Quality Worklife - Quality Healthcare Collaborative (QWQHC)

ENVIRONMENTAL SCAN

Final Report

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EXECUTIVE SUMMARY

The Quality Worklife - Quality Healthcare Collaborative (QWQHC) Environmental Scan Report includes a summary of a series of recommendations for consideration by the Collaborative working groups in general and specifically the Knowledge Exchange in Research and Leading Practices Working Group, which is one of four groups working under the Steering Committee. The recommendations are founded in a literature review of nationally significant synthesis documents and a review of activities and initiatives underway being made in all Canadian jurisdictions. In addition, new data collection, analysis of quality worklife and knowledge exchange-related information added significantly to the quality of the recommendations. The input from a diversity of experienced and knowledgeable individuals from across Canada was invaluable.

This national coalition aims to improve quality of worklife in healthcare organizations to strategically address a broad range of health human resources challenges and improve healthcare delivery and patient safety. The National Steering Committee for the Collaborative is a standing group that reports to Canadian healthcare stakeholders (organizations, governments, professional groups, union associations and the public).

The principles that emerged from the review of literature and the work underway across Canada were validated in the discussion with key informants. The principles to guide the work in developing quality worklife and exchanging knowledge to enhance quality work environments and the delivery of quality healthcare are:

- Share vision and values among all levels in healthcare delivery.
- Use existing networks and capacity as a foundation to move forward.
➢ Use experience and professionals from other sectors, as quality worklife is an issue for many economic sectors, both private and public, and a variety of professional and occupational categories.

➢ Create opportunities for innovation and new ideas in management and governance as well as new models of healthcare delivery.

➢ Create horizontal and vertical integration to move beyond silos and “turf” and ensure front-line investment.

➢ Ensure ethics in decision-making in practice environments and support individuals facing difficult choices.

➢ Show responsiveness to a range of organizational and provider groups to ensure an inclusive approach.

The recommendations developed based on the research activities include the following areas:

Knowledge Exchange

➢ Storage and access to documented knowledge resources

➢ Collection, storage and exchange of leading and promising practices

➢ Customized knowledge products

➢ Knowledge exchange options;

➢ Internal and horizontal knowledge transfer and skill development

Quality Worklife

➢ National promotion and awareness

➢ National action strategy

➢ Governance and senior management leadership and accountability
➢ Access to information on leading practices
➢ Identification and use of quality worklife indicators
➢ Worklife survey tools, specific indicators and data systems
➢ Education and training
➢ Research and organizational impact assessment
➢ New knowledge generation
➢ Collaboration and partnership
➢ Quality worklife funding programs
➢ Link to health human resources (HHR) planning and implementation
➢ Moving knowledge to implementation

National Co-ordination
➢ National co-ordinating functions related to quality worklife and related knowledge exchange activities.

The environmental scan research work has informed the work of the Collaborative throughout the planning and strategy development process. The movement of the final report of the Collaborative is fundamental to the progress in quality worklife and quality healthcare in Canada.
1.0  INTRODUCTION

The National Steering Committee for the Quality Worklife – Quality Healthcare Collaborative (QWQHC) is a standing group that reports to Canadian healthcare stakeholders (organizations, governments, professional groups, union associations and the public). The mandate of the Collaborative is the development of a formal proposal for a national framework and action strategy on quality of worklife to improve health system delivery and patient/client outcomes. This national coalition aims to improve quality of worklife in healthcare organizations to strategically address a broad range of health human resources challenges and improve healthcare delivery and patient safety. The Collaborative intends to contribute to the development of a leading knowledge exchange structure to promote knowledge dissemination and share leading practices in the area. The length of the mandate is from October 2005 to March 2007.

The structure of the Collaborative includes a Partners Group that includes the CEOs of the key founding national partners. The work is guided by a Steering Committee and completed by four working groups. Funding for the Collaborative is provided by Health Canada’s Office of Nursing Policy under its Healthy Workplace Initiative. The environmental scan project is jointly funded by the Collaborative and the Canadian Health Services Research Foundation (CHSRF).

This is the final report of an environmental scan project which was launched to inform the work of the Collaborative. It includes a summary of a literature review of nationally significant synthesis documents; a Canadian jurisdictional review; and recommendations for consideration by the Collaborative working groups in general and the Knowledge Exchange in Research and Leading Practices Working Group.
specifically. The recommendations have been informed by the results of electronic data collection and interviews with a variety of informed individuals on the subjects of quality worklife and knowledge exchange.

Creating a healthy workplace or quality worklife is a shared responsibility among all who work in an organization: those who manage, govern, externally support and fund the healthcare organization need to be engaged and committed. The purpose of the Collaborative is to support awareness, knowledge generation and exchange, and capacity-building. Implementation of the action-oriented strategy will support the creation and sharing of the indisputable evidence supporting the idea that quality worklife is an imperative and links directly to staff and patient outcomes. Highly effective social marketing initiatives are necessary to create momentum for sustained investment, ongoing commitment and the comprehensive organizational and system-level work required to improve quality worklife in healthcare.

2.0 METHODOLOGY

The objectives of the environmental scan project include the review of major national policy and management initiatives and research activities; the description of the current state of knowledge in the area of quality worklife and its relation to patient and system outcomes; the assessment of current levels of awareness, engagement and implementation of quality worklife issues in a sample of federal/provincial/territorial healthcare stakeholder organizations; identification of key individual and organizational contributors as well as leading organizational and governance initiatives; review of current research and initiatives related to knowledge transfer and exchange; and
determination of the level of interest in addressing quality worklife issues in healthcare and priority needs for supporting quality worklife efforts through knowledge exchange and other supports.

The methodology was developed in consultation with members of the research team, Collaborative staff and working group members. The literature and document search was conducted using existing databases, bibliographies, documents and research synthesis reports that are currently available through the Foundation and other partner organizations. The additional web search focused on accessing grey literature from healthcare organizations and governments. The jurisdictional reviews were done primarily using the Internet and were further informed by the interviews.

The ethics review for the project was completed at the University of Ontario’s Institute of Technology (UOIT) under the leadership of Dr. Manon Lemonde. Once the methodology and research instruments were approved, a long list of knowledgeable individuals from all sectors of the health system and academic organizations was developed. From more than 200 entries, a judgment sample of 45 individuals was drawn.

The sample included both men and women and is broadly representative of the diversity of Canadian geographical regions (urban, rural, remote), jurisdictions (provincial, territorial, federal, Aboriginal) and type of key informant (researcher, decision maker, institutional and community healthcare delivery sectors). Of the 45 individuals canvassed by e-mail to identify interest in providing information and engaging in the data collection, 22 individuals participated. The 22 participants included four Collaborative partners, two Collaborative Steering Committee members and 16 organizational representatives. Seven respondents submitted data electronically using a
set of e-mailed questions. Three of the seven also participated in a follow-up interview by telephone. Fifteen respondents completed full interviews by telephone. The respondents were managers, researchers, quality of worklife specialists and professional practice consultants. Unfortunately, the intended data collection from French-speaking respondents did not proceed.

3.0 LITERATURE AND JURISDICTIONAL REVIEWS

The strategic environment of the Canadian healthcare system within which the quality worklife issues rest is a complex and dynamic landscape of challenging, changing, actively adaptive and effective healthcare delivery. Canada has a 15-year history of healthcare reform and restructuring.

Much of the study into the effects of restructuring and other current trends on quality of worklife as it affects quality healthcare has been focused on nursing. Rising acuity, intensity and complexity of patient care environments and an erosion of nursing leadership have contributed to relentless nursing workload increases in all types of practice settings where nurses work. This workload has, in turn, reduced satisfaction and morale, contributed to a high rate of absenteeism and threatened the quality of patient care. (CNAC, 2002) Because of the high number of nurses in the system (approximately one-third of the entire healthcare workforce) it has often been suggested that as nursing goes, so goes the rest of the system. The implications and value of improving nursing work conditions for multi-professional teams and patient care is clear. (CNAC, 2002)

The future solutions need to use the nursing-specific evidence and build a broader base that includes the entire healthcare workforce. In its interim report on the state of the
healthcare system in Canada, the Standing Senate Committee on Social Affairs, Science and Technology observes that “10 years of downsizing the Canadian healthcare system have only exacerbated the situation for nurses by producing unhappy patients, horrific workloads for nurses across the system, destruction of organizational loyalty and decaying morale among healthcare workers.” (2002a)

The Atlantic Health Human Resources Association and Med-Emerg Inc. presented an HHR overview to the Atlantic premiers. In that presentation, it was noted that in the area of nurse worklife specifically, there has been some success in workforce planning, selected elements of nursing leadership, information systems and scope of practice. There has been less progress in workforce supply, workload, hours of work and work and health issues. In the same presentation, Dr. Michael Lieter looked at the uptake of specific policy-relevant reports in the area of HHR. The results of the research he was quoting indicated that what helps the uptake of reports is relevance, resources, leadership/power, collaboration, grassroots involvement, collective agreements and alignment with strategic directions. The influences that hinder report uptake include role overload, report characteristics, competing sources of information and drivers of change, structural barriers, competing agendas, political cycles and complexity of issues. The definition of knowledge transfer includes characteristics of written reports, dissemination strategies, resources, endorsement, key individuals/power, collaboration opportunities and organization knowledge-sharing culture. (M. Leiter (2006) PowerPoint presentation)

Our aging population increases the pressures on institutional and community healthcare environments to cope with chronic conditions and end-of-life issues. The cost
of healthcare is the subject of constant public debate. Ethical issues abound as technology advances beyond our capacity to engage in the necessary citizen dialogues to support decision-making in the application of this technology. We know that work-related stress and less than optimal worklife experiences are common among healthcare workers, and that unresolved problems have very real health- and employment-related outcomes. Costs related to Workers Compensation Board premiums continue to climb in response to injury and illness rates. Current and projected shortages of healthcare workers in many occupational categories are alarming and the early impacts are part of the healthcare experience throughout Canada. Four generations of an increasingly diverse working population create challenges of responsiveness, accommodation, recruitment and retention in the many organizations and workplaces that make up the Canadian health system. Other prominent issues changing the face of healthcare include the momentum toward interprofessional education for collaborative practice, the increasing entry-to-practice credentials in some professions, and the shrinking population of young people to recruit into the health professions. (AACHHR & MEI, 2005)

Important to decision makers is the notion that we should not make the problem unnecessarily complex. Positive change is readily achievable without further study. Even at a national level, some of the solutions are relatively straightforward, and some can be realized with existing funds. (CNAC, 2002) In addition, it is important to assess progress against identified and validated indicators that provide a foundation for monitoring patient outcomes, provider outcomes and system outcomes. (AACHHR & MEI, 2005) One of the key features of the health human resources model developed by the HHR Advisory Committee in the Atlantic region is the recognition of the importance of context
in policy decision-making: “The production of healthcare services and the use of HHR in the production of those services occur in prevailing social, cultural, economic and political contexts. These contexts are largely determined outside the immediate remit of HHR policy makers and planners. However, the particular contexts will define the opportunities and constraints within which these policy makers and planners operate.” (AACHHR & MEI, 2005)

Another important element to policy makers and planners that is linked to quality worklife and quality healthcare is the concept of productivity. Productivity depends on a variety of factors, including the intensity of the work (proportion of worked hours given to patient care), how work is organized, technological inputs and inputs of other types of professionals. (AACHHR & MEI, 2005) The drive toward increasing the intensity of work and creating more efficiency in the system may be counterproductive in terms of humanly manageable workloads and sustainability of the workforce over time. It is interesting to note that much of the work completed across jurisdictions and coming from academic sources on HHR planning does not include significant references to quality worklife. The more detailed literature review and jurisdictional review reports are found in Appendices 2 and 3.
4.0 ADDITIONAL FINDINGS

4.1 Quality Worklife and Quality Healthcare (cf. p. 15)

The individuals interviewed all emphasized that the beliefs, values, attitudes and actions of senior leaders must demonstrate the placement of a priority on quality worklife for it to become a lived reality for employees. Daily commitment and regular communication is required if an organization is to live up to the statement that “employees are our greatest asset.” In this, more than any other area, employees look for an alignment between the “talk” and the “walk” of bringing rhetoric of quality worklife to reality through action. Openness to change on a personal and professional level is needed to support growth and organizational change. Resources and accountability for achieving measurable results must be aligned with stated quality worklife priorities to sustain the credibility of leaders in the eyes of all employees.

Quality worklife was described by those interviewed. They stated that quality worklife is cultivated in a workplace that creates an environment in which people thrive, learn, grow and contribute their many talents to the delivery of quality healthcare with full engagement and enthusiasm. Power and control in the organization is shared and hierarchy does not disrupt communication and teamwork in ensuring care is delivered and health outcomes achieved. All individuals feel important as contributors to the delivery of quality healthcare.

Individuals interviewed during the environmental scan process described their experience of the characteristics of workplaces that do not successfully support quality worklife.
The characteristics include:

- unhealthy, worn out, frustrated employees, which reflects on patient care;
- decreased critical thinking and complex problem-solving ability, which leads to more mistakes;
- increased sick time and resignations due to physical illness, mental health issues and burnout;
- increase in staff problems related to addictions and family conflict;
- less effective communication and more conflict;
- decreased sense of being respected or valued for commitment or care delivered;
- decreased collaboration as resentment between staff members grows as some employees do not carry their “fair share” of the workload due to illness or fatigue;
- increased patient complaints;
- contagious negativity and complaining between employees and to patients/clients;
- lower job satisfaction;
- decreased sense of support for professional practice and increased complaints to professional regulatory bodies; and
- increase in reportable incidents.

On the more positive side, one senior manager suggested that “when employees are healthy, happy, engaged and feel supported personally and professionally, the
outcome is increased quality of patient care.” Accessible and responsive leaders and managers within the organization are key to creating quality worklife. Leaders, managers and specialists in human resources and quality worklife cannot do it alone. Employees at all levels also need to be engaged, committed and contributing to a quality work environment or it will not be sustained. An organizational researcher suggested that the link between quality worklife and quality healthcare is increasingly well-documented in healthcare and other sectors. Quality and safety in work environments lead to better staff outcomes, which lead to better patient outcomes.

4.2 Knowledge Exchange and Knowledge Translation

The Knowledge Exchange in Research and Leading Practices Working Group of the Collaborative states that “effective knowledge exchange involves interaction between stakeholders and results in mutual learning through the process of planning, producing, disseminating and applying and evaluating existing or new research and leading practices in decision-making on quality of worklife to improve health system delivery and patient/client outcomes. High-quality knowledge exchange will result in evidence-informed decision-making (where evidence includes both scientific and experiential evidence).” (Adapted from the CHSRF definition)

Knowledge translation is a process designed to create and facilitate the exchange of meaningful information generated from health research. The exchange of information informs decision-making at all levels in the healthcare system, from clinical decisions to government policy decisions. (NSHSRF (2003), p. 1) Using this definition, the overlap with “knowledge exchange” is obvious and the terms will be used as the same. The other
The feature of this definition is the dominance of the flow of information from the researchers to the decision makers as opposed to a two-way exchange that would ensure relevance and “fit.” The Knowledge Exchange in Research and Leading Practices Working Group defines “leading practices” as practices that have been shown to impact quality of worklife and improve health system delivery and patient/client outcomes.

4.3 Examples of Quality Worklife Initiatives

All participants identified that quality worklife related initiatives are part of their organizational strategic plans, workplace policies or research activities. Investment in research activities was more likely in larger hospital, national partners or academic environments. Examples of activities include:

**Canadian Council on Health Services Accreditation** (CCHSA) — CCHSA has developed a worklife strategy to enhance the focus on worklife within the accreditation program. The four components are refinements to the accreditation program, sharing information and communication, partnerships and contributing to knowledge and research in the area. An internal staff-focused culture is a priority and includes leadership development, team development and staff engagement.

**Canadian Healthcare Association** (CHA) — CHA recognizes the undisputed necessity of achieving a stable workforce with the right number, mix and distribution of health providers to provide reasonable access to high-quality care for all Canadians. CHA defined four priority HHR issues and developed policy positions and strategic opportunities for each. One priority area is healthy workplaces. CHA defines a healthy workplace as a workplace that maximizes the
health and well-being of providers, quality patient outcomes and organizational
performance. The policy positions support the need for a central clearinghouse of
information and best practices related to healthy workplaces, healthy workplace
policies that are designed to enable employees to provide the best care to patients
or clients, the need for consensus on indicators to measure and compare
workplaces on a regional level and the use of accreditation to encourage and
distinguish healthy workplaces. CHA also has training and professional
development initiatives in leadership and management, which include content on
healthy workplace.

Office of Nursing Policy (Health Canada) and Registered Nurses’ Association
of Ontario (RNAO) — Funded primarily by the government of Ontario, RNAO is
partnering with Health Canada, Office of Nursing Policy, to provide policy
makers and healthcare organizations with evidence-based guidelines to assist
them in achieving healthy work environments. The project will deliver six
guidelines and 14 international, systematic literature reviews related to healthy
work environments in 2006. The guidelines address the areas of leadership,
workload and staffing, embracing cultural diversity, professional practice of the
nurse, collaborative practice in nursing teams and workplace health and safety of
the nurse.

Canadian Council of Health Service Executives (CCHSE) — CCHSE is
currently building health leadership and national competencies for a certification
program. The organization is working in partnership with CHSRF, ACEN
(executive nurses) and CSPE (physician executives). CCHSE has also initially
explored starting up an award program to recognize the CEOs who support and promote healthy workplaces.

**Saskatoon Health Region (SHR)** — SHR is using a multi-disciplinary committee to focus on workplace improvement for shift workers; developing a three-year plan for “transforming the work experience” with the goal of reaching level III of the National Quality Improvement Health Workplace Progressive Excellence Program; working on a response to a large employee survey; training-the-trainer sessions and follow-up workshops on “four generations — one workplace” and “being a people centred leader” using the work of John Izzo; “Let’s Talk” forums with feedback to senior management; and departmental initiatives that respond to high sick time and overtime use in specific areas.

**Regina Health Region (RHR)** — RHR is replicating a University of Toronto nurses’ unit study by allocating 20 percent of nursing time to other than patient care. The 20 percent is used for professional education, care planning, patient-centred care initiatives, etc. The results are not in yet, but the hope is the initiative will improve attendance and quality of care.

**Capital Health (CH) in Nova Scotia** — CH has established one of four strategic directions to create a healthy workplace. CH is using a population health approach which gets at the factors that influence the health of employees in organizations. The Healthy Workplace Council is an advocacy and advisory body which is structured to include representatives from the various employee groups within CH, along with union reps. CH is also working with the Nova Scotia Association of Health Organizations to develop a provincial approach to organizational health.
British Columbia Department of Health — Occupational Health and Safety (OH&S) — OH&S has implementation underway in four health authorities with three more to follow in the next phase. The quality worklife initiative is looking at major stressors, facilitators, barriers and solutions through a methodology that includes interviews and focus groups. A literature review is also being done in specified thematic areas. The initiative is based on a stress paradigm (organization, department, individual) and looks at work-life balance. This information will be used to create a survey instrument to find gaps and inform interventions. Early return to work initiatives and mental health issues are a focus along with other health, safety and wellness issues.

First Nations and Inuit Health Branch (FNIHB) of Health Canada — FNIHB is responsible for the delivery of healthcare service to status First Nations people across Canada in those locales not controlled by the First Nations themselves. FNIHB has a number of quality worklife initiatives underway, including references in the strategic plan, nursing-specific research, professional practice staff and guidelines to support nurses’ professional development including investment in the Canadian Nurses Association NurseONE nursing portal. Their nursing sustainability plan includes measures to increase safety, manage workloads and increase management and clinical nurse specialist supports to front-line nurses.

Health and Community Services Human Resource Planning Unit (HRPU) in Newfoundland — HRPU was formed by a partnership agreement between the provincial government, the Labrador Department of Health and Community
Services and the Health Board Association. The HRPU does research to support HHR planning and lobbies government on related issues. In 2005, the HRPU completed the third iteration of the HHR Indicator report. Reporting on these indicators provides a measure of quality worklife for occupational groups and supports recommendations for quality worklife improvement. In 2004, the HRPU was successful in having a learning and development plan funded for management and health professionals. A Health Canada Healthy Workplaces Initiativ-funded project was launched to enhance a culture of safety in all health authorities.

**Association of Registered Nurses of Newfoundland and Labrador (ARNNL)** — An initiative of ARNNL reviews six areas that contribute to the quality of professional practice environments: workload, nursing leadership, control over practice and worklife, professional development, organizational support and communication and collaboration. Quality Professional Practice Environments guidelines include staffing orientation, workload, access to professional education, workplace safety/violence, and working to full scope of practice. The association uses research to provide an evidence base for guidelines and survey data (pre- and post-intervention) to track results.

**Brock University’s Workplace Health Research Laboratory (WHRL) in Ontario** — WHRL is involved in an ongoing research project to build a Strategic Human Resource Management Database, including the development of flexible data-gathering tools. WHRL works on a business model, charging fees to collect, analyze and report on data collection from organizations and is now self-
supporting. To date, 150 organizations have contracted with WHRL to use its
data-gathering tools, provide reports, consultation and action planning designed to
improve the quality of worklife of the organization. The healthcare sector has
been one of the areas of focus for project development.

**Whitehorse General Hospital (WGH) in the Yukon** — The Working on Wellness Committee has an action plan and an established budget. A staff survey, which includes quality of worklife, is completed annually and the report is directed to the board. The committee meets regularly with the union representatives. WGH is planning an Integrated Workplace Wellness Management policy.

**Seven Oaks Hospital in Manitoba** — Employee and organizational health and well-being is a primary focus, which is built into strategic priorities. The hospital is taking a values-based approach supported by a philosophy that is embedded in all organizational activities. The broad array of initiatives began years ago with an injured workers program in response to escalating workers’ compensation health and safety costs. The hospital is the site of a Wellness Institute that provides additional capacity. The most recent large investment is an 80 space daycare on site. Additional, integrated initiatives include work flexibility, caring management approach, and focused attention on knowledge transfer, which is driven by a philosophy stated as “we cannot afford to lose our employees.” The hospital has been one of Canada’s top 100 employers (all sectors) for the past two years.

When the publication comes out, it is circulated broadly along with the question “what are other employers doing to be in the top 100 that we could be doing?”
Great Place to Work! and the Graham Lowe Group — Graham Lowe has been a consistent major contributor to this field as an academic and now as the leader of a private sector consulting group. His contributions are many and his organizational research and consulting support informs strategic planning, resource allocation and prioritization as well as policy and program development at health system and organizational levels throughout Canada. Mr. Lowe and his associates are also involved in evaluative research in quality worklife. In B.C., he is engaged with the provincial ministry to look at the impact of quality worklife investments and completing a cost-benefit analysis. This is work that is leading the country as there is a scarcity of rigorous intervention studies. He is actively working in other sectors as well.

4.4 Principles to Guide Knowledge Exchange in Quality Worklife and Quality Healthcare

A set of operating principles emerged from the collective views of those interviewed. These principles provide guidance for knowledge dissemination, translation and exchange in the areas of quality worklife. The principles include:

Shared Vision and Values — The work of the Collaborative partners and members needs to be supported by a shared vision of what quality worklife is and how to go about achieving it. The values articulated by successful quality workplaces need to be understood and a consensus established in the values that guide this initiative.

Use Existing Networks and Capacity — In moving forward, it is important to build on existing relationships, capacity and fully utilize existing organizations, professional networks and quality worklife initiatives underway across the country.
Use Experience from Other Sectors and Professionals — Although healthcare has unique characteristics, much can be learned by using the experience of other sectors, including the private sector and international experience. In addition, we need to draw on the expertise of organizational development specialists, psychologists, business school graduates and others that bring new perspectives and capacities to the problems.

Create Opportunities for Innovation — Work to generate ideas to inform new governance and management practices and new models of healthcare delivery that are quality worklife “smart.”

Horizontal and Vertical Integration — Need to be process-oriented, looking beyond the silos, which also involves allocating resources differently. Develop processes across the organization that are linked and integrated with front-line employee involvement.

Investment in Prevention — As with other aspects of health and healthcare, early investments in prevention activities pay significant dividends. If the negative downstream effects of poor-quality work environments and resulting lower-quality healthcare can be prevented, the cost of mitigation and problem-solving is also reduced.

Ethics in Decision-Making — Making ethical decisions in a practice environment, in supporting colleagues facing difficult situations and in management has never been more challenging due to the complexity of care and staff shortages, among other pressures. Supporting employees and managers to work through ethical dilemmas helps to reduce stress and improve quality of worklife.

Responsive to a Range of Organizational and Provider Group Realities — Different ideas translate into different action as individuals and organizations bring a variety of cultural norms, sites, unit structures, professions, etc. As one respondent put it, “some
organizations have all the ducks lined up on the ledge and the others do not know where to look for the ducks.” A hybrid or mixed-methods approach needs to create innovative combinations of ideas from local and global sources, knowledge from research and operations to find the right mix to meet the expressed values, needs and future goals of the organization.

5.0 RECOMMENDATIONS FOR ACTION

As an alternative to formulating the findings not yet presented in the section above in the traditional style, the recommendations for action are set out followed by the rationale. The recommendations and the rationale flow directly from the data collected from respondents who were very thorough and generous with their insights and recommendations.

5.1 Knowledge Exchange

5.1.1 Storage and Access to Documented Knowledge Resources: Build on the current RefWorks database on published literature and “grey literature” documents to ensure easy access to current and relevant information.

5.1.2 Collection, Storage, Exchange of Leading and Promising Practices: Develop an easy-to-access database of leading and promising practices in quality worklife and quality healthcare. Individual respondents canvassed during the environmental scan all indicated an interest in “who is doing what” across the country.

5.1.3 Customized Knowledge Products: Develop the capacity to respond to organizational requests for “just in time” customized knowledge products such as briefing notes, background documents, research syntheses, multi-media presentations, overviews of specific leading practices and organizational quality worklife options.
5.1.4 Knowledge Exchange Options: Provide support for a range of knowledge exchange activities to bring people and knowledge together using a range of methods that hold promise or have been proven to work. A range of options needs to be available and multiple channels used to enhance effectiveness. Methods that were identified as being effective include newswire services, media relations and press releases, champions and a speaker’s bureau, stories of changing lives, electronic journals, newsletters or e-bulletins, web sites, Internet and Intranet, DVDs, written documents or reports, brief information on leading practices and other initiatives, research fact sheets, facilitating relationship building and knowledge exchange, organizational visits or exchange programs, organizational quality worklife surveys and feedback, mentorship programs, formal education and training, face-to-face dialogue opportunities, think-tanks for research on safety and quality worklife, case studies, combination methods (for example, sending an e-mail announcing a report that has been released followed up by a web link to the report in the e-mail or a mailed hard copy to follow by mail), and ready to use materials (for example, ready to use materials for creating customized posters, brochures and newsletters or a gallery of photos, graphics, articles and stories could be easily uploaded and used in developing internal communication tools). More detailed explanations of the options are found in Appendix 1.

5.1.5 Internal and Horizontal Knowledge Transfer and Skill Development: Seek out and share leading practices on how organizations create success sharing knowledge and skills internally between components of large healthcare organizations.
5.2 Quality Worklife and Quality Healthcare

5.2.1 National Promotion and Awareness: Develop and implement a comprehensive and ongoing strategy for promoting quality worklife as it contributes to quality healthcare.

5.2.2 National Action Strategy: Develop and ensure implementation and monitoring of a clear and practical action strategy that responds to the diversity of healthcare providers, healthcare delivery settings and national/regional partners and stakeholders.

5.2.3 Governance and Senior Management Leadership and Accountability: Develop and implement initiatives to encourage and support senior governance and management commitment to enhancing quality worklife and related leadership capacity and accountability.

5.2.4 Access to Information on Leading Practices: Collect, store and share information on leading practices in quality worklife and quality healthcare.

5.2.5 Identification and Use of Quality Worklife Indicators: Identify national indictors and support the use of national, regional and organization-specific quality worklife and quality healthcare indictors.

5.2.6 Worklife Survey Tools, Specific Indicators and Data Systems: Identify and support access to worklife surveys and other monitoring tools, such as specific indicator development, survey instruments, data system development and support for analysis and reporting of data collected

5.2.7 Education and Training: Identify and promote existing education and training initiatives in quality worklife and quality healthcare and support the further development of nationally recognized courses.
5.2.8 **Research and Organizational Impact Assessment:** In collaboration with national research organizations and healthcare stakeholders, develop and implement a national research agenda for quality worklife and quality healthcare that fully acknowledges the work completed to date and targets identified gaps in available knowledge.

5.2.9 **New Knowledge Generation:** Provide sources of accessible funding for development of new knowledge within organizations, collaborative research between academic researchers and operational staff and pure academic research focused on the diversity of healthcare providers and healthcare settings not yet fully addressed.

5.2.10 **Collaboration and Partnership:** Work with and further invest in the capacity in national healthcare organizations to deliver a collaborative effort directed toward improving quality worklife.

5.2.11 **Quality Worklife Funding Programs:** Establish funding programs for quality worklife-quality healthcare program delivery, research, implementation support, evaluation and assessment, capacity-building and partnership development.

5.2.12 **Link to Health Human Resources Planning and Implementation:** Ensure an active linkage between national work being done on HHR and related implementation to ensure an adequate supply of healthcare workers and reduction of problems in recruitment and retention

5.2.13 **Moving Knowledge to Implementation:** Invest in mechanisms to take work in knowledge development, dissemination, translation and exchange and connect it to organizational action in the areas of strategic planning, workplace policy, program and practice development, implementation and evaluation. Ideas from the environmental scan
include knowledge utilization (KU) support, development of “dual practitioners” in research and operations and internal resources for implementation (for example, internal capacity to support implementation such as 1) an organizational development consultant with a strong background in evaluation or 2) a person to develop and support implementation of new policies, programs and practices, and staff training within the organization). A larger KU focus on practitioners and operational levels through, for example, researchers and experts in the field of quality worklife delivering papers and presentations at conferences sponsored by practitioner organizations. More detailed explanations of the options are found in Appendix 1.

5.3 National Co-ordinating Functions

There is a well-established need for national co-ordination of quality worklife and related knowledge exchange activities. One suggestion offered for consideration is creating a QWQH National Knowledge Network that would take on some of the knowledge-related national co-ordinating functions. The support of communities of practice is one of many mechanisms that are in alignment with other recommendations. The focus would be to maximize learning and application of knowledge in developing, implementing and evaluating quality worklife initiatives.
6.0 CONCLUSION

The environmental scan provides an overview of the state of knowledge in quality worklife and knowledge exchange. Although developed specifically for the work of the QWQHC, the document provides an abundance of ideas for individuals and organizations interested in improving the quality of worklife and quality healthcare. The knowledge exchange ideas form a variety of sources provide multiple methods through which learning organizations can connect with each other in sharing the newly invented wheels driving organizational improvement in this area.

The future is promising, and with the national commitment to acting on the foundational work completed by the QWQHC, positive change is in the wind. This renewed commitment bodes well for the next generation of healthcare delivery models, those working in the system, those managing and governing the system and, ultimately, those receiving care in the system.
APPENDIX 1: Detailed Recommendations with Rationale

This appendix has the recommendations from the body of the report (in bold italics) along with the rationale (in plain text).

Knowledge Exchange

5.1.1 Storage and Access to Documented Knowledge Resources: Build on the current RefWorks database on published literature and “grey literature” documents to ensure easy access to current and relevant information. Many organizations are working in the area of quality worklife. In developing new initiatives, many organizations begin with a literature search. Many dedicated organizations are building a base of evidence to inform decision-making and doing so in isolation of others. Informants highly recommended the development of a national database that would provide easy access to highly relevant documented information to support knowledge exchange.

5.1.2 Collection, Storage, Exchange of Leading and Promising Practices: Develop an easy to access database of leading and promising practices in quality worklife and quality healthcare. Individual respondents canvassed during the environmental scan all indicated an interest in “who is doing what” across the country. Staff members and consultants engaged in the quality worklife initiatives across the country do not always have time to publish their findings or attend conferences as speakers to talk about their work. Therefore, the idea of developing a database on QWL and KE organizational initiatives in the stages of planning, implementation or evaluation emerged. The information on the database would include contact information to link people and support the development of individual or organization-to-organization relationships. The identification, collection and documentation of information on initiatives completed would need to be carefully planned and executed. We can no longer rely on formal publications and conferences alone. Organizational experience may be tapped through the development of relationships between the organizational contact people and a person with the role of collecting information on organizational experience. The provision of a person who could provide organizational support in person or long distance could make the information easier to access and share. The person could serve the organization as a scribe, historian or storyteller to actively capture organizational experience. This roving resource person would also bring stories from the other organizations on the circuit as well as providing access to the database. With permission, the write-up of the organizational experience would be provided on the database to be accessed by others seeking to learn. Key words would be assigned to make the relevant stories easy to access by those looking for assistance. This would be one method of sharing organizational experience and providing support for internal and external knowledge management.

5.1.3 Customized Knowledge Products: Develop the capacity to respond to organizational requests for “just in time” customized knowledge products such as briefing notes, background documents, research syntheses, multi-media presentations, overviews of specific leading practices and organizational QW options. Organizational
capacity to use knowledge to convince decision makers and support QW initiatives varies across the country and between organizations. Organizations with more limited financial and human resources often lack the capacity to put together decision-support documents in a timely way. Although organizational needs are somewhat unique, there are significant commonalities that would allow relevant work to be shared and re-used for other organizations. Therefore, the capacity to turn knowledge into action that positively impacts quality worklife would be enhanced by a national capacity to support organizations in the responsive and timely development of customized knowledge products; i.e., a new national group of specialists could assist organizations at a variety of levels, depending on an organization’s internal capacity. With smaller organizations, the specialists could develop materials for them to use and in working with larger organizations with their own internal capacity the specialists may assist them in developing materials using national templates, examples and advice. Sharing of materials between organizations would be encouraged and in some cases, cost recovery arrangements may need to be in place.

5.1.4 Knowledge Exchange Options: Provide support for a range of knowledge exchange activities to bring people and knowledge together using a range of methods that hold promise or have been proven to work. Different knowledge exchange methods work for different organizations and quality worklife-related work. Organizations and individuals often have learning styles that are predominantly written, oral or kinaesthetic or learn by doing. In addition, organizations may be at different development stages in their lifecycle. Depending on turnover of leadership and other external and internal factors, organizations go through cyclical development stages whereby there is start-up, full operation, renewal and into new start-up phases overall and with units and specific programmatic areas. Organizations also experience windows of opportunity where a crisis or significant change in the organization provides the opening through which new initiatives may arise. Therefore, a range of options needs to be available and multiple channels used to enhance effectiveness. Methods that were identified as being effective include:

**Newswire Services** — this e-bulletin or newsletter service would be a brief synopsis of new publications, resources and initiatives that would be delivered to subscribers weekly with up to three pages of brief descriptions with embedded web links for more information. This provides an opportunity to scan for new information, knowledge and initiatives without spending a lot of time.

**Media Relations and Press Releases** — the popular press provides an important vehicle for sharing information and with a well-planned press release or story idea supported by a comprehensive communication strategy, important information can get into hands that need it in a timely way.

**Champions and a Speaker’s Bureau** — identify national champions and knowledgeable speakers and promote them for use at events across the country. Add diverse perspectives to create interest by having a CEO speak at a physician’s conference or a physician speak at a nurse’s conference etc.
**Stories of Changing Lives** — one successful leader suggested that “hard evidence” is interesting and compelling but so are the stories that emerge from organizations of individual, group and organizational change resulting in more successful lives and improved organizational performance. To collect and share these stories is a powerful KE tool.

**Listservs** — some individuals were keen on listservs as a method of keeping subscribers informed, but one warning is to keep the information limited and highly relevant to prevent information overload.

**Electronic journals, newsletters or e-bulletins** — e-mail or electronic journals or other communications are emerging options for use in disseminating new ideas and research results. The linking of electronic articles to chat groups or online forums might be an interesting combination of methods for engaging the new knowledge and developing relationships.

**Web Site** — a web site could house a number of searchable databases, electronic reports/documents/resources, customized information or knowledge products, web streaming of multi-media segments or presentations, downloading of podcasts, a place for networking or meeting of members of specific groups or communities of practice, etc. The web site would have to be actively managed to ensure it is up to date and changing regularly to keep visitors interested. Respondents also underlined the need for a web site to have capacity to support dialogue between users.

**Internet and Intranet** — both Internet and Intranet (internal to the organization) support information access and exchange, as well as Intranet-based chat rooms, forums, teleconferences, videoconferences and other applications.

**DVD** — most individual respondents said that they would rather use a web site, although that might be different if the person did not have regular access to a computer with a high-speed Internet connection.

**Written Documents or Reports** — the circulation of written documents is another useful way of sharing information or knowledge. One participant suggested sending out an e-mail or brief introducing the document prior to mailing so the person can watch for it.

**Brief Information on Leading Practices and Other Initiatives** — to read a brief that provides three or four lines of description would give the reader some idea of the practice or initiative and then have the opportunity to access more comprehensive information and access contact people to talk about the experience of the other organization.

**Research Fact Sheets** — brief summaries of new research findings and suggestions for application within a variety of organizational contexts.
Facilitating Relationship Building and Knowledge Exchange — a matching or electronic introduction service could assist in connecting people with useful information, knowledge and experience with those that need to know.

Organizational Visits or Exchange Programs — providing representatives from one organization to talk to, visit and possibly do work exchanges with a sister organization could be a very effective vehicle for sharing information and knowledge within the context of professional relationships.

Organizational QW Surveys and Feedback — information created by the collection and analysis of data is very relevant to an organization and can be used to develop interventions. The sharing or comparison process between units or departments within one organization or with other organizations can be a foundation for relationships and knowledge exchange related to interventions and sharing success.

Mentorship Programs — Mentorships could be established on an individual or organizational level. If provided with financial support, visits and communication between mentors and mentees could be facilitated.

Formal Education and Training — Quality worklife and quality healthcare curriculum needs to be included in undergraduate and graduate programs that educate healthcare workers at all levels. In addition, ongoing professional and other education and training needs to be targeted toward all levels of decision makers and care providers. Key external organizations such as unions and professional regulatory organizations need access to training as well.

Face-to-Face Dialogue Opportunities — Meetings, seminars, workshops, conferences, national roundtable/forum and leadership gatherings all provide opportunities for dialogue in person, which is a very important vehicle for establishing relationships and opening channels of communication and sharing of information and knowledge. Bring together researchers, academics, employers, employees, regulatory bodies and other decision makers to work through a process of knowledge exchange.

Think-Tanks for Research on Safety and Quality Worklife — Develop think-tanks on a variety of subjects to engage in active problem-solving and generate operations-relevant research as is happening in other industries, such as telecommunications and hydro.

Case Studies — Case studies may be researched and published in Healthcare Management Forum or an alternative publication. A variety of case studies can be used to support education and training processes as well as informing QW implementation.
Combination Methods — For improved uptake, combining methods may be more effective. For example, sending an e-mail announcing a report that has been released followed up by a web link to the report in the e-mail or a mailed hard copy to follow by mail.

Ready to Use Materials — Individuals are asking for ready to use materials for creating customized posters, brochures and newsletters. A gallery of photos, graphics, articles and stories could be easily uploaded and used in developing internal communication tools.

5.1.5 Internal and Horizontal Knowledge Transfer and Skill Development: Seek out and share leading practices on how organizations create success sharing knowledge and skills internally between components of large healthcare organizations. Organizations have called for help in removing silos and developing increased internal capacity for sharing. The sustaining of horizontal relationships and systems across organizations is a significant challenge in organizations of all sizes. The sharing of experience developed in successful organizations may assist in breaking down barriers and improving the quality of worklife and healthcare in all areas of the organization. Several organizations reported pockets of capacity and success within the organization and difficulty translating the success to other units/departments and the organization as a whole.

5.2 Quality Worklife and Quality Healthcare

5.2.1 National Promotion and Awareness: Develop and implement a comprehensive and ongoing strategy for promoting quality worklife as it contributes to quality healthcare. When respondents were asked about what the Collaborative could do to contribute to improvement in healthcare sector worklife and the quality of healthcare delivered, individuals suggested that getting on the national agenda and keeping on the national agenda was an important and primary role. In collaboration with other national organizations, the Collaborative needs to ensure that the target audiences such as federal and provincial political leaders and senior healthcare decision makers have developed an awareness of the issue and are convinced that action must be taken. In order to influence political leaders, the public must also be convinced of the importance of the issue so that they raise it to the political leaders. The messages need to create a sense of urgency among senior decision makers with health mandates and develop understanding that quality worklife contributes significantly to quality healthcare and is also important to the sustainability of the health system. The communication strategy needs to use a range of methods including national print media, trade journals, television, radio, etc. to ensure effective coverage of the audiences from multiple sources.

5.2.2 National Action Strategy: Develop and ensure implementation and monitoring of a clear and practical action strategy that responds to the diversity of healthcare providers, healthcare delivery settings and national/regional partners and stakeholders. When asked what the most important contribution that could be made by the Collaborative in supporting the improvement of QW and QH in Canada, respondents suggested that the work underway to develop the strategy focus on priorities for action
and be followed up by an implementation plan that assures clarity of roles and responsibilities, monitoring, accountability and reporting to the partners and people of Canada. The strategy needs to include visible and clearly defined initiatives with monitoring and evaluation built in. The strategy may also include suggestions for legislation, regulation or policy-making that could further strengthen the accountability related to quality worklife on a broader scale. Guidelines on how to use the strategy or framework, including communication processes and checklists will support active engagement in implementation.

5.2.3 Governance and Senior Management Leadership and Accountability: Develop and implement initiatives to encourage and support senior governance and management commitment to enhancing quality worklife and related leadership capacity and accountability. All respondents spoke to the issue of how the level of commitment and support at the most senior levels of the organization is a strong determinant of the success of QW initiatives. The cultivation of interest, awareness, knowledge and skills with members of governing boards and senior staff is important work for the Collaborative. The turnover of governors and senior managers needs to be taken into account in supporting continuity. In order for QW to be taken seriously, it needs to be part of the accountability structure.

5.2.4 Access to Information on Leading Practices: Collect, store and share information on leading practices in quality worklife and quality healthcare. The challenges within organizations are similar; therefore organizations want to know what other organizations are doing and what is working and not working about what they are doing. Organizations want to follow relevant practices that are working and not repeat mistakes made by other organizations. The “stories of success” collected could also be used to support the national promotion and awareness campaign. The sharing of leading practices within the context of relationships between senior decision makers, specialists in quality worklife and organizations as a whole can be fostered through direct person-to-person connections as described in the knowledge exchange section above.

5.2.5 Identification and Use of QW Indicators: Identify national indictors and support the use of national, regional and organization-specific QW and QH indictors. Organizations require a process to identify and use indicators specific and unique to their organization. In addition, some organizations will choose to align their efforts with others to use some indicators and common data collection methods to ensure a foundation for comparison cross-regionally and cross-jurisdictionally.

5.2.6 Worklife Survey Tools, Specific Indicators and Data Systems: Identify and support access to worklife survey and other monitoring tools such as specific indicator development, survey instruments, data system development and support for analysis and reporting of data collected. Organizations have been successful in using surveys to assess quality worklife and quality healthcare from an employee’s perspective. Organization-specific indicators and data systems are also powerful tools. These are several elements within group of methods that need to be made available to organizations. Individual private sector and non-profit organizations provide these
5.2.7 Education and Training: Identify and promote existing education and training initiatives in quality worklife and quality healthcare and support the further development of nationally recognized courses. There are organizations with a great deal of capacity in place to be able to plan, implement and evaluate a range of quality worklife – quality healthcare initiatives. In addition, there are national and regional organizations doing good work in the development and delivery of courses in relevant subject areas. For example, conflict management, transformational leadership, management practices, coaching and mentoring, QW project management, development and implementation of quality worklife and organizational change initiatives etc. Many others are hampered by gaps in capacity at the governance, management and operational levels. Not only are the financial and human resources lacking, the availability of staff members and consultants (internal and external) to lead and implement quality worklife policies, programs and integrated initiatives is a significant gap. Therefore, the education, training and development work needs to be focused on the development of further competency at the leadership, management, operational and professional practice levels. Areas mentioned as priorities include an evidence-informed decision-making process at all levels in the organization, using evidence in developing QW initiatives, evaluation of QW initiatives, using QW indicators and data systems for monitoring implementation, QW leadership skills at all levels (formal and informal), methods for QW organizational assessment and development, etc.

5.2.8 Research and Organizational Impact Assessment: In collaboration with national research organizations and healthcare stakeholders, develop and implement a national research agenda for quality worklife and quality healthcare that fully acknowledges the work completed to date and targets identified gaps in available knowledge. During the process of completing the environmental scan, an overall sense of a number of significant gaps in knowledge was achieved. It was also acknowledged that both formal academic research and organizational reviews and assessments need to be done to fill in the missing pieces. Further, differentiation was made between the role of the academic researcher as compared to the role of individuals on staff or contract hired to fully support the organizational agenda without competing priorities. The gap areas suggested by informants included the link between quality worklife and quality healthcare; quality worklife-related evaluation tools and results; impact analysis,
costs/savings and outcomes as well as the link between quality worklife and diversity issues in the workplace.

5.2.9 New Knowledge Generation: Provide sources of accessible funding for development of new knowledge within organizations, collaborative research between academic researchers and operational staff and pure academic research focused on the diversity of healthcare providers and healthcare settings not yet fully addressed. The respondents in the environmental scan have identified significant gaps in existing knowledge. At least two individuals mentioned the competing agenda of academic researchers and organizational leaders. To succeed in academia, a researcher must publish and move through sometimes onerous ethics approval processes. The need to hold information secret prior to publication can impede knowledge sharing and implementation. The timeframes within which academic processes move are much longer than those needed to support organizations. Therefore, care must be taken in developing collaboration to fill gaps. Identified gaps include a lack of information and research on non-nursing health providers in all settings, all health providers in rural and remote community healthcare settings, all organizations serving Aboriginal and other culturally diverse populations; non-institutional and community health settings, evaluation of QW interventions and initiatives, proving the link between QW and QH, and better use of various healthcare providers. Although not everything is known about nurses in hospitals, much of the research over the past decade has been focused there. The factors influencing quality healthcare environments are well known, although what to do about improving the quality of worklife and what might be expected in the way of impacts is much less well known, particularly outside of hospitals.

5.2.10 Collaboration and Partnership: Work with and further invest in the capacity in national healthcare organizations to deliver a collaborative effort directed toward improving quality worklife. The Collaborative is an excellent example of how national partners can work together to accomplish important objectives. In order to maximize the use of available resources and reduce the potential for gaps and overlaps, it is important that the work identified by the Collaborative be organized for implementation in a way that builds on rather than competes with existing national healthcare organizations. The need for a new national body needs to be fully assessed against the opportunity to develop further capacity within and stronger linkages between existing healthcare organizations. The primary focus on quality worklife and healthcare, the co-ordination across organizations and other strategic functions may have to be held by one body with a singular focus. An example of emerging opportunities include NurseONE; the Canadian Nurses Association has launched a new nursing portal that will house important information and support nursing professional development in a variety of ways. The portal could be an important element in the knowledge exchange network supporting quality worklife for nurses and those they supervise.

5.2.11 Quality Worklife Funding Programs: Establish funding programs for QW-QH program delivery, research, implementation support, evaluation and assessment, capacity-building and partnership development. The availability of funding for a specific purpose is a powerful incentive for engagement and action. Project-based, short-
term funding is helpful to complete time-limited work but provides real discontinuity in organizations fully reliant on grants. Organizations and individuals need internal and external sources of funding to support their commitment to improving quality worklife. In many cases, both internal and external funding is project-based and unreliable in sustaining multi-year or ongoing programming or following through on commitments. Respondents indicated that external funding would support organizations in leading or participating in QW initiatives. In addition, funding can assist in the development of an evidence base for a variety of QW activities.

5.2.12 Link to Health Human Resources Planning and Implementation: Ensure an active linkage between national work being done on HHR and related implementation to ensure an adequate supply of healthcare workers and reduction of problems in recruitment and retention. Organizations are reporting shortages of nurses, physicians, rehabilitation professionals, pharmacists and other healthcare providers. Many are identifying problems with recruitment and retention and the resulting burnout of remaining staff as a very significant and pressing issue. As one respondent from a rural/remote area said, “send me enough nurses and then I will worry about quality worklife.” The QW-QH strategy can not address all HHR issues but can ensure an effective linkage, co-ordination and harmonization with other national strategies and activities.

5.2.13 Moving Knowledge to Implementation: Invest in mechanisms to take work in knowledge development, dissemination, translation and exchange and connect it to organizational action in the areas of strategic planning, workplace policy, program and practice development, implementation and evaluation. There is a well-established body of knowledge and a disconnect between the knowledge and organizational action. In order to support decision-making and implementation of QW initiatives, innovative methods of translating knowledge into action need to be used. Ideas from the environmental scan include:

**Knowledge Utilization Support** — As discussed more fully in the knowledge exchange section, the provision of packaged information, research summaries or briefs, synthesis documents for various audiences would be very helpful to organizations. These customized knowledge products and other just in time decision supports can be offered along with advice and guidance in a responsive and respectful manner.

**Development of “Dual Practitioners” in Research and Operations** — Academic researchers without a background in operations may be hesitant to fully engage in projects led and dominated by operational issues and processes. On the other side, staff and consultants from the public or private sector may not be comfortable engaged in academic research. In order to bridge these two realities, the development of individuals educated and experienced in both worlds would be helpful. In addition, relationships between researchers and those engaged in operations as part of diverse teams that represent both realities is a method ensuring the meeting of minds and the best possible. An example of a dual
practitioner is Greta Cummings, a university-based researcher at University of Alberta in leadership and nursing with 20 years of experience in operations that is called upon regularly to work with health regions in implementing initiatives, gathering and analysing data and providing expert advice and consultation.

**Internal Resources for Implementation** — All organizations need internal capacity to support implementation. Some are well-resourced and others have very little in the way of dedicated resources. One organization described its need for an organization development consultant with a strong background in evaluation. Another saw the need as a person to develop and support implementation of new policies, programs and practices within the organization, including staff training. The basic human resources functions of the organization must also be adequately covered, which is integral to quality worklife. This involves up-to-date HR policies, adequate staffing, manageable workloads, employee assistance programming, reasonable levels of management support, adequate orientation, assurance of physical safety and access to food and shelter, if needed.

**Focus on Practitioners and Operational Environments** — Researchers and experts in the field of quality worklife need to deliver papers and presentations at conferences sponsored by practitioner organizations. By increasing the focus on knowledge translation and transfer, more evidence-informed implementation may occur. Researchers working in operational environments supporting the agenda of the practitioner will contribute to the connectivity between the research and operations worlds. Surveys need to be run regularly to track change and managers need to get the results back in a timely manner.
APPENDIX 2:  Summary of the Literature Review

Quality Worklife

The literature review completed in support of the development of the recent report titled “Promoting High Quality Health Care Workplaces: Learning from Saskatchewan” provided an excellent brief summary of the elements of quality workplace. The first is the importance of leadership at all levels of an organization and how to develop, nurture and empower it (Feldman & Greenberg, 2005; Rushmer, Kelly, Lough, Wilkinson & Davies, 2004). Another is the importance of supportive social and professional relationships in the healthcare workplace (Halos & Axelrod, 2005; Lavoie-Tremblay et al., 2005; Valadares, 2004). The growing complexity of providing systems and structures in organizations that are necessary for the collection and exchange of information, evidence and knowledge to develop evidence-based practice is also widely discussed in the literature (Ashton, 2004, Rutherford, Leigh, Monk, & Murray, 2005; Owrstman & Janowitz, 2006). The identification of work characteristics that allow for autonomy of workplace decisions in quality service (Hayhurst et al, 2005; Kramer & Schmalenberg, 2004) and scope of practice and workloads (Bauman et al, 2001; Geiger-Brown et al., 2004; McGillis Hall & Kiesners, 2005; Shamian et al., 2003; Thompson, 2002) are named in the literature as being key considerations in developing quality workplaces. There are also individual determinants that predict the use of new evidence including professional characteristics, level of education, information and involvement in research activities (Estabrooks, 2003). The other key issues identified in the literature include human resource management practices that work to support these efforts (Ambrose & Schminke, 2003; Bierly & Daly, 2002; Lowe, 2005; Nutly & Davis, 2001), the organization strategies that assist (Barett, 2002; Lavoie-Tremblay et al., 2005) and the importance of organizational culture as a determinant of quality workplace (Scott-Findlay, 2005; Golden-Biddle et al, 2004).

Additional requirements for a quality worklife include:

- Predictability and Stability — One of the greatest challenges is in understanding how to retain and maximize the skills and productivity of those currently in the system. To that end, we know a high level of basic predictability is an important requirement for a health workplace (Baumann, O’Brien-Pallas, Armstrong-Stassen, et al, 2001). Glouberman stresses further that the current situation “does not provide much stability for nursing staff… unstable work environments make everyone more jittery and less respectful of each other” (2002, p. 29).

- Safe Work Environments — Exposure to verbal, physical, emotional and sexual abuse in the workplace is not new to nursing or unique to Canada. The majority of reported abuse incidents originate in nurses’ interactions with patients and families, but they also involve physicians, managers, and other co-workers. (1. p. 20) Safe parking and availability of safe, nutritious food are both fundamental issues that workers need addressed.
Respect at Work — The frustration related to lack of respect for nurses is “directed at physicians who are abusive and pay scant heed to what nurses think, administrators who control nurses’ lives but know little about patient care, financial managers who cut budgets at the expense of patient care, patients who are violent against nurses, the families of patients who are abusive and even fellow nurses who are equally frustrated” (CNAC, 2002 p. 22).

Flexible Scheduling and Time Off — Responsive, flexible and innovative scheduling that allows for balancing home and working lives and meets unpredictable family care needs (CNAC, 2002, p.12).


Productivity — Productivity in knowledge and service work demands that we build continuous learning into the job and the organization. Knowledge demands continuous learning because it is constantly changing (Drucker, 1993, P. 92).

Key Themes in High-Quality Healthcare Workplaces — The multi-method, two year research project led by Dr. Marlene Smadu, identified seven key themes critical to the creation of high-quality healthcare workplaces. Listed in order of priority, they are leadership, work relationships, system and structures, work characteristics, human resource issues, outside influences and information. The process through which leadership, work relationships are expressed through effective communication and the use of evidence is fundamental to the transition to a learning organization (Smadu, 2006, p.1).

Professional Practice Environments — Professional practice environments were negatively affected by the downsizing and budget cuts of the 1990s. There was a loss of senior nursing leadership and a loss of meaningful relationships for many nurses with a nursing supervisor who was visible and accessible. Managers accounted for 7.7 percent of the registered nursing workforce in 2000 compared to 10.1 percent in 1994 (CIHI, 2001a) — a loss of some 5,500 manager positions.

Positive Outcomes of Healthy Workplaces — As stated by Smadu and others in the recent report titled “Promoting High Quality Health Care Workplaces: Learning from Saskatchewan” (2006), existing research indicates that high-quality healthcare workplaces lead to increased recruitment and retention of healthcare providers and improved client outcomes (Child, 2004; Hayhurst, Saylor & Stuenkel, 2005; McGillis Hall & Kiesners, 2005; McGillis Hall et al., 2005; Shamian, et al, 2003; Shannon & French, 2005).
Link between Quality Worklife and Quality Healthcare

The problems documented within the nursing workforce, do not end with nursing. They are even more pressing when we relate them to their unmistakable impact on the patients/clients under the nurses’ care. The link between quality healthcare worklife and quality healthcare as measured by patient safety and patient outcomes include the following key points:

➢ **Nurse Ratios and Staff Mix** — A decade of research has established that there is a direct correlation between the ratio of nurses to patients and the health outcomes of those patients (Doran, McGillis Hall, Sidanai, et al., 2001; McGillis Hall, Irvine Doran, Baker, et al, 2001; Needleman, Buerhaus, Matke, et al., 2002; O’Brien-Pallas, Irvine Doran, Murray et al., 2002; O’Brien-Pallas, Irvine Doran, Murray et al., 2001; Prescott, 1993; Tourangeau, Giovannetti, Tu & Wood, 2002). At the most basic level, nurses’ skill mix and staffing ratios are significant predictors of mortality (Aiken, Sloane & Sochalski, 1998; Aiken, Smith & Lake, 1994; Prescott, 1993).

➢ **Nursing Hours** — Similarly, Needleman and colleagues (2002) found that a higher proportion of hours of care per day by registered nurses and a greater absolute number of hours of care per day provided by RNs were associated with shorter lengths of stay, lower rates of urinary tract infections and upper intestinal bleeding, lower rates of pneumonia, shock or cardiac arrest and failure to rescue (defined as death from pneumonia, shock or cardiac arrest, upper GI bleeding, sepsis, or deep vein thrombosis).

➢ **Other Professionals and Healthcare Workers** — Unfortunately, much of the research done on nurses has not been done with a focus on other professionals, healthcare workers or the operation of multi-disciplinary teams. The evidence indicates the presence of a “halo effect” or spillover effect that when nursing practice environments are improved, the positive effects felt by patients and families are also experienced by other health professionals. The American Nurses Association (ANA) notes that research “fully documents that high-quality nurses is one of the most important attributes in attracting high-quality physicians” (2002).

➢ **Repairing Work Environments** — What is apparent in all this work is the need not to repair nursing, but rather to renew and repair the work environment in which nurses practice. A growing body of evidence clearly supports the notion that making these changes does a great deal to recruit and retain the best nurses (1. p. 26). Between 1990 and 2006, many studies were completed, including meta-analysis of major policy documents. The factors influencing quality of worklife for nurses is well-documented, as are the recommended solutions. Other professional groups have not been as well-researched, but it could be assumed that many of the fundamental issues may be common. Issues include the need for respect, autonomy, practicing to full scope, effective communication with...
supervisors and co-workers, access to necessary equipment and supplies, continuing education opportunities, support in coping with job-related stress such as working with the dying patients, rewards and recognition.

- **Magnet Hospitals** — The discussion of health workplaces and the magnet hospital movement in the U.S. has focused on what it takes to create collaborative working relationships among members of healthcare teams, which is a significant feature of high-quality worklife. Even beyond the healthcare environment, Lowe and Schellenberg assert, “a healthy and supportive work environment is the crucial factor in creating robust employment relationships.” This includes physical, social and psychological aspects of the workplace. Individuals with strong employment relationships tend to have helpful and friendly co-workers, interesting work, assess their workplace as both healthy and safe, are supported in balancing work with personal life, and have reasonable job demands. (2001)

- **Comprehensive Approach to Staff Retention** — The literature on the quality of nursing worklife that was summarized for the Health Human Resource Planning in Canada (2002) report focused on the concept of magnet hospitals — taking a comprehensive organizational approach to recruiting and retaining nurses. The concept of the magnet hospital has been used in the United States and appears to be a successful policy innovation (Aiken et al, 1997). A magnet hospital is defined as a hospital that has a good reputation for recruiting and retaining nurses based on progressive employment policies and organizational support for the nursing profession.

- **National Co-ordinating Function** — A key recommendation of the same report is to shift health human resource policy by creating a national co-ordinating function to bring focus and expertise to the issue and to provide a neutral space for stakeholders to come together to begin integrated planning for the future (Fooks, 2002). The question to consider is whether that same co-ordinating body should be looking at recruitment and retention, including quality of worklife issues, in order to ensure a comprehensive policy approach.

- **Policy and Program Impact on Worklife** — Across the country, initiatives have been launched to address projected shortages of health professionals and respond to an urgent call for action. Part of the work of this project and the Collaborative as a national initiative is to find ways, through knowledge exchange mechanisms, to link the good work being done across the country in order to support effective implication and comparison of outcomes.
Knowledge Exchange

The scope of the environmental scan included a review of recent publications that inform the understanding of knowledge exchange. Highlights from the review follow:

- **Knowledge Transfer and Learning Organizations** — As stated by Smadu and others in the recent report titled “Promoting High Quality Health Care Workplaces: Learning from Saskatchewan” we cannot create knowledge workers, nor function in a knowledge economy without attending to the processes and approaches to facilitate knowledge transfer. The idea of creating learning organizations, with all the characteristics and benefits identified in the literature, is long overdue for healthcare workplaces (Smadu, 2006, p.49).

- **Knowledge Translation (KT)/Exchange** — In the terminology of knowledge exchange, we are including knowledge transfer or translation, utilization and diffusion. The two key agencies working in this area are the Canadian Institutes of Health Research (CIHR) and the Canadian Health Services Research Foundation (CHSRF). CIHR believes knowledge translation includes all the steps between the creation of new knowledge and its use in society, including dissemination, communication, knowledge management, knowledge utilization, two-way exchange between researchers and those who apply knowledge, implementation research, technology assessment, synthesis of results within a global context, development of consensus guidelines, and more.

- **Knowledge Cycle and KT** — CIHR developed the knowledge cycle and the knowledge translation within the research cycle. Both are graphic depictions that contribute to the understanding of how knowledge is developed, translated and used. The second noted cycle defines six points at which knowledge exchange is critical. These are: KT1: Defining research questions and methodologies; KT2: Conducting research; KT3: Publishing researcher findings in plain language and accessible formats; KT4: Placing research findings into the context of other knowledge and socio-cultural norms; KT5: Making decisions and taking action informed by research findings; and KT6: Influencing subsequent rounds of research based on the impacts of knowledge use (CIHR, 2005b).


- **Underutilization of Knowledge** — There have been numerous theories proposed to explain why knowledge is underutilized in policy decision-making. However, the majority of the literature that explores this topic focuses on two related


- **Roles of Research Agencies** — Research funding agencies can also fulfill numerous roles to support knowledge translation. These include ensuring policy relevance by including policy makers in the funding review processes, facilitating ongoing interaction between researchers and decision makers, creating incentives for knowledge translation for researchers, offering training programs and technical expertise in communication to researchers and policy makers, supporting knowledge brokers and developing other mechanisms to support local decision makers in accessing research relevant to their settings (Pyra, 2003, p. ii).

- **Categories of Evidence** — According to a recent systematic review of the literature conducted by CHSRF (Lomas et al.) evidence can be categorized into three main types: context-free scientific evidence, which is medically oriented effectiveness research; context-sensitive scientific evidence, which is social science-oriented research; and colloquial evidence, which comes from expertise, views, and realities of the stakeholder.

- **Integration of Evidence** — Lomas and his research team (2005) suggest that all three types of evidence needs to be integrated in some way and suggest the use of
deliberative processes to elicit and combine evidence in an integrated, inclusive and transparent way, to address the competition between kinds of evidence, and to produce outcomes that are rigorous, useful and contextually appropriate. A deliberative process as defined by CHSRF (Lomas et al., 2005) is a tool for producing guidance based on heterogeneous evidence. It a participatory process including representations from both experts and stakeholders, face-to-face interaction, criteria for the sources of scientific evidence and their weight, and a mechanism for eliciting evidence while making it subsidiary to the science.

➢ **Discussion on Primacy of Scientific Evidence** — The use of the terminology of “subsidiary to science” in this quote is an interesting one. This view assumes the dominance of “scientific evidence” and may be seen as disrespectful of the “lived experience” and the deep understanding of the context that decision makers and policy makers bring to a question. If mutually respectful knowledge exchange mechanism are to be developed, both types of knowledge need to be fully valued. If we think of a two- or three-strand helix, with many bridges between the strands, that would be a dynamic view of the use of knowledge. This concept is also consistent with the new thinking emerging in the field of organizational application of complexity theory. In this theoretical context, theory and practice are seen as co-emergent and interconnected phenomenon that emerge and interact in a series of dynamic and not always predictable ways. Another perspective through which to view this discussion is the through the lens of colonization and culture. First Nations people are re-claiming indigenous knowledge and ways of knowing and de-colonizing knowledge structures and systems to allow their knowledge to be fully recognized and used in the most respect way to help indigenous people. In a similar fashion, to devalue colloquial knowledge as less than “expert” because it is not well-understood is not helpful to the development of respectful relationships between decision makers, policy leaders and the researchers that want to inform them.

➢ **Dissemination of Knowledge** — A dissemination plan also needs to be context-specific. Other important considerations of knowledge transfer involve packaging the information properly depending upon the audience and utilizing appropriate communication techniques to ensure the message does get to those who will use it (Lavis, et al., 2005).

➢ **Practitioner and Decision Maker as “Expert”** — This dissemination approach provides a mechanism to deal with the evidence-based practice aspect of the transfer of research results to practitioners throughout the system. The work assumes the dominance of scientific evidence and sees the researcher or expert as the active initiator of the process. The other side of the helix is the mechanisms for practice-based evidence that views the stakeholders as experts in their own context and sees a process of the practice expert initiating research questions and processes. In this evidence generation process, the practitioner is the active initiator of research partnerships and processes.
Knowledge Transfer/Exchange Mechanisms — The facilitation of knowledge transfer can be facilitated by the development of communities of practice, knowledge networks and soft networks. Communities of practice share a specific field or discipline, are a defined community of practitioners and also have a common goal of sharing information to improve their practice and gain professional development. Knowledge networks typically consist of groups of experts who work together on a common concern to develop solutions and are more formal in their organization. These networks often develop interdisciplinary memberships around a common goal or issue. Soft networks are very informal and largely referral systems. They may be developed through word of mouth or through electronic directories or web-based chat rooms or other collaborative mechanisms (Smadu, 2006).

Characteristics of Social Epidemics — In the recent book in the popular press, The Tipping Point, the author, Malcolm Gladwell, defines three characteristics of epidemics. The characteristics are contagiousness; the fact that little causes can have big effects; and that change happens not gradually but at one dramatic moment. If the intention is to make a big difference in quality worklife by achieving a tipping point, his concepts become central to designing an approach that is most like to succeed (Gladwell, 2002, p.9). If what we are intending is a “social epidemic,” Gladwell also identifies three kinds of exceptional individuals that are key to informal network development if the objective is change or the achievement of a tipping point. These are connectors, mavens and salespeople. The connectors are people with broad-based and diverse social and professional networks with a special gift for bringing people together (Gladwell, 2002, p. 38). The mavens are people whom we rely upon to connect us to new information. These are the individuals who control word-of-mouth epidemics. The salesmen are the third group who influence people through a combination of energy, charm, enthusiasm, an amazing ability to develop relationships with individuals through a combination of personal attributes, real interest in others and developed skills. Gladwell (2002) also talks about the equivalent of “contagiousness” in a social epidemic — the “stickiness” of the message. Stickiness means that the message makes an impact, and there are specific ways to makes messages more memorable and influential (Gladwell, 2002, p. 25).

French Language Literature

The literature review on specific French materials gave the following results. It is imperative to add that most of the published documents exist in English also, most of them being sponsored by major Canadian foundations such as the Canadian Health Services Research Foundation (CHSRF) and Canadian Institutes of Health Research (CIHR).

The main themes identified and pursued by the francophone reviewers covered a wide range of topic areas related to quality worklife and knowledge exchange. Fillion and Morin (2003) worked on a research program, funded by CHSRF and other funders, which
includes the descriptive evaluation of an integrated network model in palliative care and on the impact expectation on work satisfaction, quality of life and quality of care, and a randomized trial on the effectiveness of an existential intervention to increase worklife satisfaction and quality of life of nurses in palliative care.

A research team led by Bourbonnais (2004) was interested in an evaluation research to optimize the psychosocial and organizational work environment for caregiving staff in order to reduce the mental health problems of caregiving staff. This study was conducted with the financial support of the Canadian Health Services Research Foundation, the Fonds québécois de recherche sur la société et la culture, the Social Sciences and Humanities Research Council, the RRSSSQ, and the Centre de santé et de services sociaux de Québec-Sud. The prior risk assessment revealed a significant presence of psychosocial constraints and psychological distress among caregivers at long-term care facilities and hospitals, compared with workers in the general population. These findings have revealed the empirical presence of the targeted psychosocial constraints. A participatory initiative with an intervention group in each test centre identified several constraints and their solutions.

The intervention targets were related to work and team spirit, the assignment and replacement process, the organization of work, training, communication, and ergonomics. Effectiveness of the intervention was assessed 12 months after the start of the initiative. In the hospitals, the findings indicate a significant decline in three targeted psychosocial constraints and one health problem in the test group, especially a decline in the prevalence of high psychological demand, poor reward, imbalance between effort and reward, and sleep problems. No decline in these constraints was observed in the control group. In addition, a significant deterioration in five constraints was observed in the control group, while no deterioration was observed in the test group. In the long-term care facilities where an intervention initiative was implemented, the results at 12 months indicate a significant decline in five targeted psychosocial constraints and one health problem: a decline in the prevalence of limited decision-making latitude, the combination of high demand and limited latitude, and intimidation. The first published report (2004) suggests that the participatory initiative, focusing on involvement by management and staff, uses recognized conditions for success with preventive interventions. The methodological strengths of the research (based on solid theoretical models, a quasi-experimental approach including a control group, and use of validated instruments) promote its generalization outside the hospital sector.

Viens et al. (2006) direct their interest toward nurses’ occupational health and professional integration. She was awarded funding from the Research, Exchange and Impact for System Support (REISS) Competition in 2006 for the following project: “PRO-ACTIVE: Participatory and Evaluative Research Program to Optimize Workplace Management: Application of Knowledge, Transfer of Expertise, Innovative Interventions, Training Transformational Leaders.”

Alderson (2004) works mainly on quality of worklife in long-term care and is determined to evaluate the impact of nursing workload reorganization focusing on nurses’
satisfaction. She was awarded funding with her team for the following three-year project in 2004: “Evaluation en termes de satisfaction et de santé mentale des infirmières d'une vaste réorganisation du travail infirmier en centre d'Hébergement et de soins de longue durée incluant l'implantation des soins modulaires, du concept "milieu de vie" et de l'informatisation (Projet Système d’Information Clientèle en Centre d'Hébergement et de Soins de Longue Durée (SICHELD).

Trottier and Champagne (2006) discuss the use of evidence in determining the effectiveness of interventions for public health domain.

Champagne, Contandriopoulos, Touche, Beland and Nguyen (2004) developed an evaluation framework to measure the performance of healthcare systems titled “Global evaluation performance of health care systems.”

Morin (2005), who is from the business area, has been publishing research and intervention projects for work, organizational effectiveness and health. Within her field of expertise, she focuses on potential human resources problems and dimensions of quality of worklife, which include satisfaction, feeling of belonging, self-becoming and personal value and dignity. These dimensions were also covered by nursing researchers. Morin is leading an interdisciplinary team interested in mental health in the workplace, which is funded by the Canadian Institutes of Health Research. The ultimate goal of this research initiative is to build in multidisciplinary scientific expertise from medical, social, psychological, and management fields to improve mental health in the workplace. She did contribute to a project with Alderson, Rheaume and Saint-Jean (2005) on the reorganization of nurses’ workload in long-term care.

Champagne and his colleagues Lemieux-Charles, Denis, and Contandriopoulos concentrate their research focus on health systems analysis and innovations in the organizations. Many projects or target areas are in progress.

Lemieux-Charles and Champagne (2004) published a book on quality worklife titled “Using Knowledge and Evidence in Health Care: Multidisciplinary Perspectives.” Champagne (2005) is leading a research team to develop a model of knowledge transfer in population health which is sponsored by the Canadian Institutes of Health Research in collaboration with Landry, Denis and Contandriopoulos.

Denis is a CHSRF/CIHR chair and is leading the development of a number of research and training opportunities in managing change in healthcare organizations. Current topics include the analysis of healthcare reforms and restructuring, the innovation process in healthcare organizations, and the institutionalization of changes to knowledge bases. Dr. Denis' chair web site is www.medsp.umontreal.ca/getos/.

Landry has a wealth of research on knowledge transfer in healthcare and had been researching innovative environments among many other themes. He is the CHSRF/CIHR chair on knowledge transfer and innovation, which began operating in the summer of 2000. The objective of the chair is to further the scientific understanding of knowledge transfer and innovation in health services, to train and support students pursuing master's
and PhDs in this field, and to encourage and facilitate the transfer of knowledge in

general. www.fcrss.ca/cadre/bio_landry_e.php

Bachmann (2000) for the Conference Board of Canada wrote a report titled “More than
Just Hard Hats and Safety Boots: Creating Healthier Work Environments.” This
document reports that in order to achieve high levels of employee productivity, efficiency
and morale, leading executives have learned that they need to address workplace health
and wellness in an integrated fashion. These are some of the questions that this two-phase
study set out to answer: What are the elements of an integrated approach to workplace
health? What roles do employers and others play? What are the barriers to achieving a
more integrated approach and how can these barriers be overcome? The results of the
survey show that key stakeholders, including government, NGOs, labour organizations
and various associations representing small businesses, provide assistance and
programming to Canadian employers in dealing with workplace health issues.
http://sso.conferenceboard.ca/e-Library/LayoutAbstract.asp?DID=335
The plan for improving healthcare workplaces in the province of British Columbia was focused in large part by the publication of the report by the Office of the Auditor General (OAG) in British Columbia titled *In Sickness and in Health: Health Workplaces for British Columbia’s Health Care Workers* in June 2004. The OAG audit team collected information from the province’s health authorities in three areas:

- providing leadership in establishing and maintaining a healthy work environment;
- promoting a healthy work environment; and
- monitoring and reporting on the health of their employees and the work environment.

The health authorities all began working on issues related to quality workplaces, things that would reduce injuries in healthcare workplaces, improve retention and recruitment efforts and patient safety. There were several major issues still remaining for B.C.’s Nurses Union, which they sought to resolve in their last round of collective bargaining. The union bargained for and received additional funds to increase the number of front-line supervisors and to support their leadership training. The new collective agreement also included commitments to develop responsive shift scheduling and support the evaluation and implementation of information systems to address workload issues. The leadership demonstrated in these initiatives may inform decisions by other healthcare providers.

The provincial organization that represents health employers, the Health Employers Association of British Columbia (HEABC) is co-ordinating efforts of the six health authorities in the area of quality workplace initiatives. There is $1.2 million in funding, with the B.C. Ministry of Health Services ($800,000) and Health Canada ($400,000) contributing to these efforts. Dedicated funding to these initiatives is critical.

A province-wide five-year project involves the development of an integrated model for supporting psychological health in the workplace. It is being undertaken by the Occupational Health and Safety Agency for Healthcare (OHSAH) in B.C., which is led by Dr. Elizabeth Smailes. The project will determine the incidence of mental health symptoms, determine the level and nature of stressors, identify current programs and barriers to optimal mental health, identify, pilot and evaluate interventions, and develop infrastructure to sustain ongoing development of healthy workplaces.

By way of background, OHSAH was created with joint union and employer governance to develop evidence-based programs to promote better workplace health and safety. They undertook a five-year project in 1999 with funding from the Canadian Institutes of Health Research (CIHR) through the program Community Alliances for Health Research (CAHR). That partnership resulted in several research-to-practice projects and identified
more than $108 million in savings between 2002 and 2005. There were several key aspects of knowledge development along with the financial savings resulting from that research, which demonstrates the success of effective knowledge translation initiatives. Significant contributors to the success of the project include the involvement of multiple stakeholders from the beginning of the research project; demonstrated senior management commitment; front-line worker involvement; and union advocacy for the implementation of research findings.

Under quality workplace initiatives, each of the six health authorities has planned its own initiative. **Fraser Health Authority** is focusing on the development of a healthy workplace prevention action plan through integrated data analysis. **Interior Health Authority** is expanding an existing project to involve front-line staff in designing comfortable and safe work environments. **Northern Health Authority** is planning to develop an ability management program in-house and use cost savings to expand health promotion and wellness initiatives. **Provincial Health Services Authority** will be implementing a patient safety program, which will improve quality of worklife by developing inter-disciplinary teamwork, improving communication by encouraging staff involvement in identifying issues and solving problems. **Vancouver Coastal Health Authority** will enhance a program that helps shift workers deal with issues related to a shift work lifestyle. **Vancouver Island Health Authority** will be focusing on developing a sustainable wellness program utilizing gap analysis, best service delivery models, and impact of physical activity in managing stress.

**Alberta**

Alberta has a long history of working towards improving the uptake of research knowledge. The Speedy and Efficient Access to Research in Community Health (SEARCH) program, started as a pilot two-year program back in 1996, is delivered by faculty from the University of Alberta and the University of Calgary. The purpose was to increase evidence-based practice by increasing professional and organizational capacity. This system-wide approach to knowledge translation expanded to the national stage in April 2005 and is operating independently with funding from Alberta’s nine health regions, the University of Calgary and the Alberta Heritage Foundation for Medical Research (AHFMR). AHFMR also houses another research knowledge transfer network (RTNA). Work is currently underway to develop a strategic vision for the RTNA whose goals are to strengthen the use of research findings to improve health policy and practices in Alberta.

The nine health regions in Alberta each have business plans complete with strategic goals. But again, there is little or no information available on web sites related to these activities with specifics and expected outcomes. In each case, healthy or quality workplaces are identified. The **Palliser Region** began examining the issue of quality workplaces back in 1995 (led by Janice Blair) and by 1998, a Workplace Wellness Committee was developed to determine how to address issues such as poor communication and morale, job security and continuing education. Work on these activities culminated with an employee survey in May 2003. The program was identified
as having made some improvements in communications, and the survey provided valuable baseline data against which to measure the success of future efforts. Follow-up was identified and included conducting focus groups to get a better understanding of the survey results, holding management accountable for adapting to the participatory management style prescribed by senior management, better recognition of staff and improved tracking and management of training/educational opportunities.

**Calgary Health Region** has identified the need for a regional strategy and action plans toward enabling wellness — what people can do for themselves — and for each other — toward physical, mental, spiritual and social well-being in the organization and the community. A senior manager has been appointed to this portfolio, including the creation of a healthy workplace for the region’s employees. The **David Thompson Health Authority** adopted a leadership philosophy in January 2004 which encourages the development of trust between supervisors and the building of participatory, consultative team practices, which includes open communication. These are all part of a quality workplace. An assessment or evaluation of the adoption of this philosophy does not appear anywhere on the RHA’s web site.

The fourth goal of the **Chinook Health Region** is the creation of employees as partners and the fostering of a positive work environment and the creation of a quality workplace. There is evidence on the RHA’s web site that wellness committees have been established and they have developed workshops on resolving conflicts and relaxation techniques. The **Aspen Regional Health Authority** kicked off an employee wellness drive this spring with the recruitment of 45 site champions to support wellness among Aspen employees. These activities are based on concepts including active living, healthy eating, and workplace environment. The **East Central Health Authority** has been very active on the development of quality workplaces with assistance from Health Canada’s Healthy Workplace Initiatives. They developed 36 healthy workplace teams in key locations throughout the region. Details of their activities are not evident on the web site. There was no evidence of quality workplace activities reported on the web sites of **Capital Health, Peace Country** or **Northern Lights**. The focus in the northern regional health authorities (Peace Country and Northern Lights) is primarily focused on efforts to alleviate staff shortages.

**Saskatchewan**

The province of Saskatchewan began its journey on the quality workplace path in the late 1990s by commissioning Linda Duxbury and C.A. Higgins in the examination of worklife balance in *Saskatchewan: Realities and Challenges*. Quality workplace initiatives crossed over into the healthcare sector with the commissioning of a research report by Allan Backman titled *Job Satisfaction, retention, recruitment and skill mix for a sustainable health care system in 2000*.

The Saskatchewan Registered Nurses Association (SRNA) developed and staffed a Quality Workplace program in 2001, in partnership with the Saskatchewan Nurses Union (SUN). The Saskatchewan Department of Health (SaskHealth) provided seed money.
The project was discontinued when SUN questioned the effectiveness of the program and the province withdrew its funding. Since then, SaskHealth has developed a strategy involving two streams of activities: quality workplace initiatives and occupational health and safety initiatives. The one-time dedicated funding ($2.4 million) has allowed the regional health authorities to design projects to meet their individual needs. The Saskatchewan Association of Health Organizations (SAHO), with the regional health authorities’ support, conducted a province-wide employee opinion survey in 2005. Each RHA is devising its own response to the findings. It is important to remember that the larger regional health authorities have a greater capacity to assimilate additional initiatives, unlike the smaller ones, which are often expected to add these additional responsibilities to the ones already assigned.

The Saskatchewan Health Research Foundation (SHRF) is in the planning stages of building a provincial framework to support knowledge translation in the province. In collaboration with the province’s two universities, the Health Quality Council and all key stakeholder groups, the framework is intended to improve the use of and access to current health research. Focus groups are being conducted this summer to assist in laying the foundation for this work.

Five Hills Regional Health Authority (FHRHA) has had the longest-standing quality workplace committee. The committee has changed its name now to Employee Lifestyles Committee to better reflect its mandate of developing a safety culture, respect and dignity-transfer, lift and repositioning training, with an anti-violence focus planned for the fall. The FHRHA has conducted employee opinion surveys for a decade, utilizing the responses to develop plans for improvement and providing funding to do so.

The largest RHA in the province, Saskatoon Health Region, has developed five action recommendations in response to the findings from the SAHO survey which are awaiting senior management support. The RHA is also working on an organizational culture and values training program, which is currently being delivered to leaders throughout the organization. There are hopes to extend the Values Shift program to front-line staff in the future. The RHA collaborated with Heartland RHA to pursue funding support from Health Canada. There is also leadership training occurring, although the approval of a draft strategic plan is in process.

Heartland has begun to organize its response to the survey by conducting focus groups to formulate recommendations for action. Its current quality workplace initiatives include a five-week, formalized orientation of beginning nurses. This training also involves having experienced nurses on-call for those beginning nurses working alone, for up to six months. And it has provided increased educational opportunities for front-line staff, in both clinical and worklife balance issues, including a job safety analysis and transfer, lift and repositioning training.

Regina Qu’Appelle RHA is replicating an employment model for nursing that assists nurses in developing a patient-centred nursing practice where nurses spend 80 percent of salaried time in direct patient care and 20 percent on professional development. This
RHA has also worked on conflict resolution processes to better manage workplace issues, utilizing appreciative inquiry to do visioning on a unit-by-unit basis. It has developed an employee wellness program and is working on a response to the Employee Opinion Survey (EOS). **Prince Albert Parkland** is in the process of hiring a wellness/education consultant to develop a response to the EOS.

**Prairie North** has decided to focus on the roll-out of the FISH philosophy for this fall, which is based on four principles: choose your attitude, be there (and give your best), make somebody’s day and have fun. It has seen interest in its wellness and health workplace committees flagging. The other initiative underway is an attendance support program, which is intended to provide people with whatever support they need to address workplace or personal issues that could be impacting their ability to show up for work.

**Cypress RHA** recruited a person to do follow-up with employees on the province-wide Employee Opinion Survey (EOS). Discussions are currently underway to identify priorities for action and the RHA is recruiting employees from across the region to assist. The plans will be finalized by the end of this calendar year. There are plans to hire a change management mediator and to develop an attendance management program.

**Sunrise RHA** has devised a plan to create quality worklife in response to the EOS. It hired a quality worklife co-ordinator who will conduct focus groups around the region, collect employees’ guidance and design a comprehensive one- to three-year strategy. The RHA started a healthy workplace champions program, which asked for volunteers to work on issues important to employees. There is work underway in **Sun Country RHA** to improve labour relations, including the introduction of conflict management initiatives. The region is also working on a personal fitness evaluation initiative.

**Kelsey Trail** had initiated a survey to get more specific information about individual facilities and employees who work there and their particular concerns, prior to the decision by SAHO to do a global survey. There has also been a response to the SAHO-sponsored EOS. An appreciative session was done to create a list of suggestions (improved communications in particular) and sent off to executive; decisions will be made in the fall. The quality health workplace committee is meeting in the fall to decide on future action. There is also a working group out of the QW committee to decide about a new employee and family assistance program. There is also a policy being developed on workplace footwear, and work is underway on recognition awards, beyond long service recognition.

**Mamawetan Churchill River** developed nurse self-scheduling, which has empowered staff. The RHA collaborated with two other northern RHAs in Saskatchewan to create a director of registered nurse education position to respond to the evolution of nurse practitioner legislation and regulations in Saskatchewan. The RHA also developed a program to provide tuition support for RNs wishing to become NPs to invest in meeting the needs of remote communities. **Keewatin Yatthe** is also focusing on the implementation of safety programs.
The **Saskatchewan Cancer Agency** is currently developing a response to the Employee Opinion Survey. It is introducing a TLR program and conducting a job safety analysis. The “In Motion” program is aimed at encouraging employees to be active.

**Manitoba**

In Manitoba, the Manitoba Federation of Labour (MFL) Occupational Health Centre, in operation since 1983, examines workplace health issues with a guiding motto of “Healthy Workplaces — Healthy Workers — Healthy Communities.” This organization, funded primarily by the Winnipeg Regional Health Authority with donations from unions, individuals and others, has been leading a workplace stress initiative for several years. The centre presents awards to best practice employers. In April 2006, awards were presented to three healthcare organizations: Seven Oaks Hospital, Interlake Regional Health Authority and Women’s Health Clinic.

The eleven regional health authorities are in varying stages in addressing the issue of quality workplaces. At **Interlake**, one of the core values is **workplace safety and health**. It has committed to strive for the highest degree of physical, mental and social well-being of its workforce and workers, as the most valuable asset who are recognized as partners in the decision-making process. The workplace wellness program has pursued employee participation to identify needs. In addition, local leadership teams from each site coordinate their own initiatives and develop their own action plan with the participation of employees.

**North Eastman RHA** created board ends as part of its strategic plan, including the creation of a learning organization and ensuring open communication. The strategic plan for 2006-11 calls for leadership at all levels, which creates a culture that sustains a work environment that fosters and nurtures a healthy and productive workplace. Specific details about how they will go about accomplishing that are not available on the web site.

The **Nor-Man RHA** has an employee wellness committee in place as a sub-committee of the human resource team. There are also occupational health and safety committees in place. **Burntwood RHA** appointed a new head of corporate services in 2005; one of his goals was to create an emotionally intelligent organization. There is no update on progress available on the web site. **Churchill RHA** provides little information but does mention a new human resources plan, which may contain healthy workplace initiatives, but there is no sign of it on the web site. **Parkland RHA** has the oldest workforce in Manitoba, the highest sick leave usage and one of the highest time loss injury rates in the province. The new health human resource plan for April 2006 to March 2011 identifies 12 priorities, with the ninth being “the creation of a healthy and safe workplace.” They will be working on a safety culture, attendance support and assistance program, disability management and performance management and workplace wellness.

**Central Manitoba RHA** has identified healthy worklife through a healthy workplace as the first of four overarching strategies or pillars as a means to accomplish the ENDS of the RHA. Their web site is currently under construction, so details about how this will be
achieved are not available. **Brandon RHA** established as a strategic priority for the RHA in 2004-05 the creation of an organization that recruits and retains employees by making them feel valued and supported. They also hoped to develop and implement initiatives to create a healthy workforce and workplaces along with the implementation of wellness programs. There is no update of the program available on their web site. **Assiniboine RHA** identifies recruitment and retention issues, but there is no mention of quality workplace initiatives.

**Winnipeg RHA** was a recipient of Health Canada funding for a healthy workplace project. The 27-month project will focus on health promotion and disease prevention among the 27,000 employees of the regional health authority. One hospital in this RHA has received national recognition for its efforts in developing a healthy workplace. Seven Oaks General Hospital has developed a web site providing information about wellness ([www.wellnessinstitute.mb.ca](http://www.wellnessinstitute.mb.ca)). This hospital is also a leader in providing recognition to its employees through an annual award program where anyone in the hospital can thank another employee for outstanding work. The hospital's workplace wellness program has made an outstanding effort to achieve employee participation.

**Ontario**

In Ontario, a recent reorganization of regional health authorities has made it very difficult to identify any activities currently underway in quality workplace initiatives. The 14 local health integration networks that have been created are intended to be community-based organizations that will plan, co-ordinate, integrate and fund healthcare services at the local level. Public consultations guided the development of the LHINs and the public dialogue continues during the summer of 2006.

The provincial government is focusing on critical care and is now spending significant dollars to train nurses and doctors to work in critical care. There is also money to establish a performance management system. Each of the web sites created for the LHINs contains the same information, with only a few documents related to the specific LHIN which it represents. These include a specific population health profile and an integration priority report. There is no information about quality workplace initiatives at all. The LHINs that have been created are:

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
There are some documents that have been archived on a web site titled Ontario District Health Council Archives, which provide a few insights into previous work done. In Ontario in 2003, there was a study of health human resources to develop a province-wide strategy for labour shortages. The issues of health human resources are most extreme in Northern Ontario. Many of the recommendations made included quality workplace strategies such as job sharing, working in multi-disciplinary teams, maximizing scope of practice, wellness programs to encourage better employee health, reward and recognitions initiatives, financial incentives for further education and training, flexible scheduling, equal pay for work of equal value and cross-trained teams. The only other reference to healthy workplaces was a document filed in the Grand River District Health (GRHD).

The GRDH Wellness Report 2004-06 recorded their strengths as a “healthy workplace” and identified the challenges they are facing. The challenges identified included different working styles, the costs and budgetary pressures related to addressing workplace issues, the desire for more frequent social interaction, the challenges of internal communications, and physical environment issues such as the inability to open windows and temperature regulation. The report designed an action plan for 2004-06 identifying the committee lead, the expected results and the monitoring or evaluation method. There is no evidence of follow-up reporting.

In May, 2003 the Central South District Health Councils provided an index of health human resource strategies currently being pursued. Under “Healthy Workplace Strategies” they provided information on appropriate equipment, attendance management programs, caseload size standards, clinical pathways, flexible scheduling, flexible work options/policies, flextime, flexwork, healthy workplace committees, the Ontario Hospital Association (OHA) Workplace Health and Safety Group, quality of work life co-ordinator, self-directed teams, self-scheduling and staff appreciation, to mention a few.

The Healthy Hospital Initiative, sponsored by the Ontario Hospital Association, was started in 2004 to recognize those hospitals making an effort to support improved work environments. Organization health, employee well-being and employee opinion about overall wellness are the three primary areas of interest on the employee survey. In November 2005, nine hospitals won the Healthy Hospital award in recognition of their efforts to support improved work environments. Nominations are now being accepted for this year’s awards. The Health Research Laboratory at Brock University is finalizing a report on behalf of the Ontario Hospital Association with respect to a Health Hospital Employee Survey.
Ontario has numerous research units and academics working in the area of quality workplaces. The Registered Nurses’ Association of Ontario (RNAO) is doing a comprehensive examination of the issues related to healthy work environments, funded by the Ontario Ministry of Health and Long-Term Care in partnership with Health Canada. This project is designed to support healthcare organizations in creating and sustaining positive work environments for nurses. They plan to do this by delivering six best practice guidelines and systematic literature reviews related to healthy workplaces. RNAO has distributed the first best practice guideline titled Developing and Sustaining Nursing Leadership. Work continues on the other five best practice guidelines: Embracing Cultural Diversity in Healthcare: Developing Cultural Competence Guideline, Professionalism in Nursing Guideline, Collaborative Practice Among Nursing Teams Guideline, Workplace Health, Safety and Well-being of the Nurse Guideline.

Quebec

In Quebec, the National Forum on nursing workforce planning took place in October 2001. The forum demonstrated the importance of acting on the management of care and workload to counteract the effect of the nursing shortage. In light of these results, a support program to work management was put in place in 2002 to help institutions in reviewing their work management project.

This program offered subsidies of up to $25,000 to institutions, which was followed by regional meetings recognizing the absolute need to review the work management and delivery of care. Between 2002 and 2004, institutions developed 163 different projects and received funding to carry their review. In the fall of 2004, the national support program sponsored by the Quebec Ministry of Health and Social Services expanded to larger projects in targeting shortages of other healthcare professionals. The funding offered for these projects was between $25,000 and $250,000. Between 2004 and 2006, $5,438,023 million was allocated to support the production of 36 projects related to work management. All these projects achieved measurable outcomes which can be transferable to other institutions.

http://msssa4.msss.gouv.qc.ca/f/sujets/emploi.nsf/75adce8f2e1cdd4d85256de400658b22/79952f4c0462d48485256df8004cc527/$FILE/pmo99_03.pdf

Atlantic (New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland)

The provinces of Atlantic Canada are working on synergies to address their common health human resource issues. Those issues include accurately projecting future health human resource requirements, identifying the right mix of health professionals and their respective scope of practice and identifying the implications of potential changes in scope of practice and mix of providers for the patient, provider and training institutions.
The Atlantic Advisory Committee on Health Delivery and Human Resources completed the development of a database of all relevant health education/training programs in the Atlantic region. The study, titled *Atlantic Health Human Resource Planning Study*, was released in September 2005. Each Atlantic province is planning its own initiatives in response to the findings. Each of the four Atlantic provinces released its health human resource actions plans to the federal government.

A research team led by Dr. Michael Leiter, who is based in Nova Scotia, just completed a two-year study which examined nursing environments and the use of knowledge transfer in the creation of healthy or quality workplaces in Atlantic Canada. The project, funded by Health Canada’s Health Policy Research Unit, noted that the development of a research collaborative requires time and commitment. His final report laments the dismantling of the team once the project and its funding is complete. His report noted that knowledge is transferring to more senior levels of management, but that it does not necessarily get implemented from there. The information is filtered before being shared with other managers and members of the organization. The team suggests varied methods of communicating report contents, including packaging it for the particular audience it is intended, shortening it from full-blow academic journals/articles to useable “sound bites” and building knowledge translation time into jobs, possibly by an 80/20 model.

The report details what has happened in Atlantic provinces in relation to the improvements in program capacity and expanded enrolment, education initiatives and supports for students and programs for Aboriginal nursing students in Atlantic Canada. It reports on the improvements of supply in the workplace to ensure there is sufficient funding to hire nurses and the development of creative recruitment and retention strategies, especially in rural areas. The final report can be downloaded at [http://cord.acadiau.ca/nekta/](http://cord.acadiau.ca/nekta/).

P.E.I. has altered the face of healthcare delivery by moving towards a model that sees the Department of Health and five community health boards providing healthcare to island citizens. The transition was completed in January 2006, with the disbanding of the regional health authorities. The community health boards are Souris, Montague, Tyne Valley/East Prince, O’Leary and Alberton. Specific details about quality workplace initiatives, if any, are not available since web sites from the previous regional health authorities are no longer available and there are no new web sites established for the health boards at this time. The only reference to activities was one aimed at a bid to improve recruitment and retention of nurses. The provincial government re-introduced a summer and sponsorship program in its March 2006 budget. Health Canada has funded a project titled *Provincial Musculoskeletal Injury Prevention Strategy for Health Care Workers: An Expansion and Enhancement Project*.

In New Brunswick, there are seven regional health authorities with Moncton and area split into two. An examination of each web site provided no information about quality or healthy workplace initiatives. Although Miramichi RHA7 received funding under Health Canada’s healthy workplace initiatives program, there is no information on the web site
about it. The project is titled *MRHA Workplace Wellness Initiative, Miramichi Regional Health Authority*. CEO Gary Foley is reportedly a strong advocate. It is merely referred to as workplace wellness program in the annual report for 2004-05 with no details provided.

The Nurses Association of New Brunswick in 2005 put forward a position statement describing a framework for a quality professional practice environment for registered nurses. The document highlights background information, assumptions, principles, definitions and ultimately the necessary attributes for a quality professional practice environment such as workload management, nursing leadership, control over practice, professional development, and organizational support. The attributes reflect evidence-based practice.


Newfoundland examined the issue of health human resources in 2002 with a discussion paper. It identified quality of worklife and retention and recruitment as the priorities of the province’s RN/LPNs and allied health subcommittees in the development of a health human resources plan. The report recommended that the Department of Health provide dedicated funds to pursue demonstration projects on leadership, scope of practice, collaborative work environments and quality health services. There is no evidence this recommendation or any others were pursued. Health Canada funded a project titled *Creating Culture of Safety, Labrador Grenfell Regional Integrated Health Authority*. Four regional integrated health authorities were created in 2005 — Labrador-Grenfell Health Authority, Western Health Authority, Central Health Authority and Eastern Health Authority — and given responsibility for the delivery of healthcare in Newfoundland and Labrador. A search of the web sites of each of the four provided no information about specific quality workplace initiatives.

The nine district health authorities in Nova Scotia — South West, South Shore, Annapolis Valley, Cumberland, Pictou County, Capital Health IWK, Colchester East Hants, Guysborough Antigonish Strait and Cape Breton — show no evidence of quality workplace initiatives on their web sites either. The Annapolis Valley had identified the importance of quality workplaces in its strategic plan for 2002-06 and has received funding from Health Canada to pursue these initiatives. The project is titled *Organizational Health: Quality and Healthy Workplace Integration, Annapolis Valley Health*. The annual report indicates that a volunteer, staff and physician satisfaction survey was conducted to provide baseline data to enable the measurement of improvements as efforts are undertaken to improve the workplace and the worklife of all at the district health authority. But the province of Nova Scotia has been very active in the recruitment and retention of its nursing cadre and recognizes the success of its nursing strategy of 2001, which focused on nursing recruitment. In its December 2005 HHR plan it acknowledged that the focus needs to now extend to other healthcare professions, such as medical lab technicians, physicians, radiation therapists, pharmacists, as well as nurses.
North (Northwest Territories, the Yukon, and Nunavut)

Evidence of the quality workplace initiatives in the Yukon, the Northwest Territories and Nunavut is less obvious than in southern jurisdictions.

In the Northwest Territories, a decision was made in December 2005 to centralize all human resources functions from the Department of Health and Social Services and all health and social service authorities. These activities are now the purview of the Financial Management Board Secretariat. The only exception made was the Hay River Health and Social Services Authority. The Northwest Territories developed a five-year human resources strategy for April 2004-March 2009 to address the issues related to ensuring there are sufficient, well-trained and dedicated professionals to meet healthcare needs. Many of these strategies are intended to address issues related to recruitment, retention, and training in a way that is mindful of creating a skilled northern workforce that is representative of the people and communities they serve. One of the goals is to institute a health workplace program and employee wellness events at the department and authorities levels. Another goal is the creation of safe workplaces. Again, there is no evidence on the web site of progress made on these action items.

In Nunavut, medical practice is either hospital-based in Iqaluit, the capital; or health centre-based in Kivalliq Region (west coast of Hudson Bay) or Kitikmeot Region (western Nunavut, with the administrative centre being Cambridge Bay). A new health centre was built in Kivalliq Health Region in September 2005 and brought together services that had been scattered throughout Rankin Inlet. A new centre headquartered in Cambridge Bay for the Kitikmeot Health Region was scheduled to open in October. There is no evidence of quality workplace initiatives anywhere on their web sites.

The government has worked on a health human resources strategy called Closer to Home, which aims to develop its own healthcare providers, rather than relying on recruiting workers from the south. Efforts to locate the document providing the government’s 15-year plan were unsuccessful. In a newsletter providing details of a National Nursing Leaders Tour of Nunavut (2005), the plan is purported to accomplish the hiring of locals by developing them as healthcare workers through a combination of Nunavut Arctic College programs, mentorship, on-site course work and distance learning. Dalhousie University is assisting this effort through a bachelor of science in nursing program in partnership with Nunavut Arctic College. The HHR plan has been working creatively to train current health and social services employees working at transcribing medical notes or providing custodial services to move into other healthcare careers. The department’s business plan for 2005-06 discusses the HHR plan and the goal of the healthy interconnection of mind, body, spirit and the environment (Inuuqatigiitariarniq) as a goal and a vision of healthy individuals and healthy communities throughout the territory. Presumably this would also apply to those working in healthcare.

The Yukon government introduced plans to develop a new health human resources strategy in late March 2006 in an attempt to address the shortage of health professionals.
A search of the web site did not turn up any reference to work being done on strategy development, although there is a document providing details of changes to education bursaries for health professionals. There is also an indication of additional funding provided by the federal government to provide improved access to healthcare in the territory, but no reference to work being done on the creation of quality workplaces.

**Federal/National/Aboriginal**

The federal government is supporting numerous research activities related to quality or healthy work environments/workplaces in healthcare. Health Canada provides funding for quality workplace initiatives through the Office of Nursing Policy and Health Policy Research Unit.

The Canadian Health Services Research Foundation (CHSRF) and the Canadian Council on Health Services Accreditation (CCHSA) are sponsoring the Quality Workplace – Quality Healthcare Collaborative along with supporting related research on quality worklife and knowledge brokering and exchange.

The Canadian Institute for Health Information (CIHI), in collaboration with Statistics Canada and Health Canada, conducted the first national survey of registered nurses, licensed practical nurses, and registered psychiatric nurses. The purpose was to examine the relationship between health, the work environment and worklife experiences of nurses across Canada. Approximately 80 percent of the 24,000 nurses contacted spent 30 minutes participating in the telephone interview.


Another comprehensive examination of the nursing sector is underway. Titled *Building the Future: An integrated strategy for nursing human resources in Canada*, details of this federal project can be found at [www.buildingthefuture.ca](http://www.buildingthefuture.ca). The first phase of the project was the study phase, with Phase 2 being the strategy formulation and implementation phase. In Phase 1 there were 13 technical reports exploring issues of importance to the supply of nurses and examining the individual circumstances of each province and territory. The consultation stage has now been completed with an invitational conference held late May 2006. The final report is due soon.

The Canadian Nurses Association has also contributed substantially to the research on this issue. The most recent report, written by G. Lowe in 2006, is titled *Making a Measurable Difference: Evaluating Quality of Worklife Indicators*. The report makes an important contribution to guiding the efforts of those working on the creation of quality worklife.
or healthy workplaces. In addition, the report provides tools to use in the assessment of progress on quality or health workplace related efforts.

The Registered Nurses’ Association of Ontario (RNAO) has undertaken a comprehensive examination of the issues related to healthy work environments. The best practice guidelines can be used by any healthcare organization to improve the quality of healthcare workplaces. The first guideline is titled *Developing and Sustaining Nursing Leadership*. The project is funded by the Ontario Ministry of Health and Long-Term Care working in partnership with Health Canada. The other five subject areas for future best practice guideline development can be found under the Ontario section of this report. Details of this project can be found at [http://www.rnao.org/Page.asp?PageID=751&SiteNodeID=241&BL_ExpandID=](http://www.rnao.org/Page.asp?PageID=751&SiteNodeID=241&BL_ExpandID=).
Appendix 4: References


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