Nurses: A Force for Change

A Vital Resource for Health

INTERNATIONAL NURSES DAY 2014

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Dear Colleagues,

There is growing recognition that sufficient, adequately trained and motivated health workers are essential for the health of the world's population. Equitable access to necessary health services of good quality cannot be achieved without an adequate number of appropriately prepared nurses. This is why ICN has chosen to focus on the vital resource that is the nursing workforce for this year's IND theme.

As the largest group of health professionals, who are the closest and often the only available health workers to the population, nurses have a great responsibility to improve the health of the population as well as to contribute towards the achievement of the Millennium Development Goals.

This IND kit is an essential tool to understanding the bigger picture of the healthcare labour market: the gap between the supply and demand of health workers, the effect of the financial crisis, migration and the working life span of nurses. It highlights the importance of workforce planning and the link to patient safety; how to measure nurses' workload and plan for safe staffing. Changing scopes of practice and the influence of new technology have also changed the way nurses work.

It is clear that while there is a nursing shortage in many countries, just adding more nurses is not the solution and improving the work environment is a key aspect of improving patient safety and the quality of health care. Through this IND Toolkit we hope to inspire nurses to "change the picture" and to demonstrate to governments, employers, and society that nurses are a vital resource for health. ***It is essential that nurses and world leaders focus on the global nursing workforce as a key priority for achieving better health for all.***

Sincerely,

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Chapter 1
Introduction

An educated nurse workforce + a good work environment = high quality care

This simple, evidence based, equation whether applied at a global or a local level in the health system is fundamental to understanding how to make the best of the vital resource which is nursing.

Over the past decades, we have seen changes in disease burdens as well as in demography. The heavy and increasing burden of non-communicable diseases (NCDs) including mental disorders and an ageing society has forced governments and the health professions to think differently. This has led to an increasing focus on disease prevention and health promotion and to a shift in the locus of care provision from institutions to community-based primary health care. New infectious, environmental and lifestyle risks at a time of rapid demographic changes threaten health security for all (Frenk et al 2010). This has also brought forward a need to refocus on holistic care namely person centred care and a life-course approach.

At the same time, we have recognised the inequity in health (WHO 2008) (see Box 1). As the target date of the Millennium Development Goals (MDGs) in 2015 approaches, it has been noted that there are serious variations in progress despite the achievements made globally. The burden of NCDs is heavier in low and middle income countries where access to health care including mental health services is limited. The role of all health workers in reducing this variation has long been recognised and progress has been made in health workforce development particularly in the last decade. However there is much more to do (GHWA & WHO 2013). The 2006 World Health Report, Working Together for Health, recognised that the shortage of health workers is most severe in the poorest countries, especially in sub-Saharan Africa, where health workers are most needed (WHO 2006). Additionally, the 3rd Global Forum on Human Resources for Health (HRH) notes in its declaration that "the HRH agenda transcends national borders: geographical maldistributuion and international migration affect low-, middle- and high income countries, in some cases hindering the provision of even essential health services. Given the central role of health services in the relationship between citizens and governments, addressing these problems effectively will reinforce the cohesion of societies and accelerate social and economic growth" (GHWA 2013, para 8).

Box 1: Inequity in Health

"Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

It does not have to be this way and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice. "

(WHO 2008, p1)

Under these circumstances, there has been growing attention to human rights and equity in health. World leaders have given their support to universal health coverage as an internationally agreed objective of health and development policy. Sufficient, adequately trained and motivated health workers are essential for the health of the population (WHO 2006). Equitable access to necessary health services of good quality cannot be achieved without an adequate number of appropriately prepared nurses.

Investing in nursing can make a difference. A number of researchers have demonstrated that affordable nursing interventions can effectively contribute towards achievement of the Millennium Development Goals as well as in reducing the burden of NCDs (WHO 2013a). The strengthening of primary health care will be essential in addressing the burden of chronic disease as well as in reaching the most vulnerable and marginalised members of society and nurses will play a key role in this (Browne et al 2012). To make best use of nurses in the health system they should be encouraged and supported to perform at their highest potential.

The World Health Assembly (WHA), the supreme decision making body of WHO, has repeatedly recognised the essential need for strengthening nursing and midwifery services in achieving better health for individuals, families and communities. The WHO progress report (2013b) describes achievements in response to the series of resolution adopted by the WHA to strengthen nursing and midwifery services. However this report concludes that in relation to the provision of health services many remain understaffed by nurses and midwives who in turn can be undertrained and poorly developed (WHO 2013b).

As the largest group of health professionals, who are the closest and often the only available health workers to the population, nurses have a great responsibility to improve the health of the population as well as to contribute towards achievement of the global development goals. ***It is essential that nurses and world leaders focus on the global nursing workforce as a key priority for achieving better health for all.***

The current global economic climate has had many consequences, and health services, due to their significant use of resources, have not been exempt from significant scrutiny. This scrutiny is often driven by a view that expenditure on health services is a cost rather than an investment. This

approach has introduced a language into many health systems which is drawn from the industrial sector. This language uses terms such as return on investment, efficiency and cost effectiveness and favours improvement methodologies from manufacturing such as lean and process reengineering. Indeed, whilst these ideas might have something to offer, if implemented in an appropriate way, they can also be perceived as philosophically at variance to the professional value set held by nurses. This value set is driven by a commitment to public service, equity of access and an ethos of care (North & Hughes 2012). It is increasingly apparent this managerial drive which is associated with severe fiscal restraint has pushed nurses into a difficult situation as governments and employers attempt to hold down healthcare costs. As the largest and therefore, in terms of total cost, the most expensive workforce, nurses have seen the revision of staffing mixes, the cutting of nursing positions and a constant reduction, or even suppression of their salaries. The consequences for patient confidence, nurse staff morale, quality and safety, and, ultimately, future recruitment and retention are significant. It has also led to short term decision making which has long term consequences (Keogh 2013).

It is clear that globally, nursing now has to justify itself both financially and professionally. The socio-economic value of nursing and midwifery has recently been the subject of a rapid systematic review of reviews (Caird et al 2010). The findings are drawn from 32 reviews conducted in OECD countries and targeted to three areas of strategic importance: mental health nursing, long term conditions and role substitution. Despite methodological difficulties the review found examples of the benefits of nursing and midwifery through home visiting interventions, specialist nursing and general practice based nursing including prevention and treatment. Indeed, there was clear evidence of the benefits of nursing and midwifery on a range of outcomes (Browne et al 2012; Maben et al 2012).

Nurse education has also struggled to keep up with the challenges. The investment in health professional education worldwide is insufficient to address needs (see Box 2). There are system-wide problems in the education of health professionals with a mismatch of competencies to patient and population needs, persistent gender stratification of professional status and quantitative and qualitative imbalances in the health care professions (Frenk et al 2010). As identified by ICN (2009), the capacity of educational programmes to prepare clinically safe competent nursing graduates is often jeopardised by insufficient emphasis and time allocation for clinical learning; the absence of clearly defined clinical education outcomes; use of ineffective clinical teaching methodologies; unsuitable, poor quality or crowded clinical learning places; and a lack of good clinical role models. Additionally, nursing faculty staff share the same demographic challenges as the rest of the workforce.

Box 2: Global Expenditure on Health Education

The total global expenditure for health professional education is about US$100 billion per year. This amount is less than 2% of health expenditure worldwide.

(Frenk et al. 2010)

The interdependence of the health and education sectors is paramount and a balance between the two systems is crucial for efficiency, effectiveness and equity. There are two critical interfaces: the first is the labour market, which governs the fit or misfit between the supply and demand of health professionals; and the second is the weak capacity of many populations, especially poor people, to translate their health and educational needs into effective demand for respective services (Frenk et al 2010).

The security of supply of the nurse workforce remains a real and evident problem in many countries.

Chapter 2

Seeing the Big Picture

We are in a world of constant change and responding to these changes is difficult if we take only a local approach. Whilst local context is essential for understanding and designing services, we are increasingly globally connected. This connectivity can be seen in the movement of people, technologies, finance, knowledge and information. This means we are increasingly interdependent in terms of key resources and health is no exception. Labour markets for health professionals with internationally recognised credentials are not only national but also global. Education can be delivered at a distance or through a franchise and may or may not be aligned with the education and health needs of the practitioner and the citizens they serve. Everywhere the rules are changing and many of the assumptions we made in the past simply don't apply within this new world (see Box 3).

Box 3: Changing Rules for the Healthcare Workforce

Current approach	New rules for 21st Century healthcare
Care is based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customised according to patient needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision making is based on training and experience	Decision making is evidence based
Do no harm is an individual responsibility	Safety is a system property
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continuously decreased
Preference is given to professional roles over the system	Cooperation among clinicians is a priority

Adapted from: Changing rules for the Healthcare Workforce in the 21st century and the implications. Institute of Medicine (2001)

To date, labour markets have often been characterised by multiple imbalances the most important of which, in terms of security of supply, relate to the undersupply, unemployment and underemployment of health professionals. Equally, as we noted earlier, governments very often influence the supply of health professionals in response to political situations driven by financial concerns more than market rationality or epidemiological reality. Aid, too, can have a distorting effect as non-governmental organisations (NGOs) inadvertently recruit the best professionals based on their priorities and in so doing change local labour conditions which can, in turn, create local wage inflation resulting in an aid dependent system.

§As individual countries design their local solutions for changing their health systems they need to be acutely aware of the fact that there is a predicted gap between the demand for and supply of the healthcare workforce in developed countries over the next 20 years. This is predicted to be between 22% and 29% globally (OECD 2012). As noted in a study from the United States of America (US) by Buerhaus et al (2009), the total number of full-time equivalent registered nurses (RN) per capita was forecast to peak around the year 2007 and decline steadily thereafter as the largest cohorts of RNs retire. By the year 2020, the RN workforce is forecast to be roughly the same size as it is today, declining nearly 20% below projected RN workforce requirements. This US nurse situation can been seen repeated in all OECD countries.

The 3rd Global Forum on Human Resources for Health held in Recife (2013) reviewed global progress of HRH and declared: "challenges persist: investment in HRH remains low; fundamental discrepancies exist between health worker supply and demand; HRH planning is often weakened by uncoordinated interventions on single issues, focusing on an individual cadre or illness and not on prevention; and the adoption and implementation of effective policies remains uneven, As a consequence severe shortages, deficiencies in distribution and performance, gender imbalances and poor working environments for health workers remain matters of major concern" (GHWA 2013, para 6)

Security of supply is also affected by migration. The gap in supply identified by OECD could be filled by migrant nurses from elsewhere in the global health system. Indeed Australia, Canada and the US have already indicated that they would see their future skills gap being filled by nurses from outside their own borders (RCN 2012). The effect of this migration on a local/national system can be both positive (e.g. in terms of opportunity for the individual and money generated and is sent back home) or negative (e.g. in terms of loss of vital skills often in an already vulnerable health system). Some efforts are underway to minimise the negative aspects of migration with the introduction of the WHO actions and recommendations but it remains a strongly debated area of policy often with highly polarised views (Buchan 2008, DeLeon & Malvarez 2008). As Kingma (2007) concludes in a detailed study of global nurse migration, "Today's search for labor is a highly organized global hunt for talent that includes nurses. International migration is a symptom of the larger systemic problems that make nurses leave their jobs. Nurse mobility becomes a major issue only in a context of migrant exploitation or nursing shortage. Injecting migrant nurses into dysfunctional health systems, ones that are not capable of attracting and retaining staff domestically will not solve the nursing shortage." (p.1281)

However, there is still a real need to better understand migration as it relates to nurses specifically and the availability of information in this area is not straight forward. For example, in the European Union, nurses have free mobility and are therefore not subject to immigration controls (see Box 4).

In a recent study by Squires et al (2013) considering the changing migration patterns of the nurses of El Salvador, Guatemala, Honduras, Mexico and the United States, the authors used the review to

Box 4: International Flow of European Nurses

"EU nurses have free mobility, they are not subject to immigration controls and from a UK policy and planning perspective are an "unmanaged" inflow: they cannot be directed and the length of stay in the UK cannot be determined. Given ease of movements and relatively cheap travel costs it is also likely there will be an increasing number of commuting EU nurses. These changing dynamics highlight that international flows will be less open to management by UK policy makers and regulators, with the majority inflow from the EU, and length of stay in the UK being determined primarily by individual choice and circumstances of the nurse."
(RCN 2012, p15)

explore how governments can become more effective in the management of migration across these countries. The report concludes with eight recommendations for fostering migration as a way to meet healthcare demand in all the study countries. These recommendations include investments in educational systems; ways to facilitate the credentialing of nurses across borders; developing visas based on improving language concordance between nurses and patients disproportionately affected by health disparities; integrating transitional educational programmes as part of the credentialing process for internationally educated nurses; and ways to capitalise on "hidden nurses" of Hispanic heritage who are currently living in the United States.

Internal migration is also an important factor for many health systems with challenges of retaining health workers in rural and remote settings. Nurses most often migrate from rural to urban areas (Squires et al 2013) and internal migration can exacerbate health inequality problems as health workers seek better education and health services for their own families.

The changing length of nurse careers

An additional significant factor in understanding the bigger picture is the changing working life span of the nurse workforce. To date, many of the government models used to calculate workforce participation have been based on an understanding of how men engage in the workforce and indeed the term 'manpower planning' is still occasionally used. However, nursing is, in the majority of countries, a female dominated profession and, as such, it can be difficult to develop a model which is sensitive enough to recognise the particular ways nurses engage in the workforce. In most countries, the statutory pension age for women is younger than for men. In addition, there is a global trend for health workers to retire earlier (WHO 2006). The recent global financial crisis may affect this further and underlines the need for an accurate understanding and careful planning of the workforce. The statutory pension age often differs from the actual age at which nurses retire, with poor work environments contributing to earlier retirement. The actual age distribution of the nurse workforce and different working patterns (e.g. part time hours) are additional factors. Gaining a much better knowledge about how this complex set of factors relates has been increasingly recognised by the nursing profession as a priority and has resulted in a much greater focus on understanding the needs of our workforce through better workforce planning and management. See ICN's International Centre for Human Resources in Nursing (ICHRN) web link www.icn.ch/pillarsprograms/ichrn-publications.

Reflections: Each reflection focuses on two perspectives: personal and policy. These enable you to consider the key issue from both viewpoints to encourage an active conversation at all levels of the health system.

Personal: Think of your own career to date. How have things changed? Do you think you and your colleagues could have been better prepared for these changes? Do we need a better understanding of the contribution nurses make to society throughout their working lives?

Policy: Has the legacy of manpower planning models contributed to us having a poor understanding of female dominated workforces such as the nurse workforce? Do we really have an understanding of contemporary nurses' careers?

Chapter 3

Workforce Planning

There can be no doubt that it is a health and education system-wide responsibility to plan and sustain the future nurse workforce. As we have referred to earlier, there is a clear need to extend this planning from government to employer and for it to be constantly monitored. The strong links, now supported by research evidence, between lower nurse workloads and better patient outcomes would suggest that the case for the nurse workforce as a sound investment has been made, yet still this is an area of debate (Mitchell & Mount 2010). The sheer size of the nurse workforce and its complexity means that any suggested increase is met with strong resistance even just on cost terms alone. It is evident that we need to be clear how best to identify the available workforce we have as well as the opportunities to use this scarce resource to best effect. There is still limited research on how to improve nurse staffing to reduce nursing workload and adverse patient outcomes particularly in non-hospital settings. To improve this situation we need good evidence drawn from high quality data and analysis, enabled by the systematic use of available workload and workforce planning tools.

> **Workforce Planning** is a continual process used to align the needs and priorities of the organization with those of its workforce to ensure it can meet its legislative, regulatory, service and production requirements and organizational objectives. Workforce planning enables evidence based workforce development strategies.
> (Sloan 2010)

In developing any approach to workforce the goal most frequently cited *is to get the right workers with the right skills and behaviours in the right place doing the right thing at the right time.*

Workforce planning has also to be seen in the context of the working life span of a nurse. It can be useful to think of this in terms of entry to nursing, performance of the existing workforce and exit from the workforce. Entry to nursing involves planning the number of new recruits needed to care for the population. Clearly a major goal is to produce a sufficient number of skilled nurses. To achieve this requires active planning, good training institutions with well qualified faculty, strong professional regulation and the possibility of recruiting. **A nurse recruited now could still be active in the workforce in the year 2050.** This initial preparation requires a strong working relationship between the education and health sectors. A balance between the two systems is crucial for efficiency, effectiveness and equity. Yet it can be the case that there is a disconnection between the philosophy and management practices in the two sectors with health generally being a more managed model and education a market driven model. This can lead to oversupply of some health professionals where demand for education is high – for example, physician over-supply in India (WHO 2008) – and undersupply of others due to an underprovision of educational opportunities. Professional education is increasingly linked to workforce planning and this could enable the more rapid sharing of curricula and competencies (see Box 5).

The performance of the existing workforce is also a key consideration; a productive workforce reduces the need for more nurses. Improving productivity requires a range of conditions which we will consider later in more detail, but they include support for continuous development and learning, supervision, adequate compensation and good working environments.

The time at which nurses choose to exit from the workforce is another key aspect of workforce planning. Attrition from the workforce due to migration, health concerns, civil unrest and general dissatisfaction with conditions can be expensive, as individuals need to be replaced and there is a replacement training cost. The loss of experience from the workforce is also an opportunity cost and can mean essential knowledge is lost from the system. There is a critical need to more systematically plan for this knowledge transfer as the loss of expertise, experience and knowledge with the pending retirement of a large cohort of nurses currently in their 50s could have significant consequences on the ability of the nurse workforce to respond to the challenges it faces.

There is also a need to consider developing succession planning. This can be broadly defined as a process for identifying and developing potential future leaders or senior managers, as well as individuals to fill other business-critical positions, either in the short- or the long-term. In addition to training and development activities, succession planning programmes typically include the provision of practical, tailored work experience that will be relevant for future senior or key roles. Poor succession planning has been identified as a key challenge associated with nursing in rural and remote communities (WHO 2006).

Nurses often have a unique pattern of engagement with the workplace and this can be driven by many factors – caring responsibilities feature frequently. The needs (and numbers) of returners to the workforce are often underestimated and supporting nurses to return after a career break is an area where much more could be done in many systems (ICN 2010a). As professional regulators move to maintain live registers of registrants and consider revalidation, it is important to plan to retain the skills and address the needs of this invisible but important resource.

Box 5: Five features of the globalisation of professional education:

1. Increasingly have one global pool of health professional talent.
2. There is a universal aspiration and challenge of primary health care which occurs in very different contexts
3. A growing interdependence in all health matters
4. Movement of institutions to establish affiliated campuses elsewhere
5. The expansion of global health as a field of enquiry

(Frenk et al 2010)

Workforce planning happens at different levels globally, nationally, regionally and locally. Ideally the results of systems used locally will form the basis of regional and national plans. Thus, having a sound basis for planning staffing at local level is critical, and the separate tiers of planning should be integrated. Local workforce planning can:

- identify shortages and surpluses and prevent staffing crises
- define (or redefine) workplace organisation, tasks and roles and encourage teamwork between service providers
- contribute to ensuring patient safety by having the right staff skills in place to deliver effective care
- identify drivers of both demand and supply
- establish workforce education and training needs
- provide knowledge and understanding of the workforce and its activities and ensure there is a process for systematically addressing the factors that are influencing workforce and workplace change
- provide options for decision makers
- improve the quality of decisions
- provide for the orderly implementation of activities or resources
- provide a framework for monitoring and evaluating progress towards defined goals

(NHS Education Scotland 2013)

There are many resources available to support workforce planning some of which are listed in **Annex 1**. All recognise that robust understanding of the local workforce is key and that the involvement of nurses at every level of decision making regarding the nurse workforce is valuable. It is common to have nurses at government level with a role focused on nurse workforce planning who in turn link to key nurse colleagues throughout the system (ICN 2010b).

However, it is also evident that knowing the number of nurses available is only part of the answer. This has to be linked to an understanding of the work they are required to do in terms of volume and complexity and to skills availability. This has led to the design of a range of tools to better understand the workload of nurses.

Reflections:

Personal: Do you understand how workforce planning happens in your organisation? Are you actively involved in the design and continuous improvement of the systems which are used?

Policy: Are there consistent and linked approaches used for nurse workforce planning in your health system?

Chapter 4

Nursing Workload Measurement

The concept of nursing workload has been well explored in the nursing literature but there is no single definition (Walker & Hendry 2009). Early definitions tended to focus on the volume and level of nursing work but these were criticised as too narrow as they failed to account for work that nurses do on behalf of patients, families and communities and also the work they do for their colleagues, such as education and administration. A group of senior nurses in New Zealand identified a range of factors which also influence nursing workload. These include:

- Patient demand: patient circumstances, complexity and case mix
- Environmental complexity: physical environment and resources, support services, redesign and restructuring, funding and case mix
- Medical complexity: medical diagnosis, decision making and treatment choices
- Quality-processes and outcomes: orientation, education training
- Nurse sensitive outcomes: the patient outcomes directly influenced by nursing work
- Nursing intensity: amount of care required by each patient
- Nursing skill mix: the number and attributes of the nursing workforce required and available
- Work systems: roster relief staffing, clinical support, documentation, conditions of service, recruitment and retention.

(Adapted from Walker & Hendry 2009, p12)

These factors clearly identify the complexity of measuring nursing workload in its entirety. Most tools used by organisations tend only to measure some of these factors. That said, understanding and using workload measurement can provide reliable and evidence-based data and help inform the management of the nurse workforce. Used alongside other data, it can demonstrate how the relationship between staffing levels and workload can alter the quality and cost of care and how the work environment can facilitate or limit these outcomes. The measurement of workload tends to be better developed in hospital based systems and there is still much more to be done to develop effective tools for primary care.

Workload data provides information to:

- justify human and financial resource levels
- explain utilisation of resources
- justify allocation of resources
- support trend analysis
- support management decisions regarding changing workloads, rostering and budgeting

(NHS Education Scotland 2013)

Reflections:

Personal: Why is it so much more difficult to develop workload measures for primary and community care environments? As care settings become more diverse what are the consequences for nurses of not being able to assess workload more effectively?

Policy: What steps can be taken to transfer our learning in the hospital sector to community setting. What are the gaps that need to be addressed to make community based workforce planning a reality.

Most commonly used approaches to planning staffing rely on quantifying the volume of nursing care to be provided generally on the basis of the size of population, mix of patients and type of service. This is then related to the activities undertaken by different members of the team. The systems vary according to the amount of detail considered, from basic 'top-down' ratios that relate staffing to numbers of beds or total population, through to systems requiring detailed data on the nature and volume of care needs (patient dependency) and a breakdown of how nursing activity of different team members varies in relation to this. Health information systems are increasingly been developed to support this, but as many of these systems have their routes in quantifying activity for costing purposes they have received a mixed response from the nursing profession. However, the importance of good information systems and better data collection remain (Cipriano & Hamer 2013). The poor understanding of these issues was highlighted in an international study by Dowding et al (2013). This recent international survey sought to identify priorities for nursing informatics research on patient care. The report acknowledges that, despite the growing evidence base on the design and evaluation of health information technology (HIT), these technologies focus mainly on medical practice. The study found that the two most highly ranked areas of importance for nurses were the development of systems to provide real-time feedback to nurses and the assessment of HIT's effects on nursing care and patient outcomes. For more information about health informatics see www.thetigerinitiative.org

> A well performing workforce is one that works in ways that are responsive, fair and efficient to achieve the best outcomes possible, given available resources and circumstances
>
> (WHO 2006, p67)

The focus on inputs into an understanding of workload and workload measurement has been a dominant methodology when considering workforce issues. However, before settling on any particular methodology it is important to understand that *patient needs, even when identified, are often expected to balance against other organisational features such as achieving contract targets or keeping within a budget.* This is perhaps less well understood and explored. The relationship between workforce availability, system culture and workforce outputs and outcomes does account for a significant difference in the quality of patient care.

Best practice in planning nurse staffing

Given the lack of proven reliability or recommendations about which systems to use, and the many different factors that determine staffing needs, triangulation is essential. Systems, as a minimum, need to take account of patient dependency, nursing activity and be reviewed by expert nurse judgment. Simple and easy to use systems to plan nurse staffing exist and are outlined in Annex 1.

Most successful approaches would support the adoption of a set of key principles to ensure staff planning and workload reviews are successfully implemented. These key principles are that staffing reviews need to:

- have board level commitment (with a nursing director/ chief nurse as a key requirement)
- actively involve staff and are transparent in their processes
- use established approaches and apply them consistently
- triangulate (e.g. dependency scoring system to gauge workload, professional judgement and benchmark)
- **be** evaluated regularly (against patient and staffing outcomes data)
- actively engage with the education sector and increasingly social care
- act on the results.

Ensuring safe staffing levels relies on having the right base level of staffing. *A number of factors can 'erode' the planned staffing so that even with the 'right' daily staffing, levels can be insufficient to meet patient need safely.* Safe staffing relies on good management so that budgeted posts are filled and deployed effectively, and the staff employed are available to work. The regular use of temporary and inappropriately skilled staff is associated with a reduction in quality outcomes (RCN 2012).

Support to changing roles

The increase in our understanding of the nature of the workforce and our ability to scrutinise more closely "who does what" has started to add clarity to the emergence of new roles and to the possibility of considering more actively the impact of this role substitution on patient outcomes. The division of labour in health is constantly shifting in multiple directions and applies to many roles in the health system. There is a very lively debate about the use of role substitution, or task shifting, and its importance to nursing. This occurs when nurses take on the responsibility for work currently done by other health professionals and vice versa. There is an argument for a rapid increase in the shifting of healthcare tasks to the lowest relevant cadre of health personnel (WHO 2006). This can be done to relieve short term human resource gaps. However, from a number of evaluations of this approach there is clearly a need for caution; this approach can have an unanticipated and costly impact on outcomes in the longer term (Cavendish Review 2013, WHO 2006).

> "The greater complexity of interventions and a higher proportion of the elderly with comorbidities mean that even those tasks designated as "basic" require those that do them to have not only care and compassion but sound knowledge of relevant sciences…"
>
> (Hunt 2013)

Indeed, the evidence suggests that far from being a cheap short term solution the effectiveness and long term sustainability of basic health workers depends on an appropriate linkage with other health professionals. Many community health worker programmes have failed because they did not successfully incorporate professionals into the workforce mix. Health professionals are the leaders' planners and policy makers within health systems. They generally provide the training and supervision which support workers need to be able to maintain their skills and to refer on appropriately to other trained health

workers (WHO 2006). Health systems need to commit to a system of skills development that enables all workers to step on and step off and clearly articulate how they can progress in supporting the continuum of care and their own personal development. On example is the Knowledge and Skills Framework (KSF), a competence framework to support personal development and career progression within the National Health Service (NHS) in the United Kingdom see www.ksf.scot.nhs.uk).

This would suggest that the use of more detailed tools to evaluate changes in role in terms of their impact would clearly be of value for the nurse workforce particularly at times of challenge and, as in the case of nurse consultant roles, could ensure more effective workforce planning, role development and educational preparation (Kennedy et al 2011)

Box 6: Case study: Up-skilling a workforce using telehealth

Changing roles and up-skilling existing workers is difficult in diverse and rural communities. In El Salvador a telehealth approach has been tried to improve skills to achieve institutional goals in order to enhance health access of the population as a fundamental human right. El Salvador is a very small country of 5.7 million inhabitants, trying to implement a public health system across its whole territory, a process which is still just developing. In this context, the training of human resources has a strategic role, with several initiatives incorporating distance learning activities. The telehealth actions began in October 2010 through an interinstitutional group. Up to now, it is being developed at national level with free software platform that will allow easier intercommunication between the teams and specialists as well as improving communications between the different health establishments.

(Marroquin and Martin 2013)

Patient self-management

Another important area to consider in relation to changing roles (also sometimes referred to as task substitution or task shifting) is the role of patients and communities in actively managing their own health needs. Indeed, the rapid changes in society also mean that the description of families and communities is also changing along with associated needs and wants, for example, the establishment of retirement communities which have a built-in capacity to foster physical, psychological and social wellbeing.

There is a significant expansion of the use of technologies to bring together groups of individuals. The use of social media in this context is very evident. This enables the sharing of knowledge and understanding not just of their health needs but how best to engage the system. There are many examples of how increased access to data and information is changing the way patients, carers and citizens use health services (see Box 7).

The consequences are exciting but also potentially disruptive and nurses will need to feel confident to respond to the different relationships which will emerge. This also includes nurses' understanding

of the need to deliver care in new ways such as by the use of different forms of media. Nurses will need to recognise that they will have a professional digital presence.

Box 7: Disruptive Changes

The current disruption in healthcare corresponds to the fact that patients can access tools to gather information, aggregate data, act, and see results reflected in real-time.

- **Medicine:** Patients are more engaged with managing their own illness, receive better outcomes / resistance from medical community in some quarters.
- **Research:** Patients can find out about clinical trials going on anywhere in the world and participate online or even carry out their own research programmes - increasingly being viewed as credible in the peer-reviewed world.
- **Business:** Payers want to pay for improved outcomes, not transactions. The pill must be shown to be more effective than existing alternatives in the real world, not just a placebo in a controlled trial.
- **Safety:** Patients can submit their own safety events in real-time and enter into a dialogue with manufacturers about how to improve their products.

(Hodgkin 2012)

Also see:
www.patientslikeme.com
www.bigwhitewall.com
www.renalpatientview.org

Increased patient self-management has been shown to improve health outcomes, but, as financial pressures increase, it is also an important sustainability issue. Patient self-management support has been recognised as a necessary and evolving role for health-care providers (CCL 2007). Addressing health-literacy challenges of patients is a component of patient self-management support. *Low levels of health literacy present a significant challenge to the widespread and effective use of patient self-management.* This is an area for the nurse workforce to actively develop and explore. Nursing has a long history of encouraging and enabling patients to become self-managing and, if possible, independent in their own care. There are many examples of patients' successfully managing a high degree of complexity but it is the increasing use of technologies to support them which is transforming the possibilities. There is an increasing interest in patient led innovation as people are not only recipients of services but actual coproducers of their own education and health. As described by Berwick et al. (2009), patient-centeredness reflects an "experience (to the extent the informed, individual patient desires it) of transparency, individualisation, recognition, respect, dignity, and choice in all matters – without exception – related to one's person, circumstances and relationships in health care."

If technology is to enable a step change in productivity, the health and social care workforce will need the appropriate skills and capabilities to embrace that technology and to support new ways of working.

Reflections

Personal: Identify the access that nurses currently have in your workplace to support the development of health literacy and formulate key points to improve the situation.

Policy: Supporting patients and carers to manage their own health may require a reallocation of resources from traditional forms of delivery. How is that discussed with the public?

Health literacy plays a crucial role in chronic disease self-management. In order to manage chronic or long-term conditions day-to-day, individuals have to be able to understand and assess health information (often a complex medical regimen), plan and make changes to their lifestyles, make informed decisions and understand how to access care when they need it. However, according to the Adult Literacy and Life Skills Survey, more than half (55%) of working-age Canadians do not have adequate levels of health literacy and only one in eight adults (12%) over age 65 has adequate health-literacy skills.

(Canadian Council on Learning CCL 2007)

Chapter 5
The Importance of Work Environment

The importance of the work environment has been significantly underestimated as a key aspect of understanding in the deployment of nurse resources (Aiken et al 2011a; Brown et al 2010). Without a good working environment adding additional nurses to the workforce may have little or no effect, whereas adding nurses to a good working culture will have a significantly greater benefit (Aiken et al 2011b). As Aiken et al (2011b) note "the significant interaction between nurse staffing and the work environment implies that the effect of nurse staffing is conditional upon the work environment and alternatively that the effect of the work environment is conditional on nurse staffing" (p.6). They were able to demonstrate that in hospitals the better the nurse work environment the lower the odds on deaths and failures in hospitals across the entire nurse staffing (see Box 8).

This work can be complimented by a Nigerian study (Ayamolowo et al 2013) which considered the relationship between job satisfaction and work environment of primary care nurses. It too concluded that a healthy work environment was an important factor in improving work satisfaction, reducing turnover intention and improving care outcomes. Of the five facets of work environment addressed in the study the management practices and the support structure, as perceived by the nurses, had the highest value.

Whilst adding more nurses to a workforce has an initial cost, improving the working environment does not require the same level of resources but does require the health system to manage and lead itself differently. This can also have wider benefits for patients and their families. An innovative scheme by ICN and partners in Swaziland was initiated after a survey revealed that 80% of health workers were leaving the profession as they felt uncared for and undervalued (Beleta 2008). In 2006, the Swaziland Wellness Centre, the first of its kind worldwide, was built. It offers healthcare workers and their immediate families a range of services in order to tackle many of the barriers to wellness services faced by health workers, allowing for a strengthened health care workforce better able to meet the health needs of the population (ICN 2011).

The WHO 2006 report reinforces this view and notes that strategies to support and boost worker performance are important for four reasons:

1. They will be likely to show results sooner than strategies to increase numbers.
2. The possibilities of increasing the supply of health workers will always be limited.
3. A motivated and productive workforce will encourage recruitment and retention.
4. Governments have an obligation to society to ensure that limited human and financial resources are used as fairly and efficiently as possible. (p. 67)

Box 8: The importance of the work environment

"The Penn team found that each additional patient per nurse was associated with a 6 percent to 9 percent increase in the odds of a patient's readmission with 30 days, depending on the condition. Good nurse working environments were associated with 7 percent, 6 percent and 10 percent lower rates for heart failure, acute myocardial infarction and pneumonia, respectively."

(Wood 2013)

Keeping this understanding of the importance of work environment is particularly critical at times of significant change when services are being redesigned. Many members of the profession require more education and preparation to develop their new roles quickly in order to respond effectively. Increasingly, we are seeing nurse-led clinics, outreach services and advanced nurse roles all of which create a different care environment and associated culture. It is all too easy to ignore the vital role which nurses need to play and nurses need to be considered as full partners in this process.

The link between a positive work environment and employers who work to improve staff satisfaction has led to a range of initiatives to improve health and wellbeing in the workforce. As Boorman (Department of Health 2009) notes organisations that prioritise staff health and well-being perform better, with improved patient satisfaction, stronger quality scores, higher levels of staff retention and lower rates of sickness absence. This has resulted in a range of employer-led activities to address the work life balance for nurses and to improve staff engagement (see Annex 2). This is also increasingly being linked to improvements in the involvement and engagement of the patients and the public through actively seeking their feedback and encouraging them to be active in service development and changes (Kutney- Lee et al 2009).

Nurse leaders at every level should feel confident about taking responsibility for identifying problems and issues in the work environment and also for providing solutions if we are to avoid some of the system-wide failures that we noted earlier on.

Reflections:

Personal: What are the most important issues you would like to see addressed in your work environment? In what ways could these be addressed?

Policy: How do we develop an expectation that employers regularly assess the quality of their work environment and act on this information?

Effective workplace culture

Much attention has been placed on the importance of organisational and corporate culture but perhaps less attention has been on the local conditions which enable best practice to occur (Laschinger & Leiter 2006). In a detailed concept analysis based on a theory of practice development, an international group of nurses identified five attributes all of which they considered to be necessary for an effective workplace culture to be judged (Manley et al 2011). These are:

Attribute 1: Specific values shared in the workplace; these are person centeredness; lifelong learning; high support and high challenge; leadership development; involvement and participation of key stakeholders; evidence use and development; positive attitude to change and continuous development; open communication; team work; safety.

Attribute 2: Shared vision and mission with individual and collective responsibility.

Attribute 3: Adaptability, innovation and creativity maintain workplace effectiveness.

Attribute 4: Appropriate change driven by the needs of patient's/communities.

Attribute 5: Formal systems exist to continuously enable and evaluate learning, performance and shared governance.

The authors developed the attributes into a framework to help teams develop. Whilst acknowledging the interdependence between organisational, corporate and workplace culture they argue that *it is in the workplace that most potential exists to transform care delivery and the patient experience.*

Developing high performing teams

The high-performing team is now widely recognised as an essential tool for constructing a more patient-centred, coordinated and effective health care delivery system. As a result, a number of models have been developed and implemented to coordinate the activities of health care providers. Given the range and complexity of information and interpersonal connections, it is not only difficult for one clinician to provide care in isolation, but also potentially harmful. As multiple clinicians provide care to the same patient or family, clinicians become a team. This can be defined as group working with at least one common aim. Each clinician relies upon information and action from other members of the team. Yet, without explicit acknowledgment and purposeful development of the team, many of the opportunities to improve systemic problems remain unachievable (Mitchell et al 2012).

Principles of team-based health care

- **Shared goals:** The team – including the patient and, where appropriate, family members or other support persons – works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.
- **Clear roles:** There are clear expectations for each team member's functions, responsibilities and accountabilities, which optimise the team's efficiency and often make it possible for the team to take advantage of division of labour, thereby accomplishing more than the sum of its parts.
- **Mutual trust:** Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

- **Effective communication:** The team prioritises and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.
- **Measurable processes and outcomes:** The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Reflections:

Personal: How often does the team you work with take time to reflect on its processes and outcomes? What would you like the team to do differently?

Policy: How do we develop a health system that develops and rewards team performance as well as individual performance?

Chapter 6
Improving learning and outcomes

A better skilled workforce is a more productive workforce but, as we have already noted, skills on their own will not result in greater productivity. There has to be an acknowledgement of the interrelationship of key elements of the system (demand and supply) and a greater awareness by all stakeholders about the potential of the workplace to develop the capabilities and talent of their staff (IOM 2010). The key goal for most organisations is not learning but the successful delivery of services. Learning plays an important role in meeting this objective, so we need to ensure that the workplace is a place for all types of learning and those leaders and managers in the system purposefully develop this resource. The best sort of workplace learning has meaning and benefit for both the employer and the nurse.

Box 9: A learning organisation

- Employee autonomy and involvement in decision making (e.g. self-managed work teams, quality circles)
- Support for employee performance (e.g. appraisal and peer review systems, mentoring and supervision)
- Rewards for employee performance (e.g. pay rates, performance related pay, profit sharing)
- Sharing of information and knowledge (e.g. systems for communicating with employees and to ensure employee feedback is used to develop organisational strategy)

Adapted from Ashton & Sung (2002)

As organisations have understood the need to continuously improve and develop, it is now possible to distinguish between those practices that are associated with a "high performance" organisation (Ashton & Sung 2002) (see Box 9). The behaviours they identify for employers to have in place also require workers to develop their own skills to successfully access the opportunities presented. This requires a continuous investment by individual nurses to engage actively and to commit to lifelong learning. It is no longer the case that nurses can sit and wait to be sent on courses by managers, engage in short term projects or react to external demands; a much more dynamic relationship is required.

There is now a clear continuum of development which governments, employers and individual nurses need to support to enable all stakeholders to be engaged in sustainable change and continuous improvement. This requires nurses to accept responsibility for learning and developing their own practice. In some nurse systems this is described by the professional regulator and contains the following elements: mentorship for nursing students' undertaking approved programmes; preceptorship for new nurses and those returning to practice; and clinical supervision

to support on-going development. **The most effective use of the nurse resources occurs when nurses are able to practice to the full extent of their education, training and capabilities**. This requires many parts of the system to work flexibly and increasingly at speed to support improved opportunities for learning and development, for an example see www.nipec.hscni.net/preceptorship.

Chapter 7
Key Considerations

Leaders at every level

There have been numerous reports on the critical role of leaders at all levels of the health system to build quality work environments and implement new forms of care delivery. Perhaps less well understood is the type of leadership that will achieve this. In a systematic review carried out by Cummings et al (2010) they were able to identify specific leadership approaches that are more effective at achieving positive outcomes for the nursing workforce. This report highlights the importance of relational skills (as opposed to task based skills). As roles change and work practices are redesigned it is important to remember to engage the entire workforce in this process as equal partners. This activity has significant emotional impact on teams. **Leaders at all levels in the organisation need to have concern for their employees as individuals and work collaboratively to achieve the goals they have identified for their patients and communities.**

System wide collaboration

Increased collaboration within the nursing profession and between health care professions will be required to maximise scopes of practice and address the changing health care delivery system. This will include modernising regulatory frameworks that are integral to the health system. This collaboration will increasingly rely on the sharing of workforce data and a commitment to high quality information systems needs to be developed with nurses as partners in this development. Lobbying will become increasingly important as the political field of sight (five years) and the impending global nursing shortage (five to seven years) converge. This provides a timely opportunity to reinforce the message regarding **the need for global health human resources planning; augmenting the number of health care workers; increasing productivity; and improving the quality of the educational response** which may all be required**.**

Working with resource constraint

The resource constraint apparent in all health systems will require nurses who are or will be in key leadership or management positions to be prepared to manage rapid changes in a globalised and technology driven world in which financial and human resources are limited. This will require the development of competencies for nurses to effectively and efficiently develop and manage the nursing workforce. This includes effective collaboration, developing strategic alliances and partnerships, negotiating skills, high level oral and written communication skills, building and motivating teams and decision making**. Recognising the different stages of development with nurses and NNAs will require various tools to be developed or adapted for maximised impact; this is particularly a high priority in community and primary care services.**

A commitment to education and learning

There is a clear need to develop an education and learning system aimed at improving the performance of health systems by adapting core professional competencies to specific contexts, while drawing on global knowledge. For many health systems, this will require an active conversation between the health and education sectors regarding the planning and development of the workforce. The current imbalances in the system are wasteful and both systems are too slow to respond because of this disconnection. **All health professionals including nurses should be educated to mobilise knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population centred health systems as members of locally responsive and globally connected teams** (Frenk et al 2010)**.**

A personal responsibility

Finally, as we consider the nurses and how we act as a force for change, then we need to critically assess our own personal responsibility. If we are unhappy with how nurses are viewed or treated in the workplace then we have an obligation to do something about it (Darbyshire 2010). We have to recognise our own personal responsibility over the image of nurses and how the public view us. We are vibrant and active members of many communities; we link on extensive networks. Yet all too frequently the media tell a different story; if we only portray an image of negative stories then we are part of the problem.

We need to use International Nurses Day to "change the picture"; to reinforce how a skilled nurse response can transform lives, families, communities and indeed countries. We need to model this message not just on this day but from this day onwards.

On this day of action be prepared to describe:

- **How you have made a difference.**
- **How your team has made a difference.**
- **How your nurse association has made a difference.**
- **How your government CAN make a difference.**

Annex 1

Examples of workforce planning tools, websites and links

Health Workforce New Zealand: www.healthworkforce.govt.nz/

Tools and resources - "HWNZ has overall responsibility for planning and development of the health workforce, ensuring that staffing issues are aligned with planning on delivery of services and that our healthcare workforce is fit for purpose."
http://healthworkforce.govt.nz/tools-and-resources

NHS Employers: www.nhsemployers.org

Nursing Career Framework - An interactive tool from the Department of Health helps registered nurses plan their career pathways. The framework can be used to assist employers with planning and development of their workforce.
www.nhsemployers.org/PlanningYourWorkforce/Nursing/toolsandresources/Pages/TheNursingCareerFramework.aspx

Workforce Planning -
www.nhsemployers.org/PlanningYourWorkforce/Modernising-Scientific-Careers/MSC-latest-news/Pages/Healthcaresciencesresources-newworkforceplanningtoolspage.aspx

NHS Education for Scotland [NES]: www.nes.scot.nhs

'Nursing and Midwifery Workload and Workforce Planning Learning Toolkit', NES, 2013,
www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/resources/publications/nursing-and-midwifery-workload-and-workforce-planning-learning-toolkit.aspx

National Quality Board (NQB), NHS England: www.england.nhs.uk

How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability
This guidance outlines a set of expectations of providers and commissioners relating to staffing, and provides advice on how they can be met. It signposts readers to existing evidence-based tools and resources, and provides examples of good practice. Includes links to external resources
www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Royal College of Nursing: www.rcn.org.uk

RCN Resources - workforce planning - [includes links to external resources]
http://www.rcn.org.uk/development/practice/clinical_governance/staff_focus/other_support/guidance__and__tools

'Safe Staffing levels - Setting safe nurse staffing levels. An exploration of the issues', London: Royal College of Nursing 2003
From: RCN Publications:
The paper was written in response to the concern expressed by RCN members about the lack of an objective and rational `universal formula' for staffing, which could guarantee the delivery of safe and high quality nursing care. Although the main focus is on the nursing workforce in hospitals, many of the issues discussed are equally relevant to nurses in community and primary care services.
www.rcn.org.uk/__data/assets/pdf_file/0008/78551/001934.pdf

'Guidance on safe nurse staffing levels in the UK', London: Royal College of Nursing. 2010,
www.rcn.org.uk/__data/assets/pdf_file/0005/353237/003860.pdf

'RCN Policy Position: evidence-based nurse staffing levels', London: Royal College of Nursing.2010
www.rcn.org.uk/development/publications

Skills for Health: http://skillsforhealth.org.uk

"Skills for Health is your Sector Skills Council, for all health employers; NHS, independent and third sector. Everything we do is driven by your skills and workforce needs."

Nursing Workforce Planning Tool -*"This tool aims to assist nursing workforce planning and help make better decisions about cost effective numbers and mixes of nurses."*
https://tools.skillsforhealth.org.uk/nursing_planning/

World Health Organization (WHO): www.who.int

'Models and tools for health workforce planning and projections',
Human Resources for *Health Observer*, Issue No. 3.
*"*The objective of this paper is to take stock of the available methods and tools for health workforce planning and projections, and to describe the processes and resources needed to undertake such an exercise. This review is not meant to be exhaustive, but illustrative of the tools and resources available and commonly used in countries."
www.who.int/hrh/resources/observer3/en/

The International Bank for Reconstruction and Development / The World Bank
How to Recruit and Retain Health Workers in Rural and Remote Areas in Developing Countries, World Bank Guidance note, Health, Nutrition and Population Discussion Paper Edson Araújo and Akiko Maeda June(2011) provides a summary of the evidence to date on the factors that contribute to these imbalances; presents a systematic set of policy interventions that are being implemented around the world to address the problem of recruitment and retention of health workers in rural and remote regions of the developing countries; and to introduce the potential application of the Discrete Choice Experiments (DCEs) to elicit health workers' preferences and determine the factors likely to increase their probability of taking up a rural or remote job www.who.int/workforcealliance/knowledge/resources/wb_retentionguidancenote/en/index.html

Annex 2

Examples of Workforce Environment Tools

NHS Employers: www.nhsemployers.org

Improving Staff Engagement -
www.nhsemployers.org/Aboutus/Publications/Pages/ImprovingStaffEngagement.aspx

Health, Work & Well-Being - 5 sections
1. The way to health and well-being - For strategy building, evidence gathering and best practice initiatives.
2. Keeping staff well - For preventative measures, proactive support and learning from others.
3. Sustaining the momentum - How to use data and the staff survey to engage your workforce.
4. Action on Absence - All you need to know to reduce sickness absence.
5. Leading the Way - Who's ahead of the curve and how can we learn from them?
www.nhsemployers.org/HealthyWorkplaces/Pages/Home-Healthy.aspx

American Association of Critical Care Nurses [AACN]: www.aacn.org/

Healthy Work Environment Initiative - *"AACN has prioritized three major advocacy initiatives: healthy work environments, palliative and end-of-life care, and staffing and workforce development."*

AACN Standards documents - linking healthy work environments and patient safety, nurse retention and recruitment
"The link between healthy work environments and patient safety, nurse retention and recruitment and, thus, the bottom line, is irrefutable.
AACN believes that all workplaces can be healthy if nurses and employers are resolute in their desire to address not only the physical environment, but also less tangible barriers to staff and patient safety. However, we know that this will not happen without an understanding of the factors contributing to unhealthy work environments and a commitment to embrace solutions.
The ingredients for success - skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition and authentic leadership are described in the AACN Standards for Establishing and Sustaining Healthy Work Environments."
Full Version: www.aacn.org/WD/HWE/Docs/HWEStandards.pdf
Exec. Summary: www.aacn.org/WD/HWE/Docs/ExecSum.pdf

Healthy Work Environment Assessment Tool - www.aacn.org/hwehome.aspx?pageid=331&menu=hwe

Predictive Index [PI Worldwide]: www.piworldwide.com/

Predictive Index Healthcare Briefings: Wood D, 2013, 'Creating a Great Nurse Work Environment to Improve the Bottom Line', Jan 18, 2013:
"The Predictive Index helps healthcare organizations like Indiana University Health (Bloomington Hospital) create a positive workplace culture." [By Debra Wood, RN, Contributor.]
http://www.piworldwide.com/healthcare-briefings-creating-a-great-nurse-work-environment-to-improve-the-bottom-line/

Registered Nurses' Association of Ontario (RNAO): http://rnao.ca

The Healthy Work Environments (HWE) Best Practice Guidelines (BPG) "*are designed to support health care organizations in creating and sustaining work positive environments. This work is led by the Registered Nurses' Association of Ontario, with funding from the Ontario Ministry of Health and Long-Term Care and support from Health Canada, Office of Nursing Policy. The initial goal of the program was the development of six guidelines and systematic literature reviews related to healthy work environments. The six areas included leadership, collaborative practice, workload and staffing, professionalism, embracing diversity and workplace health, safety, and well-being. For the project a healthy work environment was defined as "a practice setting that maximizes the health and well-being of nurses, quality patient outcomes and organizational and system performance".*
http://rnao.ca/bpg/guidelines/hwe

Durham Region Health Department: www.durham.ca/

Easy Steps to a Healthy Workplace
There are proven successful steps workplaces can do to create a healthy workplace.

1. Gain Commitment.
2. Create a Healthy Workplace Team.
3. Situational Assessment: Learn what your healthy workplace priorities are, and what employees want.
4. Create a Health Plan.
5. Implement the Plan.
6. Evaluate.

Celebrate and Plan for Next Year.

The Healthy Workplaces Toolkit can help because it has many examples and more information about doing the steps. The toolkit also has some tools and templates to help you complete the steps and make a Healthy Workplace Plan.
Healthy Workplace Toolkit: www.durham.ca/departments/health/haw/hwToolkit.pdf

Health & Safety Ontario: www.healthandsafetyontario.ca

'Healthy Workplaces: Journey to Excellence'.
"*Six chapters devoted to helping you establish a healthy workplace, including definitions, how to get started, and benefits versus costs.*"
www.healthandsafetyontario.ca/Resources/TopicList/Healthy-Workplaces.aspx

Centre for Workforce Intelligence: www.cfwi.org.uk

CFWI, 2011, 'Workforce risks and opportunities: Nursing and Midwifery'
www.cfwi.org.uk/publications/workforce-risks-and-opportunities-nursing-and-midwifery

Robert Wood Johnson Foundation: www.rwjf.org

'New Study Shows Improving Nurses' Work Environments and Staffing Ratios Can Reduce Hospital Readmissions for Medicare Patients'
"Our findings indicate that improving nurses' work environments and reducing their workloads can reduce readmissions for Medicare patients with common conditions," said McHugh. "It is certainly worthwhile for hospital administrators to examine these two factors and explore whether they can be optimized to improve patient outcomes and reduce readmissions."
www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2013/01/new-study-shows-improving-nurses-work-environments-and-staffing-.html

'**Hospital nursing and 30-day readmissions among Medicare patients with heart failure, acute myocardial infarction, and pneumonia**,' *Medical Care,* Vol. 51 No. 1: pp 52-59, McHugh MD & Chenjuan MA (2013).

London Health Sciences Centre (LHSC) Nursing Resource Team: www.lhsc.on.ca

Nursing Resource Unit: www.lhsc.on.ca/Careers/Nursing/Clinical_Programs/NRU.htm

LHSC leading the way in continuous quality improvement for nursing:
www.lhsc.on.ca/About_Us/LHSC/Media_Room/Media_Releases/2013/May7.htm

" ...data was collected for use by leadership and staff for creating HWE (Healthy Work Environments) strategies aimed at improving the quality of patient care."

'Building a Healthy Work Environment: A Nursing Resource Team Perspective' Nursing *Leadership*, Vol. 26[Special Issue] (May): pp 70-77, Vaughan L & Slinger T (2013).

www.longwoods.com/content/23322

Agency for Healthcare Research and Quality & Robert Wood Johnson Foundation:
www.ahrq.gov/index.html

Patient Safety and Quality: An Evidence-based Handbook for Nurses
"Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality—*Patient Safety and Quality: An Evidence-Based Handbook for Nurses*". (AHRQ Publication No. 08-0043).www.ahrq.gov/professionals/clinicians-providers/resources/nursing/resources/nurseshdbk/index.html

Centre for Health & Social Care Research, Sheffield Hallam University:
http://research.shu.ac.uk/hwb/ncimpact/index.html

Gerrish K, McDonnell A, & Kennedy F (2011), '**Capturing impact: A practical toolkit for nurse consultants**', Sheffield: Sheffield Hallam University (July). "This toolkit has been designed to help nurse consultants assess the impact they have on patients, the staff that they work with, their organisation, and the contribution they make outside their organisation. It was developed as part of a research project commissioned by the Burdett Trust for Nursing which examined approaches to measuring the impact of nurse consultants."
http://research.shu.ac.uk/hwb/ncimpact/NC Toolkit final.pdf

International Council of Nurses [ICN]: www.icn.ch

International Nurses Day 2007*:* 'Positive practice environments: Quality workplaces = quality patient care'.[Developed by Andrea Bauman]:
"The kit is designed to provide data on positive practice environments to all health stakeholders who are interested in improving the delivery of quality services.
The pages ... explore the nurse/workplace interface, overlapping factors that shape nurses' work environments, the cost of unhealthy workplaces ..."

Robert Wood Johnson Foundation/Institute of Medicine: www.thefutureofnursing.org

Future of Nursing Report -'The Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health,* is a thorough examination of the nursing workforce. The recommendations offered in the report focus on the critical intersection between the health needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce'
www.thefutureofnursing.org/IOM-Report

Success Stories -
In communities across the country, nurses are leading innovative programs to improve the health of their patients. The case studies and personal stories included here help illustrate the work of nurses and innovative models that were developed by nurses or feature nurses in a leadership role. -
www.thefutureofnursing.org/success-stories

Position Statement

Annex 3

Health human resources development (HHRD)

ICN Position:

The International Council of Nurses (ICN) judges that health human resources development (HHRD) - planning, management and development - requires an interdisciplinary, inter-sectoral and multi-service approach. This recognises the complementary roles of health service providers, and values the contribution of the different disciplines. Inputs are required from the key stake holders -- consumers, service providers, educators, researchers, employers, managers, governments, funders and health professions' organisations. Similarly, ICN acknowledges that integrated and comprehensive health human resources information systems and planning models as well as effective human resources management practices are desired outcomes of this consulting process.

Patient need should determine the categories of health personnel and skill pools required to provide care. When new categories of health workers are created or role changes are introduced, the possible consequences on national and local health human resources, career structures, and patient and community outcomes need to be identified and planned for at the outset. These would include financing arrangements and organisational impacts. Planning for this should take account of:

- Health care needs and priorities.
- Available competencies within the health care provider pool, including competencies shared by more that one health care provider group.
- Initial skills set development.
- Skill changes, such as new and advanced roles for nurses.
- Educational implications of making changes to roles and scopes of practice, including provision for life-long learning programmes.
- Appropriate and accessible supervision and mentoring programmes.
- Quality and effectiveness factors, when deciding the scope of practice of nurses and others.
- Equity as a basic value of the health system.
- Consequences for service organisation, management, delivery and financing.
- Work environment and conditions of nurses and other health care personnel.
- Regulatory implications.

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Website : www.icn.ch

- Impact on responsibilities of those workers already in the health care system.

- Effect on the career pathways for existing health care workers and career structures available for new types of health workers.

For effective participation of nursing in HHRD, the core scope of nursing needs to be identified and fully articulated. This will minimise duplication and overlap between the work of nurses and other health care providers. ICN considers that the nursing profession needs to be a leader of change, continually reappraise the consequences of planned and unplanned health service changes on nursing, nurses and patient outcomes. Continuing evaluation of and research into the contribution of nursing to health care should form an important part of HHRD processes. This should include data from evidence-based practice, informing future decision-making.

National nurses associations (NNAs) and other nursing organisations need to:

- Identify critical issues related to the supply of and demand for nursing personnel, including factors that influence recruitment, retention and motivation.
- Ensure involvement of nurses in policy, decision-making, planning, management and monitoring at all levels of HHRD. Nurses should participate in interdisciplinary reviews of the roles of different types of health workers, research and evaluation studies, and in decision-making with respect to the functions of existing and new categories of health care providers.
- Assist nurses to acquire and improve research skills, to carry out research, and to use research findings as a basis for decision-making in HHRD.
- Engage in public debate on appropriate responses to demand for health services.
- Promote the development of quality practice environments, including opportunities for professional growth and development and fair reward systems as a positive feature of recruitment and retention programmes.
- Acknowledge and reflect the cultural diversity of society in Health Human Resources Development.
- Promote capacity building in the area of health sector human resources management, including nurses working at senior and executive levels.
- Assist in the development of a humane approach to HHRD.
- Offer an inter-disciplinary analysis and develop effective interventions to address health needs.

Nurses need to be aware of and utilise HR services in their workplaces. HHRD policies need to encompass education, regulation and practice factors.

HHRD policies need to focus on self-sustainability, guaranteeing a core of health professionals in adequate numbers and with the right skills, capable of meeting the health needs of the target population.

Background

The attainment of the highest possible level of health in a country depends, to a substantial degree, on the availability of sufficient appropriately prepared and distributed health personnel, capable of providing quality cost-effective services. The goal of HHRD is to ensure that the right quality, quantity, mix and distribution of health personnel are available to meet health care needs in an environment that supports effective and safe practice. Some of the factors influencing decisions about numbers, types and distribution of health care providers include:

- Advances in health science and technology, altered patterns in the delivery of health care in hospitals and in the community, demographic changes and the emergence of patterns of disease.
- The growing public awareness of the availability of health services, resulting in greater demand for services.
- Increased health care costs, limited resources for health often necessitating a continual review of priorities, and the creation of new categories of health care providers.
- Labour laws, professional regulatory requirements, civil service rules and regulations, human resources and national health and development policies.
- Gender and cultural factors.
- Changing health risks.
- Access to and level of education.
- Culture and health beliefs.
- Access to alternative medicine.
- Intergenerational factors.
- Organisational factors.
- Socio-economic, financial constraints.
- The local, national and global labour market globalization.

Nurses need to engage in the activities and lobbying efforts of their professional associations and unions.

Adopted in 1999
Reviewed and revised in 2007

Replaces previous ICN Positions: *"Support of Nurses", adopted in 1989 and "Proliferation of New Categories of Health Workers",* adopted in 1981, revised in 1993.

Related ICN Positions:

- Scope of Nursing Practice
- Nursing Regulation
- The Protection of the Title "Nurse"
- Assistive or Support Nursing Personnel
- Socio-economic Welfare of Nurses
- Career Development in Nursing
- Nurse Retention, Transfer and Migration

ICN Publications:

Guidelines on Planning Human Resources for Nursing (1993)

It's Your Career: Take Charge
Career Planning and Development (2001)

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Position Statement

Annex 4

Promoting the value and cost-effectiveness of nursing

ICN Position:

Evidence shows that nursing is a cost effective yet often undervalued and underutilized health care resource.

Nurses must clearly articulate and demonstrate the value and cost-effectiveness of nursing and nursing outcomes to consumers, other health providers and policy-makers at all levels. They must also be able to negotiate and advocate for the resources needed to provide safe care.

Nurses have a responsibility to engage in research and develop innovative models of care delivery that will contribute evidence of nursing effectiveness to planning, management and policy development.

Nursing education, especially management and leadership development programmes, must help nurses become skilled and articulate in demonstrating the value and cost effectiveness of nursing to the health services. Nursing education institutions, and where relevant nursing regulatory bodies, should regularly review curricula to ensure the inclusion of content related to the value and cost effectiveness of nursing.

National nurses associations (NNAs) have an important role in helping determine and influence health and public policy that promotes cost effectiveness and quality of care.

National nurses associations must develop strategies to actively promote the participation of nursing in health service decision-making, nursing and health research, and health and public policy development. This requires developing and supporting strategies for the preparation of nurse leaders who are skilled and articulate, and able to demonstrate as well as promote the value and cost effectiveness of nursing to the health services.

Nurses must assert their professional involvement in policy formulation at all levels.

With rising health needs and health care costs, which includes costs associated with the provision of nursing services, nurses must take the initiative in defining, examining and evaluating the health outcomes and costs of their activities.

Nurses, especially nurse leaders, must have a good understanding of the purpose and nature of health care reform, and the contribution nursing can make at all levels of health care delivery, and in planning, management and policy development for health care services. Where health care reform is in its planning stages, nurse leaders must play a leadership role in policy development related to the appropriateness, nature and purpose of health reform.

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The International Council of Nurses (ICN) and member associations can assist nursing to develop the capacity for dealing with cost-effectiveness in health care, by:

- Promoting the role of nursing as a core resource in cost-effective care and as a critical contributor to decision making on healthcare spending.

- Offering nurses educational opportunities to gain knowledge of political skills, economic principles, budgeting and resource use and cost-effectiveness in health.

- Supporting leadership and management development that includes the role of nurses in resource management, decision-making and policy development.

- Promoting and supporting research and evaluation that links and validates costing methodologies to nursing and health outcomes.

- Encouraging the development of database systems that permit comparison of outcomes across settings to best approaches to care and the most effective design of nursing systems.

- Facilitating information dissemination and interactive networking on cost-effectiveness research, cost-saving strategies and best practice standards.

- Establishing professional networks with relevant stakeholders, to foster collegial collaboration and exchange of ideas and information aimed at promoting quality and cost effectiveness.

- Promoting equity in terms and conditions of service for nurses, to recognize and support their role in promoting cost effectiveness and quality of care in multi-disciplinary settings.

Adopted in 1995
Reviewed and reaffirmed in 2001

Related ICN Positions:

- Scope of nursing practice
- Participation of nurses in health services decision-making and policy development
- Publicly funded accessible health services

ICN Publications:

- **Cost Nursing Services**, Report of the ICN Task Force on Costing of Nursing Services, Geneva, ICN, 1992
- **Cost-Effectiveness in Health Care Services,** Guidelines for National Nurses' Associations and others, Geneva, ICN, 1993
- **Quality, Cost and Nursing**, International Nurses Day Kit, Geneva, ICN, 1993.
- **Guidelines on Planning Human Resources for Nurses**, Geneva, ICN, 1993.
- **Planning Human Resources for Nursing: Reference Document**, Geneva, ICN, 1994.
- **The Preparation of Nurse Managers and Nurses in General Health Management**, Geneva, ICN, 1990

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Fact Sheet

Health Human Resources Planning

Planning the supply of and demand for human resources for health is a significant challenge for most countries. Workforce shortages, underemployment and unemployment, skill-mix imbalances and geographical maldistribution are among some of the critical challenges at national level and within organizations Health human resources planning (HHRP) is essential for countries and systems to ensure the presence of workforces capable of meeting the needs of populations. However, ineffective HHRP is a weakness found in many countries. Few countries have planning mechanisms in place that adequately predict future demands for health care and provide for an effective and efficient workforce.[1, 2]

HHRP defined

The objective of HHRP is to provide the right number of health care workers with the right knowledge, skills, attitudes and qualifications, performing the right tasks in the right place at the right time to achieve the right predetermined health targets.

Benefits of good HHRP

Effective HHRP can result in:

- Improved health outcomes;
- Improved health services and a better functioning health system;
- Greater efficiency (both financial and operational/service) through better utilization of resources; and
- Improved retention and recruitment.

Common HHRP challenges

The literature points to a number of key HHRP challenges/obstacles encountered by countries. These include:

- Unclear/poor planning policies, and poor support for strategic planning;
- Lack of a national HHR plan or, in cases where they do exist, poorly executed or not implemented at all;
- Lack of a national coordinating body for HHRP;
- HHR planning which is performed independently and in isolation of other aspects of planning in the health care sector;
- Inadequate resources and/ or capacity to implement plan;

[1] ICNM (2007). *Nursing Self Sufficiency/Sustainability in the Global Context* developed by Jim Buchan and Lisa Little for ICNM and ICHRN. Geneva, Switzerland and Philadelphia PA http://www.intlnursemigration.org/download/SelfSufficiency_EURO.pdf

[2] ICN (2005). *Nursing workforce planning: mapping the policy trail* developed by O'Brien-Pallas et al. for ICN. Geneva, Switzerland: International Council of Nurses http://www.icn.ch/global/Issue2workforce.pdf

- Focus on single profession ("silo") -specific planning versus integrated approaches;
- Focus on short term rather than medium and long term planning;
- Limited consideration of the impact of social, political, geographical, technological and economic factors on HHRP;
- Lack of adequate and accurate workforce data and information;
- Lack of access to appropriate/suitable methods and tools needed to undertake the planning process;
- Lack of clear definitions of the functions and scope of practice for the numerous categories of personnel providing care;
- Poor communication and coordination between providers, planners, policy makers, employers, education and finance. [3, 4]

Consequences of poor HHRP

The consequences of poor HHRP can be critical to health systems. These include:

- Staff shortages; unmet demand for care;
- Inequitable access to care;
- Geographic, occupational, specialty and institutional imbalances in workforce;
- Over qualification or under qualification in the workforce;
- Mis-ultilisation (including under /over-utilisation);
- High attrition in the workforce;
- Unemployment or underemployment; and
- Delayed response to meeting health care trends (i.e. new technology, procedures, etc.). [5]

Characteristics of good HHRP

- Undertaken by appropriately trained personnel;
- Utilizes appropriate planning tools and methods;
- Reflects an integrated human resources planning approach which is needs-based, outcome oriented and informed by service planning;
- Takes into account the influence of social, political, geographical, technological and economic factors that impact planning and deployment decisions;
- Considers the policy options for addressing imbalances in supply and demand;
- Based on the health needs of the population;
- Based on sound workforce data and information;
- Involves health professionals in the planning process;
- Involves ongoing monitoring an evaluation of the planning process;
- Ensures effective and ongoing coordination among policy makers, planners, government, research and administrative stakeholders; and
- Focused on the short, medium and long term needs. [6, 7]

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[3] ICN (2006). *The global nursing shortage: priority areas for intervention*. Geneva, Switzerland: International Council of Nurses http://www.icn.ch/global/report2006.pdf

[4] Ibid. ICN (2005).

[5] ICN (1994). *Planning human resources for nursing: reference document.* Geneva, Switzerland: International Council of Nurses.

[6] Ibid. ICN (2005).

[7] Ibid. ICN (2006).

Principles for effective workforce planning

Buchan[8] describes eight key principles for effective workforce planning. These are:

1. Ensure commitment to and involvement in the planning process by the main functions/stakeholders (e.g. finance, service planners, education providers, public/private sector employers), with clear lines of responsibility and accountability being defined.
2. Build from a structured information base on current staffing, staff budgets and relevant activity whether planning for a ward, organization, region or country.
3. Assess workforce dynamics and "flows" between sectors and organizations within the system being planned for – assessing sources of supply and turnover.
4. Develop an overview analysis to identify need for, and scope for, change.
5. Develop and agree a set of planning parameters linking workforce and activity data.
6. Use "what if" analysis to model different scenarios of demand for services, and related staffing profile.
7. Develop an agreed workforce national plan which aggregates local/ regional plans.
8. Establish a framework to monitor staffing changes in comparison to the plan – develop a cycle of review and update.

ICN/ICHRN actions

[8] Buchan J (2007). *Nursing workforce planning in the UK: A report for the Royal College of Nursing.* http://www.rcn.org.uk/__data/assets/pdf_file/0016/107260/003203.pdf

PC/June 2008

The International Council of Nurses and its International Centre for Human Resources in Nursing:

- Advocate for the development and/or revision of national workforce plans that reflect integrated human resources (HR) planning approaches; the creation of HR intersectoral planning bodies at national levels involving all key stakeholders; and investments in creating and maintaining HR data collection and information systems to inform policy and planning practices at the national level.
- Lobby for and help develop HR national minimum data sets.
- Develop position statements on the issues at international level e.g. Health Human Resources Development (www.icn.ch/pshhrd.htm), Nurse Retention, Transfer and Migration (www.icn.ch/psretention.htm), etc. Also see www.icn.ch and www.ichrn.org.
- Work with others to strengthen strategic and technical capacities of individuals, organizations and systems to plan for human resources for health.
- Develop international competencies for nursing human resources planning and management.
- Develop and update guidelines for nursing human resources planning.
- Evaluate and disseminate good HR planning practices through presentations at meetings and other forums and through the ICN-ICHRN website and published case studies. See www.ichrn.org.
- Present and discuss research and analysis of HR planning issues at international conferences, congresses and regional forums such as the ICN International Workforce Forum and ICN Asia Workforce Forum.
- Discuss key HHRP trends and challenges during Workforce Forum meetings.
- Explore nurses' experiences in developing human resources planning and policies during conferences, congresses and regional forums.

For further information, please contact: ichrn@secretariat.org

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Fact Sheet

Positive Practice Environments

We are immersed in a global health workforce crisis – one marked by critical imbalances. Many countries are faced with the challenge of underemployed and unemployed nurses side by side with dramatic shortages. The reasons for the crisis are varied and complex, but key among them are unhealthy work environments and the poor organisational climate that characterise many workplaces. The ongoing underinvestment in the health sector, coupled with poor employment conditions and policies (such as exposure to occupational hazards, discrimination and physical and psychological violence; insufficient remuneration; unfavourable work-life balances; unreasonable work loads, limited career development opportunities, etc.) have resulted in a deterioration of working conditions in many countries. There is clear evidence globally that this has a serious negative impact on the recruitment and retention of health professionals, the productivity and performance of health facilities, and ultimately on patient outcomes.

Positive Practice Environments Defined

Positive Practice Environments are settings that support excellence and decent work. In particular, they strive to ensure the health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations.[1]

Elements of Positive Practice Environments

Positive practice environments are characterised by:

- Occupational health, safety and wellness policies that address workplace hazards, discrimination, physical and psychological violence and issues pertaining to personal security
- Fair and manageable workloads and job demands/stress
- Organisational climate reflective of effective management and leadership practices, good peer support, worker participation in decision-making, shared values
- Healthy work-life balance
- Equal opportunity and treatment
- Opportunities for professional development and career advancement
- Professional identity, autonomy and control over practice
- Job security
- Decent pay and benefits

- Safe staffing levels
- Support and supervision
- Open communication and transparency
- Recognition programmes
- Access to adequate equipment, supplies and support staff [2]

Benefits of Positive Practice Environments

The beneficial effects of positive practice environments on health service delivery, health worker performance, patient outcomes and innovation are well documented.

- Positive changes in the work environment result in a higher employee retention rate, which leads to better teamwork, increased continuity of patient care, and ultimately improvements in patient outcomes.
- PPEs demonstrate a commitment to safety in the workplace, leading to an overall job satisfaction.
- When nurses are satisfied with their jobs, rates of absenteeism and turnover[14] decrease, staff morale and productivity increase, and work performance as a whole improves.[3]
- Fostering a sense of communication and leadership within the work environment produces a level of confidence that nurses feel toward their workplace that also aids in the overall satisfaction of employees.[4]
- Maintaining a level of autonomy over their work allows nurses to feel that they are respected and valued members in their places of employment.
- Research demonstrates that nurses are attracted to and remain at their place of employment when opportunities exist that allow them to advance professionally, to gain autonomy and participate in decision-making, while being fairly compensated.[5]
- Effective nursing teamwork is essential to the work in health care organisations.[6] It improves the quality of nursing work life as well as patient care.[7]
- A significant number of research studies have linked higher numbers and a richer mix of qualified nurses to reductions in patient mortality, rates of respiratory, wound and urinary tract infections, number of patient falls, incidence of pressure sores and medication errors.[8, 15]

Cost of Unhealthy and Unsafe Workplaces

Unhealthy environments affect nurses' physical and psychological health through the stress of heavy workloads, long hours, low professional status, difficult relations in the workplace, problems carrying out professional roles, and a variety of workplace hazards. The costs of these unhealthy and unsafe workplaces for nurses have been well documented:

- Evidence indicates that long periods of job strain affect personal relationships and increase sick time, conflict, job dissatisfaction, turnover, and inefficiency.
- A disconnect between the work demanded of nurses and what they can reasonably provide threatens their health and puts patients at risk.
- Negative experiences in the workplace or clinical placements seem to turn these new graduates away from the profession,[9] and contributes to high turnover in the first two years of employment[13]
- A study of nurses in the United States, Canada, England, Scotland and Germany showed that 41% of hospital nurses were dissatisfied with their jobs and 22% planned

to leave them in less than one year; findings confirmed the relationship between workplace stress and nurses' morale, job satisfaction, commitment to the organisation and intention to quit.

- Research has found that in a given unit the optimal workload for a nurse is four patients. Increasing the workload to six resulted in patients being 14% more likely to die within 30 days of admission. A workload of eight patients versus four was associated with a 31% increase in mortality.[10]
- Overworked nurses may display slower reaction times, less alertness to changes in patients' conditions, and medication errors, which translate into adverse risks to patients.[11]
- High turnover, a symptom of a poor work environment is likely to lead to higher provider costs, such as in recruitment and training of new staff and increased overtime and use of temporary agency staff to fill gaps. Turnover costs also include the initial reduction in the efficiency of new staff and decreased staff morale and group productivity.[12]

Making Positive Practice Environments a Reality

Developing, promoting and maintaining positive practice environments is multifaceted, occurs on many levels of an organisation and involves a range of players (e.g. governments, employers, nursing organisations, regulatory bodies, unions, schools of nursing, etc.). For their part, nurses and their representative organisations can advance the development of positive practice environments by:

- Improving the recruitment and retention of nurses
    - Continuing to promote the nursing role
    - Defining the scope of nursing practice so that nurses work to their full potential for patient care. This legal framework can then be used to raise the awareness of other disciplines, as well as the public, of the profession's competencies and evolution
    - Lobbying for professional recognition and remuneration.
- Developing and disseminating a position statement on the importance of a safe work environment.
- Building capacity of nurses and others involved in health sector management and policy-making positions.
- Ensuring that the nurse voice is heard
    - Strengthening nursing organisations
    - Having access to decision-making bodies.
- Supporting research, collecting data for best practice, and disseminating the data once it is available.
- Encouraging educational institutes to enhance teamwork by providing opportunities for collaboration and emphasising teamwork theory.
- Presenting awards to health care facilities that demonstrate the effectiveness of positive practice environments through recruitment and retention initiatives, reduced drop-out rates, public opinion, improved care and patient satisfaction.
- Establishing alliances with other health professionals and health sector stakeholders, e.g. patients/consumer associations.
- Ensuring that other disciplines are involved in the development of policies for safe work environments.
- Developing a Call to Action detailing core elements of a positive practice environment that organisations and individuals can sign up to and support.
- Raising awareness, understanding and support of all relevant stakeholders about the positive impact healthy and supportive work environments have on the

recruitment and retention of staff, patient outcomes and the health sector as a whole.

For further information, please contact: ichrn@secretariat.org

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