
- providing registered nurses with guidelines for resolving professional practice problems through guidance for resolving practice issues
- providing consultation to assist registered nurses in identifying issues that contribute to poor practice and potential resolutions.

The College intervenes in unacceptable practice through:

- the professional conduct review process.

Context of Practice

Registered nurses practise within a complex and continually evolving healthcare system and are an integral part of the sustainability of that system. The context of practice is defined as conditions or factors that affect the practice of nursing, including client population, (e.g., age, diagnostic grouping); location of practice setting (e.g., urban, rural); type of practice setting and service delivery model (e.g., acute care, community); level of care required (e.g., complexity, frequency); staffing (e.g., number, competencies); and availability of other resources. In some instances, context of practice could also include factors outside the healthcare sector (e.g., community resources, justice).

Principles Related to the Standards

The Standards statements are broad in nature, capturing the diverse practice settings and areas in which nurses practise.

The Standards:

- apply at all times to all registered nurses in RN practice roles, including nurse practitioners.
- provide guidance to assist registered nurses in decision-making and self-assessment as part of continuing competence.
- are the foundation for the development of standards specific to various contexts of practice.
- may be used in conjunction with other resources to guide nursing practice (e.g., agency mission statements, models of care delivery).
- may be used to develop position descriptions, and performance appraisal and quality improvement tools.
- support registered nurses by outlining practice expectations of the profession.
- inform the public and others about what they can expect from practising registered nurses.
- are used as a legal reference for reasonable and prudent practice (e.g., professional conduct processes).

Principles Related to Indicators for the Standards

Indicators have been developed to illustrate how each of the five standards is to be met.

The indicators:

- provide specific criteria against which actual performance is measured.
- are not intended to be all-inclusive or an exhaustive list of criteria for each standard (i.e., additional methods of assessing the performance of a registered nurse could include job descriptions, performance appraisals, quality assurance processes, peer review processes, and comparisons to the "reasonable and prudent" practice of other nurses).
- may be further refined or developed to address specific roles and contexts of practice as well as corresponding required competencies.
- may be expanded to describe the practice expectations of registered nurses of varying levels of competence; ranging from entry-level to advanced-level practitioners.
- apply to all registered nurses, with additional indicators established for managers/administrators, educators and researchers.

Standards of Practice for Registered Nurses

How to use the Standards

The *Standards of Practice for Registered Nurses* are interrelated and equally important. They form the foundation for professional standards upon which all other standards (e.g., specialty, agency) are based.

- Each of the five standards identified in these professional Standards is separated into four categories, with indicators for each category.
- The first category in each Standard is comprised of indicators intended for all registered nurses regardless of the practice settings in which they apply their nursing knowledge and expertise.
- The next three categories in each Standard identify additional indicators for managers/ administrators, educators and researchers.
- The indicators are not intended to be a complete list, and should be interpreted in the context of the specific practice setting of an individual nurse.

Standard 1: Responsibility and Accountability – Registered nurses are responsible and accountable to practise safely, compassionately, competently and ethically in accordance with their legislated and individual scopes of practice.

Standard 2: Knowledge-Based Practice and Competence – Registered nurses continuously attain, maintain and demonstrate competence (knowledge, skill and judgment) relevant to their individual scope of practice.

Standard 3: Client Relationships and Advocacy – Registered nurses establish professional, therapeutic relationships, using a client-centred approach, and advocate for clients in their relationships with the health system.

Standard 4: Professional Relationships and Leadership – Registered nurses establish professional relationships with healthcare team members and demonstrate leadership to deliver quality nursing and healthcare services.

Standard 5: Individual Self-Regulation – In addition to the role of the regulator, to self-regulate the nursing profession, individual registered nurses are accountable to regulate themselves.

Standard 1: Responsibility and Accountability

Registered nurses are responsible and accountable to practise safely, compassionately, competently and ethically in accordance with their legislated and individual scopes of practice.

INDICATORS

Each registered nurse:

1.1 is responsible and accountable for her/his own actions and decisions.

1.2 is accountable to evaluate her/his own practice.

1.3 questions policies and practices in conflict with the Standards of Practice for Registered Nurses.

1.4 exercises reasonable judgment and makes timely decisions.

1.5 seeks assistance appropriately.

1.6 demonstrates behaviours that uphold the public trust in the profession.

1.7 recognizes and reports near misses and/or adverse events, and takes all necessary action to prevent or minimize harm arising from an adverse event.

1.8 takes appropriate action in situations where client safety and well-being is potentially or actually compromised.

1.9 contributes to safe, supportive and professional practice environments.

In addition, the nurse manager/administrator:

1.10 promotes practice environments that support professional accountability.

1.11 intervenes when registered nurses are not practising in accordance with the *Standards of Practice for Registered Nurses*.

1.12 promotes quality practice environments that support best practices and the ability of registered nurses to practise safely, effectively and ethically.

1.13 makes appropriate decisions about the distribution of resources under her/his control.

In addition, the nurse educator:

1.14 promotes a learning environment that supports professional accountability.

1.15 intervenes when learners are not practising in accordance with the *Standards of Practice for Registered Nurses*.

1.16 provides appropriate supervision of learners that supports their ability to provide safe, compassionate, competent and ethical nursing practice.

In addition, the nurse researcher:

1.17 promotes research environments that support professional accountability.

---

[1]*Nurse educator* refers to nurse educators in academic and practice settings.

Standard 2: Knowledge-Based Practice and Competence

Registered nurses continuously attain, maintain and demonstrate competence (knowledge, skill and judgment) relevant to their individual scope of practice.

INDICATORS

Each registered nurse:

2.1 has appropriate competencies to practise safely and provide client-centered care.

2.2 applies a theoretical and/or evidence-informed rationale for decisions.

2.3 uses critical inquiry to assess, plan, intervene, monitor and evaluate client care and related services.

2.4 establishes, maintains and evaluates the nursing component of a plan of care.

2.5 monitors the effectiveness of a plan of care and revises the plan appropriately in collaboration with the healthcare team.

2.6 completes written and/or electronic documentation in a manner that is clear, timely, accurate, comprehensive, legible and chronological, and reflective of relevant observations.

2.7 uses appropriate and effective communication skills.

2.8 demonstrates cultural competence and promotes culturally safe environments for members of the healthcare team and the public.

2.9 demonstrates continuing professional development, including completion of the College's Continuing Competence Program and keeping a record of her/his continuing competence activities.

2.10 promotes practice environments that encourage learning and evidence-informed practice.

2.11 utilizes and integrates current research findings in her/his practice.

In addition, the nurse manager/administrator:

2.12 encourages and supports the integration of research, evidence-informed theory and best practices to enhance client-centered care.

2.13 promotes practice environments that contribute to the ongoing demonstration and evaluation of competencies.

2.14 encourages, supports and promotes practice environments that facilitate engagement in continuous professional development for competent practice.

In addition, the nurse educator:

2.15 promotes learning environments that contribute to the ongoing demonstration and evaluation of competencies.

2.16 encourages and supports learners to engage in continuous learning and professional development for competent practice.

2.17 integrates research findings into educational activities.

In addition, the nurse researcher:

2.18 promotes research environments that support and facilitate research utilization.

2.19 communicates best practice and research findings to others.

2.20 supports and evaluates practice through research activities and the application of evidence-informed knowledge.

Standard 3: Client Relationships and Advocacy

Registered nurses establish professional, therapeutic relationships, using a client-centred approach, and advocate for clients in their relationships with the health system.

INDICATORS

Each registered nurse:

3.1 establishes, maintains and appropriately ends professional, therapeutic relationships with clients.

3.2 maintains appropriate boundaries between professional, therapeutic relationships and non-professional, personal relationships.

3.3 recognizes potential and actual boundary crossings and/or violations, and takes appropriate action.

3.4 demonstrates a professional presence with clients.

3.5 respects clients' diversity (e.g., needs, values, wishes, cultural beliefs, sexual orientation, age, gender) and ensures that this diversity is considered by the healthcare team.

3.6 provides relevant information to clients regarding their health.

3.7 respects and promotes clients' rights to informed decision-making and informed consent.

3.8 protects the privacy and dignity of clients.

3.9 maintains the confidentiality of client and health information gained in the context of a professional relationship, and discloses this information (outside of the healthcare team) only with a client's consent or when there is a specific ethical or legal obligation to do so.

3.10 coordinates resources to promote quality care (e.g., human, physical, educational).

3.11 participates in and supports the development and implementation of policies to ensure that clients' rights are respected.

3.12 respects clients' experiences and perspectives, and works to optimize clients' central role in the care process.

3.13 advocates for practice environments that have organizational and human support systems, as well as resource allocation necessary for safe, quality and ethical care.

In addition, the nurse manager/administrator:

3.14 advocates for systems of care and services that assist nurses to advocate for clients.

3.15 promotes practice environments that support client advocacy and enable nurses to fulfill their advocacy role.

3.16 assists staff to recognize potential and actual boundary crossings and/or violations.

In addition, the nurse educator:

3.17 implements educational activities to assist learners to develop, maintain and enhance therapeutic relationships.

3.18 maintains appropriate professional relationships with learners, recognizing potential authority imbalances between learner and educator.

3.19 assists learners to recognize potential and actual boundary crossings and/or violations.

3.20 promotes learning environments that support client advocacy.

In addition, the nurse researcher:

3.21 communicates evidence-informed and best practice knowledge related to therapeutic client relationships.

3.22 promotes research environments that support the enhancement of client relationships.

Standard 4: Professional Relationships and Leadership

Registered nurses establish professional relationships with healthcare team members and demonstrate leadership to deliver quality nursing and healthcare services.

INDICATORS

Each registered nurse:

4.1 demonstrates leadership in developing strategies to improve client care outcomes.

4.2 coordinates client care and/or health services throughout the continuum of care.

4.3 shares relevant information and knowledge with the healthcare team in a timely manner.

4.4 practises independently and collaboratively as a member of the healthcare team.

4.5 develops and sustains collaborative relationships with members of the healthcare team.

4.6 demonstrates professional judgment and accountability when assigning or delegating interventions to other members of the healthcare team.

4.7 demonstrates professional judgment and accountability when assuming interventions from other members of the healthcare team.

4.8 supports and participates in developing, implementing and evaluating quality initiatives that improve nursing and/or healthcare.

4.9 acts as a role model, resource, preceptor, coach and/or mentor to clients, learners, nursing peers and colleagues.

4.10 articulates the contributions of registered nurses within the healthcare system.

4.11 seeks continuing education opportunities to facilitate growth in leadership skills.

4.12 facilitates healthy work environments based on trust and respect among members of the healthcare team, consistent with the mission, vision and values of her/his agency.

In addition, the nurse manager/administrator:

4.13 promotes healthy violence-free workplace environments in which everyone is treated respectfully.

4.14 participates in the development, implementation and evaluation of policies and programs designed to prevent workplace violence.

4.15 seeks to ensure that available resources and competencies of members of the healthcare team are used efficiently and effectively.

4.16 promotes practice environments that support staff to develop leadership qualities.

4.17 creates practice environments that support consultation among members of the healthcare team.

In addition, the nurse educator:

4.18 facilitates learning environments that encourage learners to further develop expertise and leadership skills.

4.19 role models the development of expertise, leadership, professional qualities and effective interpersonal skills.

4.20 promotes healthy violence-free workplace environments in which everyone is treated respectfully.

In addition, the nurse researcher:

4.21 advances nursing leadership through communicating research and best practice findings.

4.22 communicates evidence-informed and best practice knowledge related to therapeutic client relationships.

Standard 5: Individual Self-Regulation

In addition to the role of the regulator to self-regulate the nursing profession, individual registered nurses are accountable to regulate themselves.

INDICATORS

Each registered nurse:

5.1 practises in accordance with:
- 5.1.1 the Registered Nurses Act, Regulations and By-Laws
- 5.1.2 the CRNNS Standards of Practice for Registered Nurses
- 5.1.3 the CNA Code of Ethics for Registered Nurses
- 5.1.4 other relevant acts and legislation
- 5.1.5 entry-level competencies for registered nurses in Nova Scotia
- 5.1.6 relevant College position statements, guidelines, and other documents
- 5.1.7 competence within individual scope of practice.

5.2 maintains a current licence to practise.

5.3 recognizes and addresses violations of practice, legal and ethical obligations by self or others in a timely and appropriate manner.

5.4 reports to employers and/or appropriate regulatory body concerns related to incompetence, professional misconduct, conduct unbecoming the profession, and/or incapacity of registered nurses and/or other healthcare providers.

5.5 attempts to resolve professional practice issues.

5.6 maintains individual fitness to practise.

5.7 complies with employer and/or agency/facility policies that are not in conflict with the RN Act, Regulations, Code of Ethics and Standards of Practice for Registered Nurses.

In addition, the nurse manager/administrator:

5.8 facilitates staff to work within and comply with their professional, ethical and legal obligations.

5.9 supports and facilitates staff to maintain individual fitness to practise.

5.10 supports staff who reasonably report violations of practice, legal and ethical obligations by self or others to employers or appropriate regulatory body.

In addition, the nurse educator:

5.11 provides education for learners regarding their professional, ethical and legal obligations.

5.12 facilitates education for learners to develop skills in addressing unethical, unprofessional or unsafe practices or behaviours of peers and colleagues.

In addition, the nurse researcher:

5.13 communicates research and best practice knowledge related to self-regulation to other nurses and members of the healthcare team.

Operational Definitions

Accountability: the obligation to acknowledge the professional, ethical, and legal aspects of one's activities and duties, and to answer for the consequences and outcomes of one's actions. Accountability resides in a role and can never be shared or delegated.

Adverse event: an activity/intervention that results in unintended harm to a client, and is related to the care and/or service provided rather than to the client's underlying condition (CPSI, 2008).

Advocacy: actively supporting, protecting and safeguarding clients' rights and interests: an integral component of nursing and also contributes to the foundation of trust inherent in nurse-client relationships.

Agency: facility or organization through which health services are provided or offered (e.g., district health authorities, hospitals, community health centres, physicians' offices, home care programs).

Assignment: allocation of clients or client care activities consistent with an individual provider's scope of practice and/or scope of employment.

Autonomous: the ability to make decisions and the freedom to act independently, in accordance with a registered nurse's professional knowledge, competence and authority.

Boundary: defining line which separates the professional, therapeutic behaviour of a registered nurse from any behaviour which, well-intentioned or not, could harm or could detract from achievable health outcomes for clients or clients receiving appropriate nursing care.

Boundary crossing: a deviation from what a registered nurse knows to be expected professional behaviour; intended to benefit and have no detrimental impact on a client. For a deviation to be considered a crossing, the registered nurse must return to the established limits of the professional, therapeutic relationship within a short period of time.

Boundary violation: a deviation from expected professional behaviour, resulting in a nurse meeting her/his own needs at the expense of a client. Boundary violations are non-therapeutic, non-professional and never acceptable. While boundary crossings may be insignificant in a single instance, there is the potential for them to become boundary violations if the frequency or severity of crossings increases (NCSBN, 1995).

Client(s): the individual, group, community or population who is the recipient of nursing services and, where the context requires, includes a substitute decision-maker for the recipient of nursing services (RN Act, 2006).

Client safety: pursuit of the reduction and mitigation of unsafe acts within the healthcare system, as well as the use of best practices shown to lead to optimal patient outcomes (CPSI, 2007).

Collaborate: building consensus and working together on common goals, processes, and outcomes (CNA, Code of Ethics, 2008).

Communication: the transmission of verbal and/or nonverbal messages between a sender and a receiver for the purpose of exchanging or disseminating meaningful, accurate, clear, concise, complete, and timely information (includes transmission by technological mechanisms).

Compassionate: the ability to convey in speech and body language the hope and intent to relieve the suffering of another. Compassion, which must coexist with competence, is a "relational process that involves noticing another person's pain, experiencing an emotional reaction to his or her pain, and acting in some way to help ease or alleviate the pain" (CNA, Code of Ethics, 2008).

Competence: the ability to integrate and apply the knowledge, skills and judgment required to practise safely and ethically in a designated role and practice setting and includes both entry-level and continuing competencies (RN Act, 2006).

Confidentiality: the ethical obligation to keep someone's personal and private information secret or private (CNA, Code of Ethics, 2008).

Conflict resolution: the various ways in which individuals or institutions address conflict (e.g., interpersonal, work) in order to move toward positive change and growth. Effective conflict resolution requires critical reflection, diplomacy, and respect for diverse perspectives, interests, skills and abilities.

Context of practice: conditions or factors that affect the practice of nursing, including client population, (e.g., age, diagnostic grouping), location of practice setting (e.g., urban, rural), type of practice setting and service delivery model (e.g., acute care, community), level of care required (e.g., complexity, frequency), staffing (e.g., number, competencies); and availability of other resources. In some instances, context of practice could also include factors outside of the healthcare sector (e.g., community resources, justice).

Continuing competence: the ongoing ability of a registered nurse or a nurse practitioner to integrate and apply the knowledge, skills and judgment required to practise safely and ethically in a designated role and setting (RN Act, 2006).

Continuum of care: activities relating to health promotion, illness/injury prevention, curative care, rehabilitative care and supportive care, including palliative care (CRNBC, 2011).

Coordination of care: a legislated function of registered nurses (RN Act, 2006), driven by comprehensive nursing assessments and aimed at achieving optimal health outcomes through team-based activities. The functions of care coordination include establishing relationships with clients and other healthcare professionals; developing written plans of care that reflect mutual goals; arranging and coordinating referrals; providing supportive resource information; building on client strengths; and coordinating client-centred team meetings (Antonelli, R.C. et al 2009).

Critical inquiry: a process of purposeful thinking and reflective reasoning where practitioners examine ideas, assumptions, principles, conclusions, beliefs, and actions in the context of nursing practice. This term expands on the meaning of critical thinking to encompass critical reflection on actions (Brunt, 2005).

Cultural competence: provision of care within the cultural context of a client; congruent behaviours, attitudes and policies that come together to enable effective care in cross-cultural situations.

Cultural safety: recognizing and fostering the cultural expression of clients. Unsafe cultural practice is any action that demeans, diminishes or disempowers a client's cultural identify or well-being.

Delegation: transferring the responsibility to perform a function or intervention to a care provider who would not otherwise have the authority to perform it (i.e., function/intervention is within the delegating provider's scope of practice, but not within that of the care provider to whom it is being delegated). Delegation not does involve transferring accountability for the outcome of the function or intervention.

Determinants of health: the range of social, economic, geographic and systemic factors that influence a person's health status and outcomes (e.g., access to appropriate health services, education, income or social supports).

Diversity: the variation between people in terms of a range of factors such as ethnicity, national origin, race, gender, ability, age, physical characteristics, religion, values, beliefs, sexual orientation, socio-economic class or life experiences (CNA, Code of Ethics, 2008).

Documentation: written or electronically generated information about a client that describes the care (observations, assessment, planning, intervention and evaluation) or service provided to that client.

Evidence-informed practice: practice based on successful strategies that improve client outcomes and are derived from a combination of various sources of evidence, including client perspective, research, national guidelines, policies, consensus statements, expert opinion and quality improvement data (CRNBC, 2005a, 2005b; CHSRF, 2005).

Evolving health system: one that advances the delivery of quality health care by anticipating and proactively addressing changes in client population needs, economic environments, research findings, and technological advancements.

Family: those people identified by a person receiving care or in need of care as providing familial support, whether or not there is a biologic relationship: in matters of legal decision-making it must be noted that provincial legislation is not uniform across Canada and may include an obligation to recognize family members in priority according to their biologic relationship (CNA, Code of Ethics, 2008).

Fitness to practise: the capacity of a registered nurse to practise safely, competently, ethically and compassionately (i.e., not suffering from a medical, physical, mental or emotional condition, disorder or addiction that either renders a registered nurse unable to practise with reasonable skill or judgment or may endanger the health or safety of clients).

Healthcare team: providers from different disciplines (often including both regulated professionals and unregulated workers) working together to provide care for and with individuals, families, groups, populations or communities. (CNA, Code of Ethics, 2008).

Incapacity: status whereby a registered nurse suffers from a medical, physical, mental or emotional condition, disorder or addiction that either renders her/him unable to practise with reasonable skill or judgment or may endanger the health or safety of clients (RN Act, 2006).

Incompetence: display of lack of knowledge, skill or judgment in a registered nurse's care or delivery of nursing services that, having regard to all the circumstances, renders the registered nurse unsafe to practise at the time of such care or delivery of nursing service or to continue to practise without remedial assistance (RN Act, 2006).

Indicators: specific criteria which illustrate how standards of practice are to be applied and met, and against which the actual performance of an individual registered nurse is measured.

Individual scope of practice: the roles, functions, and accountabilities which members of a profession are legislated, educated and authorized to perform. The individual scope of practice for a registered nurse is based on the scope of practice of the nursing profession, and further defined by the registered nurse's specific education, experience, and context of practice (e.g., hospital, community).

Informed consent: a phrase used in law to indicate that the consent given by a person has been based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts at the time consent is given. In some instances, a substitute decision maker may be involved in giving informed consent.

Intervention: a task, procedure, treatment or action with clearly defined limits, which can be assigned or delegated within the context of client care.

Leadership: process of influencing people to accomplish common goals; not limited to formal leadership roles.

Licence or licence to practise nursing: means an active-practising licence, an active-practising licence with conditions or restrictions, a transitional licence, a transitional licence with conditions or restrictions, a nurse practitioner's licence, a nurse practitioner's licence with conditions or restrictions, a temporary licence, a temporary licence with conditions or restrictions, a termpoaray licence (nurse practitioner) or a temporary licence (nurse practitioner) with conditions or restrictions issued in accordance with the RN Act and the regulations (RN Act, 2006).

Managers/administrators: registered nurses in a management or management-like role (e.g., clinical or team leader).

Mentoring: experienced registered nurses (mentors) guiding, counseling and/or teaching novice and other experienced nurse learners (mentees) in their adjustment to new environments, roles and/or responsibilities.

Near miss: an event, situation or error that could have resulted in unwanted consequences, but did not occur because, either by chance or through timely intervention, the event did not reach a client (ISMP, 2009).

Optimal scope of practice: individual practitioners performing at the highest level of their competencies (knowledge, skills and judgment) enabling them to make their greatest contribution to client outcomes.

Plan of care: an individualized, comprehensive and current guide to clinical care designed to identify and meet clients' healthcare needs; developed by registered nurses in collaboration with other members of the healthcare team, including clients. These plans serve as vehicles to communicate, monitor and track progress.

Professional misconduct: includes such conduct or acts relevant to the profession that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonorable or unprofessional (RN Act, 2006).

Professional practice issue: any issue or situation that poses a risk for either clients or registered nurses and/or compromises a registered nurse's ability to provide care/services consistent with the *Standards of Practice for Registered Nurses*, Code of Ethics, and other standards, guidelines, or policies.

Professional presence: demonstration of respect, confidence, integrity, optimism, passion, and empathy, in accordance with professional standards, guidelines and codes of ethics; includes a registered nurse's verbal and nonverbal communications and the ability to articulate a positive role and professional image, including the use of full name and title.

Quality improvement: an ongoing process of establishing indicators of quality, monitoring performance against indicators, and utilizing findings to make improvements (CRNBC, 2009).

Reasonable: a comparison of the practice of one registered nurse with that of another with similar education and experience.

Reflective thought/practice: a deliberate attempt to enhance personal growth and continuing professional competence by analyzing and evaluating aspects of one's nursing practice, as well as personal values, beliefs and experiences.

Responsibility: an activity, behaviour or intervention expected or required to be performed within a professional role and/or position: may be shared, delegated or assigned.

Scope of employment: range of responsibilities defined by an employer through job descriptions and policies: must be within practitioner's legislated scope of practice.

Scope of practice: the roles, functions and accountabilities which members of a profession are legislated, educated and authorized to perform. In Nova Scotia, the scope of practice of registered nurses is defined within the *Registered Nurses Act*.

Self-regulation: the relative autonomy by which a profession is practised within the context of public accountability to serve and protect the public interest.

Standards: authoritative statements that promote, guide, direct and regulate professional nursing practice: describe the desirable and achievable level of performance expected of all registered nurses, including nurse practitioners, against which actual performance can be measured.

Standards for nursing practice: the minimal professional practice expectations for any registered nurse in any setting or role, approved by Council or otherwise inherent in the nursing profession (RN Act, 2006).

Therapeutic relationship: a purposeful, goal-directed relationship between a registered nurse and a client that is based on trust and respect and, ultimately, protects the client's best interests: central to all nursing practice.

Timely: ensuring that a response or action occurs within a timeframe required to achieve safe, effective and positive client outcomes.

References

Brunt, B.A. (2005). Critical thinking in nursing: An integrated review. *The Journal of Continuing Education in nursing*, 36(2), 60-67.

Canadian Health Service Research Foundation. (2005). How CHSRF defines evidence. Links, 8(3), 1-8. Retrieved July 27, 2011, from http://www.chsrf.ca/PublicationsAndResources/Mythbusters/MythbustersTeachingResources/SearchingForEvidence.aspx

Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. Ottawa: Author.

Canadian Patient Safety Institute. (2008). *Canadian disclosure guidelines*. May. Edmonton: Author.

College of Registered Nurses of British Columbia. (2005a). *Scope of practice for registered nurses: Standards, limits and conditions*. (Pub.No.433). Vancouver: Author.

College of Registered Nurses of British Columbia. (2005b). *Position Statement: nursing and research*. (Pub.No. 94). Vancouver: Author.

College of Registered Nurses of British Columbia. (2009). Glossary. Retrieved July 25, 2011 from https://www.crnbc.ca/Glossary/Pages/Default.aspx

Davies, J.M., Hebert, P., & Hoffman, C. Cited in *Draft National Guidelines for the Disclosure of Adverse Events*, CPSI, 2007.

Institute for Safe Medication Practice. (2009). *ISMP survey helps define near miss and close call*. Sept 24. Retrieved July 25, 2011 from: http://search.ismp.org/cgi-bin/hits.pl?in=517791&fh=80&ph=1&tk=srPVJ%20QLvv%20QLv%26v%20kPeLrLXLFr%20kPeLrLXLFr%26v%20kPeLrLXLFrv&su=mEFFpSzzJJJ.qQup.L%3AVzwWJQeWFFW%3AQz-%3F_FW%3F-%3AWz-%3AFq%3FeWQz20090924.-Qp&qy=mwW-%3A%20uqQQ%20%26WKqwqFqLw&pd=1

National Council of State Boards of Nursing. (2005). *Respecting professional boundaries CE course*. Retrieved from http://learningext.com/hives/03fbf38973/summary

National Professional Regulatory Standards Committee. (2010). *The development of national professional regulatory standards phase two committee report to the executive director counterparts*. November: Author.

Registered Nurses Act, c. 21. (2006). Statutes of Nova Scotia. Halifax, NS: Government of Nova Scotia.

Bibliography

Accreditation Canada. (2007). Quality moves from theory to practice in healthcare. Retrieved July 25, 2011, from http://www.accreditation.ca/en/news.aspx?id=174&terms=Quality+Improvement+and+Client+centered+Accreditation+Program.

Canadian Nurses Association. (2002). *Position Statement: Evidence-based decision-making and nursing practice*. Ottawa: Author.

Canadian Nurses Association. (2004). *Position Statement: Promoting culturally competent care*. Ottawa: Author.

Canadian Nurses Association. (2006). *Position Statement: Practice environments: Maximizing client, nurse and system outcomes*. Ottawa: Author.

Canadian Nurses Association. (2007). *Framework for the practice of registered nurses in Canada*. Ottawa: Author.

Canadian Nurses Association. (2009). *Position Statement: nursing leadership*. Ottawa: Author.

Canadian Nurses Association. (2010). *Position Statement: Spirituality, health and nursing practice*. Ottawa: Author.

Canadian Nurses Association. (2011). *Invitational roundtable nursing care delivery models and staff mix: using evidence in decision-making*. Ottawa: Author. Retrieved July 27, 2011, from http://www.cna-aiic.ca/CNA/documents/pdf/publications/Roundtable_Report_Evidence_Decision_e.pdf

College of Nurses of Ontario. (2009). *Practice Guideline: Consent*. Toronto: Author.

Canadian Nurses Protective Society. (2008). *Confidentiality of health information*. infoLAW, Vol1: No2. Ottawa: Author.

Canadian Patient Safety Institute. (2009). *The safety competencies*. First Edition revised Aug. Edmonton: Author. Retrieved July 25, 2011, from http://www.patientsafetyinstitute.ca/English/toolsResources/safetyCompetencies/DocumentsSafety%20Competencies.pdf

College & Association of Registered Nurses of Alberta. (2003). *Nursing practice standards*. Edmonton: Author.

College of Registered Nurses of Nova Scotia. (2004). *Standards for nursing practice*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2005). *Documentation guidelines for registered nurses*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2006). *Promoting culturally competent care*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2007). *Quality nursing practice environments*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2008). *Position Statement: Interprofessional collaborative practice*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2008). *Position Statement: Professionalism and registered nurses in Nova Scotia*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2009). *Entry-level competencies for registered nurses in Nova Scotia*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2011). *Guidelines for delegated medical functions and care directives*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2011). *Professional expectations and boundaries for nurse-client relationships: Guidelines for registered nurses*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2011). *Professional practice issues resolution framework*. Halifax: Author.

College of Registered Nurses of Nova Scotia. (2012). *Nurse Practitioner Standards of Practice*. Halifax: Author.

Fry, B. J. (2010). *Fast Facts for the Clinical Nurse Manager: Managing a Changing Workplace in a Nutshell*. New York: Springer.

Registered Nurses Act, c. 21. (2006). Statutes of Nova Scotia. Halifax, NS: Government of Nova Scotia.

Registered Nurses Association of Ontario. (2006). *Establishing therapeutic relationships. Nursing best practice guidelines supplement*. Toronto: Author

Registered Nurses Association of Ontario. (2006). *Best practice guidelines for collaborative practice among nursing teams*. Toronto: Author.

Registered Nurses Association of Ontario. (2010). *The healthy work environments quick reference guide for nurse managers*. Toronto: Author.

Registered Nurses Regulations. (2009). Made under Section 8 of the *Registered Nurses Act*, c. 21, 2006. Halifax, NS: Government of Nova Scotia.

Ross-Kerr, J.C., & Wood, M. J. (2011). *Canadian Nursing: Issues and Perspectives*. 5th Ed. Toronto: Mosby.

Standards of Practice for Registered Nurses (Effective January 16, 2012)

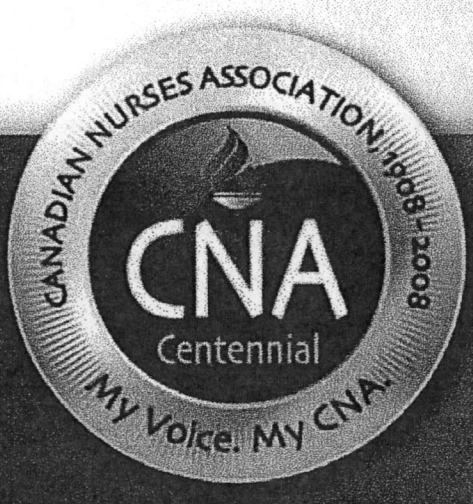
First printing (1983)
Revisions (1996/2003/2011)

College of Registered Nurses of Nova Scotia
4005-7071 Bayers Road
Halifax, NS B3L 2C2

Tel 902.491.9744
Toll-free (NS) 1.800.565.9744
Fax 902.491.9510
Email info@crnns.ca
Website www.crnns.ca

CODE OF Ethics

FOR REGISTERED NURSES



2008 CENTENNIAL EDITION

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

50 Driveway
Ottawa, ON K2P 1E2

Tel.: 613-237-2133 or 1-800-361-8404
Fax: 613-237-3520
www.cna-aiic.ca

June 2008

ISBN 978-1-55119-182-9

CONTENTS

PREAMBLE

The Canadian Nurses Association's *Code of Ethics for Registered Nurses*[1] is a statement of the ethical[2] **values**[3] of **nurses** and of nurses' commitments to persons with health-care needs and **persons receiving care**. It is intended for nurses in all contexts and domains of nursing practice[4] and at all levels of decision-making. It is developed by nurses for nurses and can assist nurses in practising ethically and working through ethical challenges that arise in their practice with individuals, **families**, communities and public health systems.

The societal context in which nurses work is constantly changing and can be a significant influence on their practice. The quality of the work environment in which nurses practise is also fundamental to their ability to practise ethically. The code of ethics is revised periodically (see Appendix A) to ensure that it is attuned to the needs of nurses by reflecting changes in social values and conditions that affect the public, nurses and other **health-care providers**, and the health-care system (see Appendix B for a list of societal changes envisioned to affect nursing practice in the coming decade). Periodic revisions also promote lively dialogue and create greater awareness of and engagement with ethical issues among nurses in Canada.

Purpose of the Code

The *Code of Ethics for Registered Nurses* serves as a foundation for nurses' ethical practice. The specific values and ethical responsibilities expected of registered nurses in Canada are set out in part I. Endeavours that nurses may undertake to address social **inequities** as part of ethical practice are outlined in part II.

---

[1] In this document, the terms *registered nurse* and *nurse* include nurses who are registered or licensed in extended roles, such as nurse practitioners.

[2] In this document, the terms *moral* and *ethical* are used interchangeably based upon consultation with nurse ethicists and philosophers. We acknowledge that not everyone concurs in this usage.

[3] Words or phrases in bold print are found in the glossary. They are shown in bold only on first appearance.

[4] In this document, *nursing practice* refers to all areas of nursing practice, including direct care (which includes community and public health), education, administration, research and policy development.

The code provides guidance for ethical relationships, responsibilities, behaviours and decision-making, and it is to be used in conjunction with the professional standards, laws and regulations that guide practice.

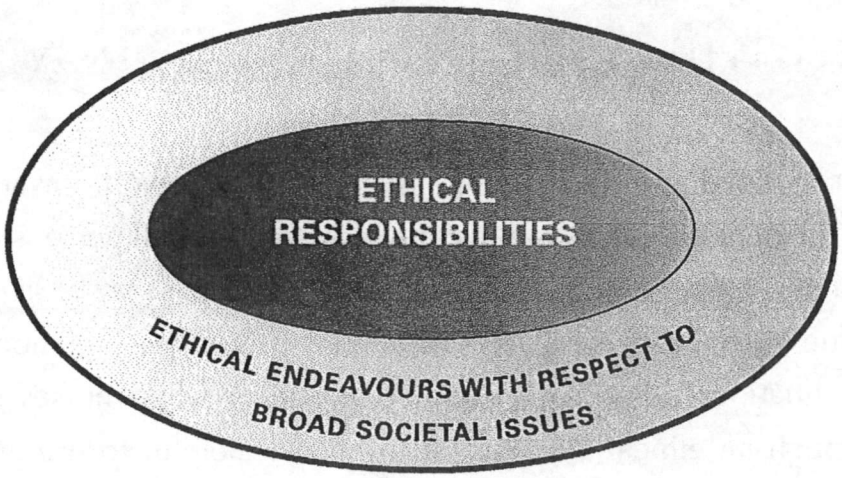
It serves as a means of self-evaluation and self-reflection for ethical nursing practice and provides a basis for feedback and peer review. The code also serves as an ethical basis from which nurses can **advocate** for **quality work environments** that support the delivery of safe, **compassionate**, competent and ethical care.

Nurses recognize the privilege of being part of a self-regulating profession and have a responsibility to merit this privilege. The code informs other health-care professionals as well as members of the public about the ethical commitments of nurses and the responsibilities nurses accept as being part of a self-regulating profession.

Foundation of the Code

Ethical nursing practice involves core ethical responsibilities that nurses are expected to uphold. Nurses are accountable for these ethical responsibilities in their professional relationships with individuals, families, groups, populations, communities and colleagues.

As well, nursing **ethics** is concerned with how broad societal issues affect **health** and **well-being**. This means that nurses endeavour to maintain awareness of aspects of **social justice** that affect health and well-being and to advocate for change. Although these endeavours are not part of nurses' core ethical responsibilities, they are part of ethical practice and serve as a helpful motivational and educational tool for all nurses.



The code is organized in two parts:

PART I: Part I, "Nursing Values and Ethical Responsibilities," describes the core responsibilities central to ethical nursing practice. These ethical responsibilities are articulated through seven primary values and accompanying responsibility statements, which are grounded in nurses' professional relationships with individuals, families, groups, populations and communities as well as with students, colleagues and other health-care professionals. The seven primary values are:

1. Providing safe, compassionate, competent and ethical care
2. Promoting health and well-being
3. Promoting and respecting informed decision-making
4. Preserving dignity
5. Maintaining **privacy** and **confidentiality**
6. Promoting **justice**
7. Being accountable

PART II: Ethical nursing practice involves endeavouring to address broad aspects of social justice that are associated with health and well-being. Part II, "Ethical Endeavours," describes endeavours that nurses can undertake to address social inequities.

USING THE CODE IN NURSING PRACTICE

Values are related and overlapping. It is important to work toward keeping in mind all of the values in the code at all times for all persons in order to uphold the dignity of all. In health-care practice, values may be in conflict. Such value conflicts need to be considered carefully in relation to the practice situation. When such conflicts occur, or when nurses need to think through an ethical situation, many find it helpful to use an ethics model for guidance in ethical reflection, questioning and decision-making (see Appendix C).

Nursing practice involves both legal and ethical dimensions. Still, the law and ethics remain distinct. Ideally, a system of law would be completely compatible with the values in this code. However, there may be situations in which nurses need to **collaborate** with others to change a law or policy that is incompatible with ethical practice. When this occurs, the code can guide and support nurses in advocating for changes to law, policy or practice. The code can be a powerful political instrument for nurses when they are concerned about being able to practise ethically.

Nurses are responsible for the ethics of their practice. Given the complexity of ethical situations, the code can only outline nurses' ethical responsibilities and guide nurses in their reflection and decision-making. It cannot ensure ethical practice. For ethical practice, other elements are necessary, such as a commitment to do good; sensitivity and receptiveness to ethical matters; and a willingness to enter into relationships with persons receiving care and with groups, populations and communities that have health-care needs and problems. Practice environments have a significant influence on nurses' ability to be successful in upholding the ethics of their practice. In addition, nurses' self-reflection and dialogue with other nurses and health-care providers are essential components of ethical nursing practice. The importance of the work environment and of reflective practice is highlighted below.

Quality Work Environments

Nurses as individuals and as members of groups advocate for practice settings that maximize the quality of health outcomes for persons receiving care, the health and well-being of nurses, organizational performance and societal outcomes (Registered Nurses' Association of Ontario [RNAO], 2006). Such practice environments have the organizational structures and resources necessary to ensure safety, support and respect for all persons in the work setting. Other health-care providers, organizations and policy-makers at regional, provincial/territorial, national and international levels strongly influence ethical practice.

Nurses' Self-Reflection and Dialogue

Quality work environments are crucial to ethical practice, but they are not enough. Nurses need to recognize that they are **moral agents** in providing care. This means that they have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care. Nurses in all facets of the profession need to reflect on their practice, on the quality of their interactions with others and on the resources they need to maintain their own well-being. In particular, there is a pressing need for nurses to work with others (i.e., other nurses, other health-care professionals and the public) to create the **moral communities** that enable the provision of safe, compassionate, competent and ethical care.

Nursing ethics encompasses the breadth of issues involved in health-care ethics, but its primary focus is the ethics of the everyday. How nurses attend to ethics in carrying out their daily interactions, including how they approach their practice and reflect on their ethical commitment to the people they serve, is the substance of **everyday ethics**.

In their practice, nurses experience situations involving ethics. The values and responsibility statements in the code are intended to assist nurses in working through these experiences within the context of their unique practice situations.

Types of Ethical Experiences and Situations

When nurses can name the type of ethical concern they are experiencing, they are better able to discuss it with colleagues and supervisors, take steps to address it at an early stage, and receive support and guidance in dealing with it. Identifying an ethical concern can often be a defining moment that allows positive outcomes to emerge from difficult experiences. There are a number of terms that can assist nurses in identifying and reflecting on their ethical experiences and discussing them with others:[5]

Ethical problems involve situations where there are conflicts between one or more values and uncertainty about the correct course of action. Ethical problems involve questions about what is right or good to do at individual, interpersonal, organizational and even societal levels.

Ethical (or moral) uncertainty occurs when a nurse feels indecision or a lack of clarity, or is unable to even know what the moral problem is, while at the same time feeling uneasy or uncomfortable.

Ethical dilemmas or questions arise when there are equally compelling reasons for and against two or more possible courses of action, and where choosing one course of action means that something else is relinquished or let go. True dilemmas are infrequent in health care. More often, there are complex ethical problems with multiple courses of actions from which to choose.

Ethical (or moral) distress arises in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and **integrity** as moral agents are affected and they feel moral distress.

[5] These situations are derived from CNA, 2004b; Fenton, 1988; Jameton, 1984; and Webster & Baylis, 2000.

Ethical (or moral) residue is what nurses experience when they seriously compromise themselves or allow themselves to be compromised. The moral residue that nurses carry forward from these kinds of situations can help them reflect on what they would do differently in similar situations in the future.

Ethical (or moral) disengagement can occur if nurses begin to see the disregard of their ethical commitments as normal. A nurse may then become apathetic or disengage to the point of being unkind, non-compassionate or even cruel to other health-care workers and to persons receiving care.

Ethical violations involve actions or failures to act that breach fundamental duties to the persons receiving care or to colleagues and other health-care providers.

Ethical (or moral) courage is exercised when a nurse stands firm on a point of moral principle or a particular decision about something in the face of overwhelming fear or threat to himself or herself.

PART I: NURSING VALUES AND ETHICAL RESPONSIBILITIES

Nurses in all domains of practice bear the ethical responsibilities identified under each of the seven primary nursing values.[6] These responsibilities apply to nurses' interactions with individuals, families, groups, populations, communities and society as well as with students, colleagues and other health-care professionals. The responsibilities are intended to help nurses apply the code. They also serve to articulate nursing values to employers, other health-care professionals and the public. Nurses help their colleagues implement the code, and they ensure that student nurses are acquainted with the code.

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care as well as with families, communities, groups, populations and other members of the **health-care team**.

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

3. Nurses build trustworthy relationships as the foundation of meaningful communication, recognizing that building these relationships involves a conscious effort. Such relationships are critical to understanding people's needs and concerns.

[6] The value and responsibility statements in the code are numbered and lettered for ease of use, not to indicate prioritization. The values are related and overlapping..

4. Nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same. See Appendix D.

5. Nurses admit mistakes[7] and take all necessary actions to prevent or minimize harm arising from an **adverse event**. They work with others to reduce the potential for future risks and preventable harms. See Appendix D.

6. When resources are not available to provide ideal care, nurses collaborate with others to adjust priorities and minimize harm. Nurses keep persons receiving care, families and employers informed about potential and actual changes to delivery of care. They inform employers about potential threats to safety.

7. Nurses planning to take job action or practising in environments where job action occurs take steps to safeguard the health and safety of people during the course of the job action. See Appendix D.

8. During a natural or human-made disaster, including a communicable disease outbreak, nurses have a **duty to provide care** using appropriate safety precautions. See Appendix D.

9. Nurses support, use and engage in research and other activities that promote safe, competent, compassionate and ethical care, and they use guidelines for ethical research[8] that are in keeping with nursing values.

10. Nurses work to prevent and minimize all forms of **violence** by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk to protect others and themselves.

---

[7] Provincial and territorial legislation and nursing practice standards may include further direction regarding requirements for disclosure and reporting.

[8] See *Ethical Research Guidelines for Registered Nurses* (CNA, 2002) and the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council, 1998).

B. Promoting Health and Well-Being

Nurses work with people to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of the person, family or community in their care.
2. When a community health intervention interferes with the individual rights of persons receiving care, nurses use and advocate for the use of the least restrictive measures possible for those in their care.
3. Nurses collaborate with other health-care providers and other interested parties to maximize health benefits to persons receiving care and those with health-care needs, recognizing and respecting the knowledge, skills and perspectives of all.

C. Promoting and Respecting Informed Decision-Making

Nurses recognize, respect and promote a person's right to be informed and make decisions.

Ethical responsibilities:

1. Nurses, to the extent possible, provide persons in their care with the information they need to make informed decisions related to their health and well-being. They also work to ensure that health information is given to individuals, families, groups, populations and communities in their care in an open, accurate and transparent manner.

2. Nurses respect the wishes of **capable** persons to decline to receive information about their health condition.

3. Nurses recognize that capable persons may place a different weight on individualism and may choose to defer to family or community values in decision-making.

4. Nurses ensure that nursing care is provided with the person's **informed consent**. Nurses recognize and support a capable person's right to refuse or withdraw **consent** for care or treatment at any time.

5. Nurses are sensitive to the inherent power differentials between care providers and those receiving care. They do not misuse that power to influence decision-making.

6. Nurses advocate for persons in their care if they believe that the health of those persons is being compromised by factors beyond their control, including the decision-making of others.

7. When family members disagree with the decisions made by a person with health-care needs, nurses assist families in gaining an understanding of the person's decisions.

8. Nurses respect the informed decision-making of capable persons, including choice of lifestyles or treatment not conducive to good health.

9. When illness or other factors reduce a person's capacity for making choices, nurses assist or support that person's participation in making choices appropriate to their capability.

10. If a person receiving care is clearly **incapable** of consent, the nurse respects the law on capacity assessment and substitute decision-making in his or her jurisdiction (Canadian Nurses Protective Society [CNPS], 2004).

11. Nurses, along with other health-care professionals and with **substitute decision-makers**, consider and respect the best interests of the person receiving care and any previously known wishes or **advance directives** that apply in the situation (CNPS, 2004).

D. Preserving Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

1. Nurses, in their professional capacity, relate to all persons with respect.

2. Nurses support the person, family, group, population or community receiving care in maintaining their dignity and integrity.

3. In health-care decision-making, in treatment and in care, nurses work with persons receiving care, including families, groups, populations and communities, to take into account their unique values, customs and spiritual beliefs, as well as their social and economic circumstances.

4. Nurses intervene, and report when necessary,[9] when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behaviour. See Appendix D.

5. Nurses respect the physical privacy of persons by providing care in a discreet manner and by minimizing intrusions.

6. When providing care, nurses utilize practice standards, best practice guidelines and policies concerning restraint usage.

7. Nurses maintain appropriate professional **boundaries** and ensure their relationships are always for the benefit of the persons they serve. They recognize the potential vulnerability of persons and do not exploit their trust and dependency in a way that might compromise the therapeutic relationship. They do not abuse their relationship for personal or financial gain, and do not enter into personal relationships (romantic, sexual or other) with persons in their care.

[9] See footnote 7.

8. In all practice settings, nurses work to relieve pain and suffering, including appropriate and effective symptom and pain management, to allow persons to live with dignity.

9. When a person receiving care is terminally ill or dying, nurses foster comfort, alleviate suffering, advocate for adequate relief of discomfort and pain and support a dignified and peaceful death. This includes support for the family during and following the death, and care of the person's body after death.

10. Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way. See Appendix D.

E. Maintaining Privacy and Confidentiality

Nurses recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship.

Ethical responsibilities:

1. Nurses respect the right of people to have control over the collection, use, access and disclosure of their personal information.
2. When nurses are conversing with persons receiving care, they take reasonable measures to prevent confidential information in the conversation from being overheard.
3. Nurses collect, use and disclose health information on a need-to-know basis with the highest degree of anonymity possible in the circumstances and in accordance with privacy laws.
4. When nurses are required to disclose information for a particular purpose, they disclose only the amount of information necessary for that purpose and inform only those necessary. They attempt to do so in ways that minimize any potential harm to the individual, family or community.
5. When nurses engage in any form of communication, including verbal or electronic, involving a discussion of clinical cases, they ensure that their discussion of persons receiving care is respectful and does not identify those persons unless appropriate.
6. Nurses advocate for persons in their care to receive access to their own health-care records through a timely and affordable process when such access is requested.
7. Nurses respect policies that protect and preserve people's privacy, including security safeguards in information technology.

8. Nurses do not abuse their access to information by accessing health-care records, including their own, a family member's or any other person's, for purposes inconsistent with their professional obligations.

9. Nurses do not use photo or other technology to intrude into the privacy of a person receiving care.

10. Nurses intervene if others inappropriately access or disclose personal or health information of persons receiving care.

F. Promoting Justice

Nurses uphold principles of justice by safeguarding **human rights**, equity and **fairness** and by promoting the public good.

Ethical responsibilities:

1. When providing care, nurses do not discriminate on the basis of a person's race, ethnicity, **culture**, political and spiritual beliefs, social or marital status, gender, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability or socio-economic status or any other attribute.

2. Nurses refrain from judging, labelling, demeaning, stigmatizing and humiliating behaviours toward persons receiving care, other health-care professionals and each other.

3. Nurses do not engage in any form of lying, punishment or torture or any form of unusual treatment or action that is inhumane or degrading. They refuse to be complicit in such behaviours. They intervene, and they report such behaviours.

4. Nurses make fair decisions about the allocation of resources under their control based on the needs of persons, groups or communities to whom they are providing care. They advocate for fair treatment and for fair distribution of resources for those in their care.

5. Nurses support a climate of trust that sponsors openness, encourages questioning the status quo and supports those who speak out to address concerns in good faith (e.g., **whistle-blowing**).

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the *Code of Ethics for Registered Nurses* and in keeping with the professional standards, laws and regulations supporting ethical practice.

2. Nurses are honest and practise with integrity in all of their professional interactions.

3. Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, seek help from their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurse is available.

4. Nurses maintain their **fitness to practise**. If they are aware that they do not have the necessary physical, mental or emotional capacity to practise safely and competently, they withdraw from the provision of care after consulting with their employer or, if they are self-employed, arranging that someone else attend to their clients' health-care needs. Nurses then take the necessary steps to regain their fitness to practise.

5. Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform his or her duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care. See Appendix D.

6. Nurses clearly and accurately represent themselves with respect to their name, title and role.

7. If nursing care is requested that is in conflict with the nurse's moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person's needs or desires. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers or, if the nurse is self-employed, persons receiving care in advance so that alternative arrangements can be made. See Appendix D.

8. Nurses identify and address conflicts of interest. They disclose actual or potential conflicts of interest that arise in their professional roles and relationships and resolve them in the interest of persons receiving care.

9. Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other health-care team members. See Appendix D.

PART II: ETHICAL ENDEAVOURS

There are broad aspects of social justice that are associated with health and well-being and that ethical nursing practice addresses. These aspects relate to the need for change in systems and societal structures in order to create greater **equity** for all. Nurses should endeavour as much as possible, individually and collectively, to advocate for and work toward eliminating social inequities by:

i. Utilizing the principles of **primary health care** for the benefit of the public and persons receiving care.

ii. Recognizing and working to address organizational, social, economic and political factors that influence health and well-being within the context of nurses' role in the delivery of care.

iii. In collaboration with other health-care team members and professional organizations, advocating for changes to unethical health and social policies, legislation and regulations.

iv. Advocating for a full continuum of accessible health-care services to be provided at the right time and in the right place. This continuum includes **health promotion**, disease prevention and diagnostic, restorative, rehabilitative and palliative care services in hospitals, nursing homes, home care and the community.

v. Recognizing the significance of **social determinants of health** and advocating for policies and programs that address these determinants.

vi. Supporting environmental preservation and restoration and advocating for initiatives that reduce environmentally harmful practices in order to promote health and well-being.

vii. Working with individuals, families, groups, populations and communities to expand the range of health-care choices available, recognizing that some people have limited choices because of social, economic, geographic or other factors that lead to inequities.

viii. Understanding that some groups in society are systemically disadvantaged, which leads to diminished health and well-being. Nurses work to improve the quality of lives of people who are part of disadvantaged and/or **vulnerable groups** and communities, and they take action to overcome barriers to health care.

ix. Advocating for health-care systems that ensure accessibility, universality and comprehensiveness of necessary health-care services.

x. Maintaining awareness of major health concerns such as poverty, inadequate shelter, food insecurity and violence. Nurses work individually and with others for social justice and to advocate for laws, policies and procedures designed to bring about equity.

xi. Maintaining awareness of broader **global health** concerns such as violations of human rights, war, world hunger, gender inequities and environmental pollution. Nurses work individually and with others to bring about social change.

xii. Advocating for the discussion of ethical issues among health-care team members, persons in their care, families and students. Nurses encourage ethical reflection, and they work to develop their own and others' heightened awareness of ethics in practice. See Appendix C.

xiii. Working collaboratively to develop a moral community. As part of the moral community, all nurses acknowledge their responsibility to contribute to positive, healthy work environments.

GLOSSARY

The glossary is intended to provide nurses with a common language for their reflections and discussions about nursing ethics. It may also be instructive, since nurses who read the glossary terms are more likely to investigate these concepts further, especially if they are unfamiliar. The glossary does not necessarily provide formal definitions of terms, but rather it presents information in a manner and language that is meant to be helpful and accessible. Some terms in the glossary are not included in the main body of the code but are in the appendices, others may not appear exactly as noted in the text, and others may not be included in the text but may be useful to nurses in their ethical reflection and practice.

ADVANCE DIRECTIVES: a person's written wishes about how and what decisions should be made if they become incapable of making decisions for themselves. In decisions about life-sustaining treatment, advance directives are meant to assist with decisions about withholding or withdrawing treatment. Also called living wills or personal directives.

ADVERSE EVENTS: unexpected, undesirable incidents resulting in injury or death that are directly associated with the process of providing health care or health services to a person receiving care (Hebert, Hoffman & Davies, 2003).

ADVOCATE: actively supporting a right and good cause; supporting others in speaking for themselves or speaking on behalf of those who cannot speak for themselves

BOUNDARIES: a boundary in the nurse-person relationship is the point at which the relationship changes from professional and therapeutic to unprofessional and personal (College and Association of Registered Nurses of Alberta [CARNA], 2005a).

CAPABLE: being able to understand and appreciate the consequences of various options and make informed decisions about one's own care and treatment.

COLLABORATE: building consensus and working together on common goals, processes and outcomes (RNAO, 2006).

COMPASSIONATE: the ability to convey in speech and body language the hope and intent to relieve the suffering of another. Compassion must coexist with competence. "Compassion is a relational process that involves noticing another person's pain, experiencing an emotional reaction to his or her pain, and acting in some way to help ease or alleviate the pain" (Dutton, Lilius & Kanov, 2007).

COMPETENCY: the integrated knowledge, skills, judgment and attributes required of a registered nurse to practise safely and ethically in a designated role and setting. (Attributes include, but are not limited to, attitudes, values and beliefs.)

CONFIDENTIALITY: the ethical obligation to keep someone's personal and private information secret or private (Fry & Johnstone, 2002).

CONFLICT OF INTEREST: occurs when a nurse's personal or private interests interfere with the interests of a person receiving care or with the nurse's own professional responsibilities (College of Registered Nurses of British Columbia [CRNBC], 2006c).

CONSENT: *See Informed consent.*

CONSCIENTIOUS OBJECTION: a situation in which a nurse requests permission from his or her employer to refrain from providing care because a practice or procedure conflicts with the nurse's moral or religious beliefs (CRNBC, 2007).

CULTURES: the processes that happen between individuals and groups within organizations and society, and that confer meaning and significance; the health-care system has its own culture(s) (Varcoe & Rodney, 2002).

DETERMINANTS OF HEALTH: these include income and social status, social support, education and literacy, employment and working conditions, physical and social environments, biology, genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture (Public Health Agency of Canada, 2003).

DIVERSITY: the variation between people in terms of a range of factors such as ethnicity, national origin, race, gender, ability, age, physical characteristics, religion, values, beliefs, sexual orientation, socio-economic class or life experiences (RNAO, 2007a).

DUTY TO PROVIDE CARE: Nurses have a professional duty and a legal obligation to provide persons receiving care with safe, competent, compassionate and ethical care. There may be some circumstances in which it is acceptable for a nurse to withdraw from care provisions or to refuse to provide care (CRNBC, 2007; College of Registered Nurses of Nova Scotia [CRNNS], 2006a). See Appendix D.

EQUITABLE: determining fairness on the basis of people's needs.

EQUITY: in health care, the fulfillment of each individual's needs as well as the individual's opportunity to reach full potential as a human being (Canadian Nurses Association [CNA], 2006).

ETHICS: the moral practices, beliefs and standards of individuals and/or groups (Fry & Johnstone, 2002).

EVERYDAY ETHICS: how nurses pay attention to ethics in carrying out their common daily interactions, including how they approach their practice and reflect on their ethical commitments to persons receiving care and those with health-care needs.

FAIRNESS: equalizing people's opportunities to participate in and enjoy life, given their circumstances (Caplan, Light & Daniels, 1999), and society's equitable distribution of resources (in health care this means an expectation of equitable treatment).

FAMILY/FAMILIES: In matters of caregiving, family is recognized to be those people identified by the person receiving care or in need of care as providing familial support, whether or not there is a biologic relationship. However, in matters of legal decision-making it must be noted that provincial legislation is not uniform across Canada and may include an obligation to recognize family members in priority according to their biologic relationship (CNA, 1994).

FITNESS TO PRACTISE: all the qualities and capabilities of an individual relevant to his or her capacity to practise as a registered nurse, including, but not limited to, freedom from any cognitive, physical, psychological or emotional condition and dependence on alcohol or drugs that impairs his or her ability to practise nursing (CRNBC, 2006a; CRNNS, 2006b).

GLOBAL HEALTH: the optimal well-being of all humans from the individual and the collective perspective. Health is considered a fundamental right and should be equally accessible by all (CNA, 2003).

HEALTH: a state of complete physical, mental (spiritual) and social well-being, not merely the absence of disease (CNA, 2007; World Health Organization [WHO], 2006).

HEALTH-CARE PROVIDERS: all those who are involved in providing care; they may include professionals, personal care attendants, home support workers and others (CNA, 1994).

HEALTH-CARE TEAM: a number of health-care providers from different disciplines (often including both regulated professionals and unregulated workers) working together to provide care for and with individuals, families, groups, populations or communities.

HEALTH PROMOTION: a continuing process of enabling people to increase their control over and improve their health and well-being.

HUMAN RIGHTS: the rights of people as expressed in the *Canadian Charter of Rights and Freedoms* (1982) and the *United Nations Universal Declaration of Human Rights* (1948), and as recorded in the CNA position statement *Registered Nurses and Human Rights* (CNA, 2004a).

INCAPABLE/INCAPACITY: failing to understand the nature of the treatment decisions to be made, as well as the consequences of consenting to treatment or declining treatment.

INEQUITY: an instance of unjust or unfair treatment of each individual's needs; health inequity means a lack of equitable access and opportunity for all people to meet their health needs and potential (CNA, 2006).

INFORMED CONSENT: the process of giving permission or making choices about care. It is based on both a legal doctrine and an ethical principle of respect for an individual's right to sufficient information to make decisions about care, treatment and involvement in research. In the code, the term *informed decision-making* is primarily used to emphasize the choice involved.

INTEGRITY: (1) for persons receiving care, integrity refers to wholeness, and protecting integrity can mean helping them to become whole and complete again; (2) for health-care providers, showing integrity means consistently following accepted moral norms. Implicit in integrity is soundness, trustworthiness and consistency of convictions, actions and emotions (Burkhart & Nathaniel, 2002).

INTERDISCIPLINARY: the integration of concepts across different disciplines. An interdisciplinary team is a team of people with training in different fields: such teams are common in complex environments such as health care (RNAO, 2007b) and may also be referred to as interprofessional teams.

INTERSECTORAL: all sectors of society (government, community and health).

JUSTICE: includes respecting the rights of others, distributing resources fairly, and preserving and promoting the common good (the good of the community).

MORAL AGENT/AGENCY: the capacity or power of a nurse to direct his or her motives and actions to some ethical end; essentially, doing what is good and right.

MORAL CLIMATE: in health care, the implicit and explicit values that drive health-care delivery and shape the workplaces in which care is delivered (Rodney, Hartrick Doane, Storch & Varcoe, 2006).

MORAL COMMUNITY: a workplace where values are made clear and are shared, where these values direct ethical action and where individuals feel safe to be heard (adapted from Rodney & Street, 2004). Coherence between publicly professed values and the lived reality is necessary for there to be a genuine moral community (Webster & Baylis, 2000).

NURSE(S): in this code, refers to registered nurses, including nurses in extended roles such as nurse practitioners.

PERSON/PERSONS RECEIVING CARE: an individual, family, group, community or population that accesses the services of the registered nurse; may also be referred to as client(s) or patient(s).

PRIMARY HEALTH CARE: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (WHO, 1978).

PRIVACY: (1) physical privacy is the right or interest in controlling or limiting the access of others to oneself; (2) informational privacy is the right of individuals to determine how, when, with whom and for what purposes any of their personal information will be shared.

PUBLIC GOOD: the good of society or the community, often called the common good.

QUALITY PRACTICE ENVIRONMENTS: practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care (CNA, 2001).

SOCIAL DETERMINANTS OF HEALTH: factors in the social environment, external to the health-care system, that exert a major and potentially modifiable influence on the health of populations (Evans, 1994). See also *Determinants of health.*

SOCIAL JUSTICE: the fair distribution of society's benefits and responsibilities and their consequences. It focuses on the relative position of one social group in relation to others in society as well as on the root causes of disparities and what can be done to eliminate them (CNA, 2006).

SUBSTITUTE DECISION-MAKER: an individual designated by operation of a provincial or territorial statute or in an advance directive of a person in care to make decisions about health care and treatment on the person's behalf (CNA, 1994).

UNREGULATED CARE PROVIDER: paid providers who are neither licensed nor registered by a regulatory body (CRNBC, 2006b).

VALUES: standards or qualities that are esteemed, desired, considered important or have worth or merit (Fry & Johnstone, 2002).

VIOLENCE: includes any abuse of power, manipulation or control of one person over another that could result in mental, emotional, social or physical harm.

VULNERABLE GROUPS: groups disadvantaged by attitudes and systems in society that create inequities.

WELL-BEING: a person's state of being well, content and able to make the most of his or her abilities.

WHISTLE-BLOWING: speaking out about unsafe or questionable practices affecting people receiving care or working conditions. This should be resorted to only after a person has unsuccessfully used all appropriate organizational channels to right a wrong and has a sound moral justification for taking this action (Burkhardt & Nathaniel, 2002).

APPENDICES

Appendix A: **The History of the Canadian Nurses Association Code of Ethics**

Appendix B: **Context of the Code**

Appendix C: **Ethical Models**

- An Ethical Model for Reflection: Questions to Consider
- Other Models and Guides for Ethical Reflection and Decision-Making: Resources and Applications

Appendix D: **Applying the Code in Selected Circumstances**

- Responding Ethically to Incompetent, Non-compassionate, Unsafe or Unethical Care
- Ethical Considerations in Addressing Expectations That Are in Conflict with One's Conscience
- Ethical Considerations for Nurses in a Natural or Human-Made Disaster, Communicable Disease Outbreak or Pandemic
- Ethical Considerations in Relationships with Nursing Students
- Acting Ethically in Situations That Involve Job Action

APPENDIX A: THE HISTORY OF THE CANADIAN NURSES ASSOCIATION CODE OF ETHICS

1954	CNA adopts the International Council of Nurses' code as its first code of ethics
1980	CNA adopts its own code, entitled *CNA Code of Ethics: An Ethical Basis for Nursing in Canada*
1985	CNA adopts a new code, called *Code of Ethics for Nursing*
1991	*Code of Ethics for Nursing* revised
1997	*Code of Ethics for Registered Nurses* adopted as the updated code of CNA
2002	*Code of Ethics for Registered Nurses* revised
2008	*Code of Ethics for Registered Nurses* revised

The CNA *Code of Ethics for Registered Nurses* is not based on a particular philosophy or ethical theory but arises from different schools of thought, including relational ethics, an ethic of care, principle-based ethics, feminist ethics, virtue ethics and values. It has been developed over time by nurses for nurses, and it therefore continues to have a practical orientation supported by theoretical diversity.

CNA prepares position papers, practice papers on specific ethics issues, booklets and other ethics-related resources, and it maintains an electronic mailing list that provides a forum for dialogue on ethics in nursing. In addition, CNA works with other health professional associations and colleges to develop interprofessional statements (e.g., about no-resuscitation policies) related to issues or concerns of an ethical nature.

APPENDIX B: CONTEXT OF THE CODE

The Canadian Nurses Association's *Code of Ethics for Registered Nurses* is revised periodically to reflect changes that affect the public, nurses, other health-care providers and the health-care system and that create both new challenges and opportunities for nursing practice. Examples[10] of changes currently occurring, as well as those envisioned in the coming decade, can be found below:

Challenges and opportunities affecting the public

- Greater public access to health information from a variety of formal and informal sources
- Increased public use of alternative and complementary therapies
- Increasing health-care expectations by some persons who are receiving care, and increasing disenfranchisement of others who are having difficulty accessing care
- Continued and escalating societal expectations that people will practise self-care
- Increasing societal expectations that families and communities will "look after their own"
- Individual or family isolation in the provision of self-care or care for a family member
- Widening and deepening local, regional and global inequities in health and social resources and in access to health care based upon gender, class and race

[10] Reference to these contextual realities are found in the following documents: Government of Canada. (2002). *Building on values: The future of health care in Canada – Final report.* Ottawa: Commission on the Future of Health Care in Canada; Health Canada. (2002). *Our health, our future. Creating quality workplaces for Canadian nurses. Final report of the Canadian nursing advisory committee.* Ottawa: Author; Canadian Health Services Foundation. (2006). *What's ailing our nurses?* Ottawa: Author; Canadian Health Services Research Foundation. (2006). *Staffing for safety.* Ottawa: Author; Villeneuve, M., & MacDonald, J. (2006). *Toward 2020: Visions for nursing.* Ottawa: Canadian Nurses Association; Torgerson, R. (2007). *Not there yet: Improving the working conditions of Canadian nurses.* Ottawa: Canadian Policy Research Networks; UNESCO International Bioethics Committee (ICB). (2007). *Preliminary draft report of the IBC working group on social responsibility and health.* Retrieved on February 22, 2008, from http://unesdoc.unesco.org/images/0015/001505/150522e.pdf

- Demographic shift as baby boomers age and the very old live longer, resulting in increasing numbers of people who require complex health care
- Increasing rates of chronic illness and lack of accessible social supports
- Greater recognition that pain and suffering are underdiagnosed and undertreated
- New and emerging infectious disease
- Increasing rates of infections that originate in hospitals or similar settings (health-care acquired infections) and an increased awareness of other care-related injury and harms
- Threats of natural and human-made disasters, pandemics and bioterrorism
- Continued presence of war, human trafficking and racial tensions

Challenges and opportunities affecting nurses and other health-care providers

- Increasing **diversity** in the populations of people receiving care
- Increasing diversity among health-care professionals and other health-care providers
- A continuing and worsening shortage of nurses and shortage of all health-care professionals and allied health-care providers
- Shortages of clinical support workers with related increasing demands on nurses to do additional non-nursing work so that safe patient care is maintained
- Excessive hours of work and work overload with associated increases in nurse injury, illness and turnover of nursing staff

- Nurse staffing deficiencies that are associated with increased rates of morbidity and mortality among persons receiving care, as demonstrated in research-based findings
- Limited numbers of well-prepared managers to lead the development of healthy work environments and effective nurse retention strategies
- Broader and evolving scopes of practice for nurses and other health-care providers
- Increased numbers of complex **intersectoral** health-care teams that include other health-care professionals and **unregulated workers**
- Increased requirements for well-functioning, innovative health-care teams as a result of the changing roles and scopes of practice of registered nurses and other health-care providers
- Emerging challenges for nurses with regard to potential situations of **conflict of interest** (e.g., relationships with pharmaceutical companies) as roles evolve to broader scopes of practice
- A growing cadre of nurses involved in conducting and participating in research to develop and use evidence-based guidelines and other knowledge for nursing practice and health

Challenges within the socio-political context of the health-care system

- Increasing disparity between resources for urban and rural health-care centres
- Increasing need for health promotion and prevention (primary care), including mental health
- Ongoing tension between individual good and the **public good**

- Ongoing debate within Canadian society over the acceptable amount and mix of public and private interests in the financing and delivery of health care
- Ongoing challenges to preserving an adequately publicly funded, universal and accessible health-care system that equitably serves health-care needs across the continuum of care
- Difficult choices in the allocation of resources, program and services
- Increasing recognition that social inequities drive health-care decision-making and health-care inequities
- A sense that financial gain by health-care agencies and health-care providers in public and private health-care delivery may be influencing health-care decisions (e.g., early discharge of people from hospitals)
- Shorter hospital stays and increased reliance on home and community care and self-care
- Increase in the complexity of care needed in all settings and lack of accessible social supports for people needing care and their families
- Rapid introduction of new technology and pharmaceutical drugs
- Advances in genetics and genomics
- Greater expectations of the public to have access to new technology with the sometimes unfounded expectation that new technology will lead to better health outcomes
- Increasing use of information technology and electronically stored health data in the health-care system
- An accelerating trend toward public-private sector delivery and information systems that increase potential risks to the privacy of persons receiving care

- Rise in the number of policies and legislation related to access to private information
- Increased emphasis on safety and on developing a just culture in health care, in which individuals, organizations and health-care systems share accountability for reducing risks and preventing avoidable harms
- Proliferation of research findings in health care that need to be impartially assessed to determine the quality of evidence
- Ongoing tensions between preserving scientific integrity and maximizing commercial interests in the research and development of health-care technologies and therapies
- Pressing need to understand the relations between human health and environmental health (e.g., global warming) and to act on issues related to the environment on which health depends

APPENDIX C: ETHICAL MODELS

An Ethical Model for Reflection: Questions to Consider

The code points to the need for nurses to engage in ethical reflection and discussion. Frameworks or models can help people order their approach to an ethical problem or concern, and they can be a useful tool to guide nurses in their thinking about a particular issue or question.

When it is appropriate, colleagues in nursing and other disciplines, ethics committees, ethicists, professional nurses associations and colleges of registered nurses and other experts should be included in discussions of ethical problems. Legislation, standards of practice, policies and guidelines of nurses' unions and professional associations and colleges may also be useful in ethical reflection and decision-making.

Ethical reflection (which begins with a review of one's own ethics) and judgment are required to determine how a particular value or responsibility applies in a particular nursing context. There is room within the profession for disagreement among nurses about the relative weight of different ethical values and principles. More than one proposed intervention may be ethical and reflective of good ethical practice. Discussion and questioning are extremely helpful in the resolution of ethical problems and issues.

Ethical models also facilitate discussion among team members by opening up a moral space for everyone to participate in the conversation about ethics. There are many models for ethical reflection and for ethical decision-making in the health-care ethics literature, and some of these are noted in this section. The model provided here[11] was selected because it offers a nursing model for considering ethics issues in practice, promotes reflection and is applicable to all types of ethical situations.

[11] This model is adapted from *Nursing Ethics in Canadian Practice* by Oberle & Raffin (in press).

Oberle & Raffin Model

1. ***Understanding the ethics of the situation: Relationships, goals, beliefs and values***

   In reflecting on what will best fulfil the goal of improving a person's well-being, nurses must first *want* to do good. They clarify their own values as well as the values in the code of ethics that apply to a given situation. They ask some of the following questions:

   - What are my own values in this situation?
   - What are the values of all those involved?
   - What are the goals people hope to achieve?
   - What do others consider to be a good outcome?
   - What is the level of knowledge of the persons receiving care or in need of care?
   - What information do they need?
   - What are the relationships within the family of the person receiving care or in need of care and between the family and health-care providers?
   - What value differences exist among the caregivers and those receiving care or in need of care?

2. ***Reflecting on the range of available choices***

   When reflecting on possible choices, nurses ask:

   - What will help individuals and families clarify what they think will do the most good for their situation?
   - What do other health-care providers think is best?
   - What might be the effects of the various choices?
   - What values would society consider appropriate in this situation?

- What economic, political, legal, institutional and cultural factors are at play in the person's health situation?
- What options require further information and discussion?

3. *Maximizing the good*

Nurses try to act in accordance with the capable person's expressed desires. Questions that need to be asked to achieve this end are the following:

- Will what the individual desires conflict with the good of other individuals or of the community?
- Can ways be found to respect the wishes of the person receiving care or in need of care, while keeping the needs of others in mind?
- What might prevent nurses from taking an ethical action?
- Will taking action in this situation require moral courage?
- Will the nurses and other health-care providers be supported in taking action?

4. *Taking ethical action*

Before taking action, nurses reflect on how that action fits with the code of ethics and whether it is what a reasonably prudent and ethical nurse would do in this situation. They assess their ability to act with care and compassion and to meet their professional and institutional expectations.

5. *Reflecting on and reviewing an ethical action*

In reviewing and reflecting on their actions, nurses consider both the process and outcome. They ask if the situation was handled in the best way possible, including both *how* things were done as well as *what* was done. They also consider how everyone involved in the situation was affected, and whether harm was minimized and a good choice was found.

Other Models and Guides for Ethical Reflection and Decision-Making: Resources and Applications

Several other models for ethical reflection and decision-making are in common use. Nurses find that some models are helpful in particular areas of practice (e.g., in acute care practice, long-term care, public health) and that some models are more meaningful to them than others.

Many models include the four principles of biomedical ethics – autonomy, beneficence, nonmaleficence and justice – which some nurses find practical because these models may bridge biomedical and nursing ethics in acute care. Some nurses prefer a model that offers a diagram rather than text: examples of diagram models are the Bergum and the Storch models (CARNA, 2005b). Others prefer an algorithm, such as the one developed by Matthews (2007), and still others prefer a more philosophically based model, such as that offered by Yeo and Moorhouse (1996).

A few key sources are listed below. The first source is likely the most comprehensive, since it analyzes cases using three models.

- CNA's ***Everyday Ethics: Putting the Code into Practice*** (2nd ed.) (2004b) is a study guide to help nurses use the CNA code of ethics and reflect on ethical practice. It offers three models: "A Guide for Moral Decision-Making" (developed by Chris McDonald), "The Four Topics Method" (by Jonsen, Siegler & Winslade, 1997) and "The Circle Method for Ethical Decision-Making" (by Jan Storch), with examples of their application to practice. Numerous other models are listed and briefly described in the appendix to this study guide.
- CARNA published ***Ethical Decision-Making for Registered Nurses in Alberta: Guidelines and Recommendations*** in 2005. Included in CARNA's paper is the Bergum model for questioning (in the image of a flower) and a full case analysis using the Bergum model.

- The ***Framework for Ethical Decision-Making,*** developed by Michael McDonald with additions provided by Patricia Rodney and Rosalie Starzomski, provides detailed questions to consider in ethical decision-making. It is available from www.ethics.ubc.ca/people/mcdonald/decisions.htm

- ***Nursing Ethics: Cases and Concepts*** (1996) by M. Yeo & A. Moorhouse. These authors provide a way to think through ethical problems using three types of analysis (descriptive, conceptual and normative).

- ***Nursing ethics decision-making algorithm*** developed by J. Matthews at Brock University (included in the ethics resources on the CNA website).

APPENDIX D:
APPLYING THE CODE IN SELECTED CIRCUMSTANCES

Responding Ethically to Incompetent, Non-compassionate, Unsafe or Unethical Care

> *Nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same. (Code, A4)*
>
> *Nurses admit mistakes*[12] *and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harms. (Code, A5)*
>
> *Nurses intervene, and report when necessary,*[13] *when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behaviour. (Code, D4)*
>
> *Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the* Code of Ethics for Registered Nurses *and in keeping with the professional standards, laws and regulations supporting ethical practice. (Code, G1)*
>
> *Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform his or her duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care. (Code, G5)*

If a nurse encounters a situation where harm is underway or there is a clear risk of imminent harm, he or she should take immediate steps to protect the safety and dignity of the persons receiving care. Some examples

[12] See footnote 7.

[13] See footnote 7.

of appropriate immediate steps in cases of actual or imminent harm could include, but are not limited to, speaking up if a potential error in drug calculations is detected, questioning an unclear order, intervening to prevent unsafe restraint practices, protecting patients when a colleague's performance appears to be impaired for any reason (see CRNNS, 2006b) or interfering with a serious breach of confidentiality involving people with sexually transmitted infections. Nurses should be aware of provincial and territorial legislation and nursing practice standards that may include direction regarding disclosure and reporting and provide further clarity on whether there is a clear risk of imminent harm.

When nurses encounter situations where harm is not imminent but there is potential for harm, they work to resolve the problem as directly as possible in ways that are consistent with the good of all parties. As they work through these situations, nurses review relevant statements in the *Code of Ethics for Registered Nurses* and other relevant standards, legislation, ethical guidelines, policies and procedures for reporting incidents or suspected incompetent or unethical care, including any legally reportable offence.

Some additional actions for nurses to consider, if they do not contravene requirements under professional standards or provincial or territorial legislation, include:

- Maintain a high level of confidentiality about the situation and actions at all times.
- Review all information available about the current situation. Separate personal from professional issues. Concentrate on the situation at hand.
- Where appropriate and feasible, seek information directly from the colleague(s) whose behaviour or practice has raised concerns.
- Pay attention to the moral distress nurses are experiencing in trying to find an ethical course of action. Consider the risks of not taking action to persons receiving care, colleagues, self, and the organization, and reflect on the potential harms and breaches in trust that

could result if no action is taken. Nurses need to consider as well the consequences that may occur for them and for others in taking various courses of action.

- If possible, speak with an impartial and trusted colleague outside of the situation who can preserve appropriate confidential information and help validate or rule out the conclusions being drawn.
- Seek information from relevant authorities (e.g., supervisor or manager) on expected roles and responsibilities for all of the parties who share responsibility for maintaining safe, competent, compassionate and ethical care.
- Consult, as appropriate, with colleagues, other members of the team, professional nursing associations or colleges or others who are able to assist in addressing and resolving the problem.
- Advise the appropriate parties regarding unresolved concerns and, when feasible, inform the colleague(s) in question of the reasons for your action. Know what immediate help is available to colleague(s) and be ready to help the colleague(s) find these resources.

Nurses who engage in responsible reporting of incompetent, unsafe or unethical care should be supported by their colleagues, professional association and/or professional college.

Ethical Considerations in Addressing Expectations That Are in Conflict with One's Conscience

Nurses are not at liberty to abandon those in need of nursing care. However, nurses may sometimes be opposed to certain procedures and practices in health care and find it difficult to willingly participate in providing care that others have judged to be morally acceptable. The nurse's right to follow his or her conscience in such situations is recognized by CNA in the *Code of Ethics for Registered Nurses* in its provision for **conscientious objection.**

If nursing care is requested that is in conflict with the nurse's moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person's needs or desires. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers or, if the nurse is self-employed, persons receiving care in advance so that alternative arrangements can be made. (Code, G7)

Steps in Declaring a Conflict with Conscience (American Nurses Association [ANA], 2006; Registered College of Nurses, Australia [RCNA], 2000)

1. **Before employment**

   Nurses have a moral responsibility to advise their prospective employer if they are conscientiously opposed to certain practices and procedures that are likely to occur in their prospective workplace, particularly if the expression of conflict of conscience "would significantly interfere with the provision of services offered by the employing agency" (RCNA, 2000, p. 1). Similarly, employers should advise prospective employees about services provided by the organization that may be sensitive for some employees.

2. **Anticipating and planning to declare a conflict with conscience**

   Ideally, the nurse would be able to anticipate practices and procedures that would create a conflict with his or her conscience (beliefs and values) in advance. In this case, the nurse should discuss with supervisors, employers or, when the nurse is self-employed, persons receiving care what types of care she or he finds contrary to his or her own beliefs and values (e.g., caring for individuals having an abortion, male circumcision, blood transfusion, organ transplantation) and request that his or her objections be accommodated, unless it is an emergency situation.

Ideally, nurses in positions of formal leadership would ensure that workplaces have a policy in place to deal with matters of conscience so that a nurse can be exempt from participating in procedures he or she considers morally objectionable without being penalized.

3. **Finding oneself caught in providing care that is in conflict with one's conscience**

When a nurse finds herself or himself involved in nursing care that creates a conflict with her or his conscience, he or she should notify the supervisor, employer or, if she or he is self-employed, the persons receiving care. Declaring a conflict with conscience, or "conscientious objection," and requesting accommodation is a serious matter that is not to be taken lightly. In all cases, the nurse remains until another nurse or health-care provider is able to provide appropriate care to meet the person's needs.

Key guidelines with respect to a declaration of a conflict with conscience include the following:

1. The nurse who decides not to take part in providing care on the grounds of moral objection communicates his or her desires in appropriate ways.

2. Whenever possible such refusal is made known in advance and in time for alternative arrangements to be made for persons receiving care.

3. Moral objections by the nurse are motivated by moral concerns and an informed, reflective choice and are not based upon prejudice, fear or convenience.

4. When a moral objection is made, the nurse provides for the safety of the person receiving care until there is assurance that other sources of nursing care are available.

5. Employers and co-workers are responsible for ensuring that nurses and other co-workers who declare a conflict of conscience receive fair treatment and do not experience discrimination (RCNA, 2000, p.2).

6. Nurses need to be aware that declaring a conflict of conscience may not protect them against formal or informal penalty.

Ethical Considerations for Nurses in a Natural or Human-Made Disaster, Communicable Disease Outbreak or Pandemic

Historically and currently, nurses provide care to those in need, even when providing care puts their own health and life at risk (for example, when they work in war-torn areas, places of poverty, in places with poor sanitation, etc.). Nurses also encounter personal risk when providing care for those with known or unknown communicable or infectious disease. However, disasters and communicable disease outbreaks call for extraordinary effort from all health-care personnel, including registered nurses. The code states:

> *During a natural or human-made disaster, including a communicable disease outbreak, nurses have a duty to provide care using appropriate safety precautions. (Code, A8)*

A duty to provide care refers to a nurse's professional obligation to provide persons receiving care with safe, competent, compassionate and ethical care. However, there may be some circumstances in which it is acceptable for a nurse to withdraw from providing care or to refuse to provide care (CRNBC, 2007; CRNNS, 2006a). Unreasonable burden is a concept raised in relation to the duty to provide care and withdrawing from providing or refusing to provide care. An unreasonable burden may exist when a nurse's ability to provide safe care and meet professional standards of practice is compromised by unreasonable expectations, lack of resources or ongoing threats to personal well-being (CRNBC, 2007).

The following criteria could be useful for nurses to consider when contemplating their obligation to provide care in a disaster or communicable disease outbreak:

- the significance of the risk to the person in care if the nurse does not assist;
- whether the nurse's intervention is directly relevant to preventing harm;
- whether the nurses' care will probably prevent harm; and
- whether the benefit of the nurse's intervention outweighs harms the nurse might incur and does not present more than an acceptable risk to the nurse (ANA, 2006).

When demands on the health-care system are excessive, material resources may be in short supply and nurses and other health-care providers may be at risk. Nurses have a right to receive truthful and complete information so that they can fulfil their duty to provide care. They must also be supported in meeting their own health needs. Nurses' employers have a reciprocal duty to protect and support them as well as to provide necessary and sufficient protective equipment and supplies that will "maximally minimize risk" to nurses and other health-care providers (Human Resource Recommendations, SARS Human Resources Working Group, Ontario Hospital Association, as recorded in Godkin & Markwell, 2003). Nurses will also need to use their professional judgment to select and use the appropriate prevention measures; select, in collaboration with the health-care team, the appropriate agency, manufacturer and government guidelines concerning use and fit of personal protective equipment; and advocate for a change when agency, manufacturer or government guidelines do not meet the infection control requirements regarding appropriate use and fit of personal protective equipment (College of Nurses of Ontario, 2005).

Nurses need to carefully consider their professional role, their duty to provide care and other competing obligations to their own health, to family and to friends. In doing so, they should be clear about steps they might take both in advance of and during an emergency or pandemic situation so that they are prepared for making ethical decisions (Faith, Gibson, Thompson & Upshur, 2005). Value and responsibility statements in the code should support nurses' reflection and actions.

In anticipation of the need for nursing care in a disaster or disease outbreak, nurses:

- work together with nurses and others in positions of leadership to develop emergency response practice guidelines, using available resources and guidelines from governments, professional associations and regulatory bodies;
- learn about and provide input into the guidelines the region, province or country has established regarding which persons are to receive priority in care (e.g., priority based on greatest need, priority based on probability of a good outcome, and so on);
- learn how support will be provided for those providing care and carrying the physical and moral burden of care;
- request and receive regular updates about appropriate safety measures nurses might take to protect and prevent themselves from becoming victim to a disaster or disease;
- assist in developing a fair way to settle conflicts or disputes regarding work exemptions or exemptions from the prophylaxis or vaccination of staff; and
- help develop ways that appeals or complaints can be handled.

B. ***When in the midst of a disaster or disease outbreak, nurses have an ethical obligation to:***

- refer to regulations and guidelines provided by government, regulatory bodies, employers and professional associations;
- help make the fairest decisions possible about the allocation of resources;
- help set priorities in as transparent a manner as possible;
- provide safe, compassionate, competent and ethical care (in disasters, as much as circumstances permit);
- help determine if, when and how nurses may have to decline or withdraw from care; and
- advocate for the least restrictive measures possible when a person's individual rights must be restricted.

Ethical Considerations in Relationships with Nursing Students

Registered nurses in all roles share the responsibility of supporting nursing students in providing safe, competent, compassionate and ethical care. Several statements in the code include specific references to students and their relationships with others in providing nursing care:

> *Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way. (Code, D10)*

> *Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other health-care team members. (Code, G9)*

On the basis of these statements in the code, the following guidelines are suggested:

- All teacher-student interactions are to be in keeping with ethical nursing practice.
- All nurses and nursing students treat each other with respect and honesty.
- All nurses endeavour to provide nursing students with appropriate guidance for the development of nursing competence.
- The primary responsibility for the care of the person remains that of the primary nurse to whom the person has been assigned.
- Nursing students ensure that persons receiving care are informed of their student status. The person's right to refuse care or assistance provided by a student is to be treated with respect.
- Nursing students are expected to meet the standards of care for their level of learning. They advise their faculty clinical instructor and their clinical unit nurse supervisors if they do not believe they are able to meet this expectation.
- If nursing students experience difficulties with disrespectful actions from nurse(s) in practice that they are not able to overcome through conversation with the nurse(s) involved, they discuss these incidents with their faculty clinical instructor and, failing helpful outcomes from that discussion within an appropriate period, they enlist the assistance of the appropriate nursing education administrator in their nursing program.

Acting Ethically in Situations That Involve Job Action

Job action by nurses is often directed toward securing conditions of employment that enable safe and ethical care of current and future persons receiving care. However, action directed toward such improvements could

hinder persons receiving care in the short term. Nurses advocate for their involvement in workplace planning for the safety of those receiving care before and during job action. Members of the public are also entitled to information about the steps taken to ensure the safety of persons during any job action.

> *Nurses planning to take job action or practising in environments where job action occurs take steps to safeguard the health and safety of people during the course of the job action. (Code, A7)*

- Each nurse is accountable for decisions made about her or his practice at all times in all circumstances, including during a legal or an illegal strike (Nurses Association of New Brunswick [NANB], 2004).
- Individual nurses and groups of nurses safeguard persons receiving care when planning and implementing any job action.
- Individuals and groups of nurses participating in job action, or affected by job action, share the ethical commitment to the safety of persons in their care. Their particular responsibilities may lead them to express this commitment in different but equally appropriate ways.
- Persons whose safety requires ongoing or emergency nursing care are entitled to have those needs satisfied throughout any job action.
- During job action, if nurses have any concern about their ability to maintain practice and ethical standards or their ability to ensure the safety of persons in their care, they are responsible for communicating this concern in accordance with identified lines of accountability so that corrective action can be taken as quickly as possible (NANB, 2004).

REFERENCES

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements.* Washington, DC: Author.

American Nurses Association. (2006). *Position statement: Risk and responsibility in providing nursing care.* Washington, DC: Author.

Burkhardt, M. A., & Nathaniel, A. K. (2002). *Ethics & issues in contemporary nursing* (2nd ed.). Toronto: Delmar Publishers.

Canadian charter of rights and freedoms, Schedule B, *Constitution Act, 1982.*

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (1998, with 2000, 2002 and 2005 amendments). *Tri-council policy statement: Ethical conduct for research involving humans.* Ottawa: Public Works and Government Services Canada. Retrieved October 22, 2007, from http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm

Canadian Nurses Association. (1994). *Joint statement on advance directives* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2001). *Quality professional practice environments for registered nurses* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2002). *Ethical research guidelines for registered nurses* (3rd ed.). Ottawa: Author.

Canadian Nurses Association. (2003). *Global health and equity* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2004a). *Registered nurses and human rights* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2004b). *Everyday ethics: Putting the code into practice.* Ottawa: Author.

Canadian Nurses Association. (2006). *Social justice... a means to an end, an end in itself.* Ottawa: Author.

Canadian Nurses Association. (2007). *Framework for the practice of registered nurses in Canada.* Ottawa: Author.

Canadian Nurses Protective Society. (2004). Consent of the incapable adult. *InfoLaw 13*(3), 1-2.

Caplan, R. L., Light, D. W., & Daniels, N. (1999). Benchmarks of fairness: A moral framework for assessing equity. *International Journal of Health Services, 29*(4), 853-869.

College and Association of Registered Nurses of Alberta. (2005a). *Professional boundaries for registered nurses: Guidelines for the nurse-client relationship.* Edmonton: Author.

College and Association of Registered Nurses of Alberta. (2005b). *Ethical decision-making for registered nurses in Alberta: Guidelines and recommendations.* Edmonton: Author.

College of Nurses of Ontario. (2005). *Infection, prevention and control.* Toronto: Author.

College of Registered Nurses of British Columbia. (2006a). *Competencies in the context of entry-level registered nurse practice in British Columbia.* Vancouver: Author.

College of Registered Nurses of British Columbia. (2006b). *Delegating tasks to unregulated care providers.* Vancouver: Author.

College of Registered Nurses of British Columbia. (2006c). *Practice standard: Conflict of interest.* Vancouver: Author.

College of Registered Nurses of British Columbia. (2007). *Practice standard: Duty to provide care.* Vancouver: Author.

College of Registered Nurses of Nova Scotia. (2006a). *Emergency preparedness plan.* Halifax: Author.

College of Registered Nurses of Nova Scotia. (2006b). *Problematic substance use in the workplace: A resource guide for registered nurses.* Halifax: Author.

Dutton, J., Lilius, J., & Kanov, J. (2007). The transformative potential of compassion at work. In S. K. Piderit, R. E. Fry, & D. L. Cooperrider (Eds.), *Handbook of transformative cooperation: New designs and dynamics.* Palo Alto, CA: Stanford University Press.

Evans, R. G. (1994). Introduction. In R. G. Evans, M. L. Barer, & T. R. Marmor (Eds.), *Why are some people healthy and others are not? The determinants of health of populations* (pp. 3-26). New York: Aldine de Gruyter.

Faith, K., Gibson, J., Thompson, A., & Upshur, R. (2005). *Ethics in a pandemic influenza crisis: Framework for decision-making.* Toronto: Clinical Ethics Centre at Sunnybrook & Women's College Health Sciences Centre.

Fenton, M. (1988). Moral distress in clinical practice: Implications for the nurse administrator. *Canadian Journal of Nursing Administration, 1,* 8-11.

Fry, S., & Johnstone, M-J. (2002). *Ethics in nursing practice: A guide to ethical decision-making* (2nd ed.). International Council of Nurses. Oxford: Blackwell.

Godkin, D., & Markwell, H. (2003). *The duty to care of healthcare professionals: Ethical issues and guidelines for policy development.* Toronto: Submission to the SARS Expert Panel Secretariat.

Hebert, P. C., Hoffman, C., & Davies, J. M. (2003). *The Canadian safety dictionary.* Edmonton: Canadian Patient Safety Institute.

International Council of Nurses. (2006). *ICN code of ethics for nurses.* Geneva: Author.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice Hall.

Matthews, J. (2007). *Nursing ethics decision-making algorithm.* Available at www.cna-aiic.ca.

Morin, K., Higginson, D., & Goldrich, M. (2006). Physician obligation in disaster preparedness and response. *Cambridge Quarterly Healthcare Ethics, 15,* 417-431. [This paper was prepared for the Council on Ethical and Judicial Affairs of the American Medical Association.]

Neufeldt, V., & Guralnik, D. G. (1988). *Webster's new world dictionary* (3rd ed.). New York: Simon & Schuster.

Nurses Association of New Brunswick. (2004). *Professional accountability during a strike.* Fredericton: Author.

Oberle, K. & Raffin, S. (in press). *Nursing ethics in Canadian practice.* Toronto: Pearson.

Office of the High Commissioner for Human Rights, United Nations. (1948). *The universal declaration of human rights: A magna carta for all humanity.* Geneva: Author.

Public Health Agency of Canada. (2003). *What determines health?* Retrieved October 22, 2007, from http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html

Registered College of Nurses, Australia. (2000). *Position statement: Conscientious objection.* Canberra: Author.

Registered Nurses Association of Nova Scotia. (1996). *Violence in the workplace: A resource guide.* Halifax: Author.

Registered Nurses' Association of Ontario. (2006). *Collaborative practice among nursing teams.* Healthy work environments best practice guidelines. Toronto: Author.

Registered Nurses' Association of Ontario. (2007a). *Embracing cultural diversity in health care: Developing cultural competence.* Healthy work environments best practice guidelines. Toronto: Author.

Registered Nurses' Association of Ontario. (2007b). *Professionalism in nursing.* Healthy work environments best practice guidelines. Toronto: Author.

Rodney, P., Hartrick Doane, G., Storch, J., & Varcoe, C. (2006). Toward a safer moral climate. *Canadian Nurse, 102*(8), 24-27.

Rodney, P., & Starzomski, R. (1993). Constraints on moral agency of nurses. *Canadian Nurse, 89*(9), 23-26.

Rodney, P., & Street, A. (2004). The moral climate of nursing practice: Inquiry and action. In J. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (pp. 209-231). Toronto: Pearson-Prentice Hall.

Storch, J., Rodney, P., & Starzomski, R. (2004). *Toward a moral horizon: Nursing ethics for leadership and practice.* Toronto: Pearson-Prentice Hall.

Varcoe, C., & Rodney, P. (2002). Constrained agency: The social structure of nurses' work. In B. S. Bolaria & H. Dickenson (Eds.), *Health, illness and health care in Canada* (3rd ed., pp. 102-128). Scarborough, ON: Nelson Thomas Learning.

Webster, G., & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, MD: University Publishing Group.

World Health Organization. (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978. Retrieved March 19, 2008, from http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

World Health Organization. (2006). Constitution of the World Health Organization (45th ed. Suppl.). Retrieved October 31, 2007, from http://www.who.int/governance/eb/who_constitution_en.pdf

Yeo, M., & Moorhouse, A. (1996). *Concepts and cases in nursing ethics* (2nd ed.). Peterborough, ON: Broadway Press.

ETHICS RESOURCES

In addition to the resources listed in the references, there is a wide range of ethics resources available from the websites of CNA and the provincial and territorial registered nurses' associations and colleges, as well as from the websites of other national organizations such as the Public Health Agency of Canada, Health Canada, other health profession associations, and ethics or bioethics centres across Canada and internationally.

Nurses should also consult with members of their health-care team, ethics consultants in their agency, ethics committees in their facilities or region, practice consultants at nursing associations and colleges, and others with ethics knowledge and skill in its application to health-care practice.

To visit CNA's ethics resources, go to **www.cna-aiic.ca**.