Issues Related to Healthy Workplaces and Recruitment and Retention of Home and Community Care Nurses: A Synthesis Paper

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HEALTHY WORKPLACES FOR HOME AND COMMUNITY CARE NURSES

A Synthesis Paper

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The Views expressed herein do not necessarily represent the views of Health Canada.

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In April 2005, VON Canada launched the "Healthy Workplaces Related to Home and Community Care Nursing and Impact on Recruitment and Retention" project with three year funding support from the Office of Nursing Policy, Health Canada. This project is intended to explore the impact of the work environment on recruitment and retention of nurses and how to address the current nursing shortage in this sector, including the identification of barriers in the home and community health care settings and strategies that lead to healthy work environments.

I am pleased to enclose, the Synthesis of Learning Paper that has been prepared after an extensive review of the literature related to the project's focus and purpose. This paper's purpose is to synthesize the information identified in the literature review to provide a brief overview of the unique challenges in recruiting and retaining nurses in home and community settings. It is not meant to be exhaustive. It is meant to be the basis for beginning dialogue and the first step on which the remaining phases of the project can be built. It does provide evidence of the necessity of the study being undertaken. I am delighted with the project's progress and know that this foundation paper will enhance engagement in determining how best to move forward the creation of healthy workplaces for nurses and volunteers working in homes and communities.

As a national organization, we are committed to responding to the new vision for developing a policy framework to support healthy workplaces for home and community care nurses identified in this Synthesis Paper. VON Canada is pleased to respond to the urgent need for recruitment and retention of nurses so that clients and their families will continue to have access to services when they need them. This response is linked with VON Canada's network of 6, 000 staff and 15,000 volunteers with whom important home and community care programs are sustained and expanded.

As we continue to realize that knowledge, learning, and service intersect, we also have a sense of excitement and collective wisdom that moves us toward the achievement of the goals and objectives of the Project and its primary focus – proactive recruitment and creation of working environments that retain staff and volunteers to provide services required by clients as they remain in their homes and other community care settings.

I extend best wishes for an enjoyable comprehensive and productive discussion of this paper at the Consultation Meeting, of which the report is included as an addendum to this paper. We look forward to the outcomes of this project to inform our policy in support of healthy workplaces.

Sincerely,

Faye Porter
Vice President, National Programs and Volunteerism

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Executive Summary

The health care system is facing a nursing shortage in all clinical settings – a trend that is manifesting itself not only in Canada, but around the world. While the labour market in nursing has fluctuated over the years from periods of oversupply to shortages, the existing situation is more severe. Unlike past shortages, this one results from a broad set of factors including an aging population requiring more care over a longer period of time; fewer younger workers entering the healthcare workforce; an aging nursing workforce; increased options for women; and increased dissatisfaction with the workplace caused by stress, burnout and more than a decade of work cutbacks and upheaval.

Nationally and internationally home care is becoming an increasingly important component of health care systems. The demand for home health services is expected to rise well into the 21st century as an aging population; early discharges from hospital, and the shifting emphasis on community-based care drive demand. Yet, despite the rapid growth of the aging population and the fact that so much care is moving to the community, community health nurses are still paid less than those working in hospitals.

More research is being undertaken to explore the challenges nurses face - but to date this has focused mainly on acute care settings. The Victorian Order of Nurses for Canada (VON) has undertaken a three year project funded by Health Canada in conjunction with a National Advisory Committee to address the need for information on the situation of nurses in other settings and to add to the knowledge on how to best recruit and retain nurses in home and community care settings.

This literature review was commissioned in an early phase of the project to provide a synthesis of the unique challenges in recruiting and retaining nurses in home and community care settings. Produced in four weeks in the late summer of 2005, this paper is not meant to be exhaustive. Rather it is designed to be a snapshot – a first step on which subsequent phases of the project can build. Additional phases of the project to be undertaken over the next three years include a national consultation in October 2005 to provide stakeholders with an opportunity to have input into the project; the compilation of case studies from regions across the country to illustrate best practices; and the development and implementation of supportive strategies.

Findings highlighting the state of home and community care nursing identified in the literature indicate:

- On a positive note, home care nurses find job satisfaction in their ability to practice independently and deliver one-on-one direct patient care in a flexible work environment. They also enjoy the opportunity to teach patients and their families within the home setting.
- Dissatisfaction is most often related to the amount of paperwork and documentation required in home care followed by the amount of overtime and salary. Dealing with inclement weather, wear on personal automobile, isolation, and lack of professional peer support are other negative aspects of practice.
- Demographic characteristics of home and community care nurses differed from those of their hospital colleagues.
    - Community nurses were significantly older than hospital nurses;
    - Nurses working full time in community settings had been employed longer as nurses, but nurses working in the hospitals had been employed in their current workplace and position longer than community health nurses; and

    - In terms of education:
        - More nurses in hospital settings (77%) had an RN diploma from a college of hospital-based school of nursing than did nurses working in a community setting (50%); and
        - 46% of community nurses vs. 19% of hospital nurses had a baccalaureate.
- Despite the increasing shift of care into the home and other community settings, nurses in home and community care are often paid less than their hospital colleagues.
- The high cost of nurse recruitment provides a strong rationale to introduce strategies to retain nurses.
- The challenges faced by nurses in rural and remote areas have been vastly underestimated. Their practice is more complex and multi-faceted than previously believed.
    - RNs in rural and remote Canada face greater demands for an expanded role of practice – in spite of the fact that they have a comparatively lower level of formal education than their urban colleagues.
    - RNs in rural and remote communities have significantly fewer clinical supports than urban colleagues.
    - They have more difficulty obtaining additional academic qualifications and professional development because of challenges related to travel and isolation.
    - RNs working in rural and remote areas are highlighting the need to develop a rural lens and underscore the need for new nurses, administrators, policy-makers and educators to actively listen to the communities they are serving.
    - New ways to address migration are required, as migration is often perceived as a greater challenge than retirement.

As a whole, the literature is calling for a new vision of health human resources that value nurses as assets rather than seeing them as costs that need to be controlled. This new vision and associated policies should be based on:

- Adequate long-term funding within a stable policy context;
- Organizational best practice and change guided by comprehensive strategies addressing recruitment and retention;
- Good quality leadership;
- Engaged employees working in healthy stable environments;
- Quality care and positive outcomes for patients and their families; and
- A commitment to research, evaluation and documentation to ensure that best practices forms the foundation of enhancing existing workplace models and to develop new models.

Moving this vision forward requires commitment from individuals, organizations and systems. Federal and provincial governments, professional associations and unions, management and employees, educators and researchers, and the voluntary sector are all crucial players in designing and building healthier workplaces that will enhance recruitment and retention of nurses in home and community care settings.

This foundation paper was produced as away to begin a dialogue about how best to create healthy workplaces for nurses working in home and community care settings. The paper was discussed at a national consultation organized by the VON in October 2005 where next steps will be identified to guide the future work of the project.

Introduction

The health care system is facing a nursing shortage in all clinical settings – a trend that is manifesting itself not only in Canada, but also around the world. As an aging population of nurses prepares to leave nursing and there are inadequate spaces to train new workers, the workforce is not renewing itself – a situation some are calling "a demographic time bomb" (O'Brien-Pallas, L., et al., 2004 pp. viii).

While the labour market in nursing has fluctuated over the years from periods of oversupply to shortages, the existing situation is more severe (O'Brien-Pallas, L. et al., 2004). Unlike past shortages, this one results from a broad set of factors including an aging population requiring more care over a longer period of time; fewer younger workers entering the healthcare workforce; an aging nursing workforce, increased options for women; and increased dissatisfaction with the workplace (Anthony A., Milone-Nuzzo, P., 2005).

While caring for the sick and dying has always been demanding, many of the problems facing nurses today arise from work environments that have become increasingly difficult through the upheavals and cutbacks of the 1990s (Baumann, A., et al., 2001). Massive restructuring of the health care system, undertaken to contain costs, has impacted negatively on nurses, the largest group of health care providers.

Increases in workload, over utilization of nursing staff for non-nursing duties, increased overtime, use of unregulated health care providers, patient acuity, as well as casualization of the nursing workforce, massive layoffs, a wage and compensation freeze, and a decline in the number of senior nursing positions along with the aging of the nursing workforce has created an untenable crisis causing stress, anxiety and burnout among the profession (O'Brien-Pallas, L., et al., 2004).

Current statistics and projections tell a chilling story about the state of nursing. The Canadian Nurses Association predicts a shortage of approximately 60,000 nurses in Canada by 2011 – about 25 percent of the current nursing labour force (Koehoorn, M., et al., 2002). While there was a modest increase in the total number of registered nurses (RNs) employed in nursing over the last five years, the aging of the workforce means that 70% of nurses surveyed were 40 years of age and older. It is estimated that by 2006 Canada could lose approximately 30,000 practicing RNs if nurses retire at age 65. However, if RNs were to retire at 55, 64,000 RNs would be lost (O'Brien-Pallas, L. et al., 2004).

Recent studies on retention indicate that many nurses are quitting because of physical and mental exhaustion; others because they are unable to find secure jobs with hours that suit them. Meanwhile employers are unable to fill vacancies. Nursing schools can not keep up with the number of applications while at the same time limited spaces in schools and a lack of clinical placements continue to limit capacity to train new recruits (Baumann, A., et al., 2001). As students wait longer to get into fewer training places, they are older when they graduate which means that they will practice for a shorter period of time.

Other studies on the state of the health care system in Canada underscore that there are just too few funded nursing hours for too many health care needs - a situation that can seriously threaten patient care (Canadian Nursing Advisory Committee, 2002).

In its report, the Canadian Nursing Advisory Committee underscored the need for urgent action:

> *The implications of not acting now to resolve these nursing workforce issues are plain. The regulated nursing professions make up over one-third of the entire Canadian healthcare workforce, and the care nurses provide has direct and significant impact on outcomes for the patients, clients and families the system is designed to serve.*
>
> *Simply put, as nursing goes, so goes the rest of the system. The value of improving nursing working conditions is clear – and the need to act now is urgent* (Canadian Nursing Advisory Committee, 2002, pp. iii).

Project Context

As discussed above, current challenges facing nurses are being recognized and studied. However, most of the research that has been conducted on nursing human resource issues has focused on acute care settings.

To address the need for information on the situation of nurses in other settings and to add to the knowledge on how to best recruit and retain nurses in home and community settings, the Victorian Order of Nurses for Canada (VON Canada) has undertaken a three year project. “Healthy Workplaces Related to Home and Community Care Nursing and the Impact on Recruitment and Retention” is funded by Health Canada and is supported by a National Advisory Committee.

This paper was commissioned in an early phase of the project. The purpose of the paper is to synthesize the information identified in the literature review to provide a brief overview of the unique challenges in recruiting and retaining nurses in home and community settings. Produced in four weeks in the late summer of 2005, this paper is not meant to be exhaustive. Rather it is designed to be a snapshot – a first step on which subsequent phases of the project can build. Additional phases of the project to be undertaken over the next three years include a national consultation in October 2005 to validate the findings of the paper and advise on next steps in the project; the compilation of case studies from regions across the country to illustrate best practices; and the development and implementation of supportive strategies.

The work of the project began in April 2005 with the formation of the National Advisory Committee in June. Following up on advice from the Committee a literature review was undertaken in July 2005 to identify published and grey literature relevant to recruitment and retention issues among nurses working in home and community settings.

A search of Medline, CINAHL, and psycINFO databases using key/topic words related to healthy workplaces; home and community care; human resources; recruitment; retention; nurses/nursing; volunteers/volunteer service; competency; orientation; and professional development yielded almost one hundred articles and reports published over the last ten years. When the extent of current information was revealed in the search, a decision was made to use only articles and reports produced in the last five years.

Values and Beliefs Underlying Home and Community Care Nursing

Home and community care has experienced enormous growth over the past 30 years as its benefits to the Health Care System in Canada became more evident. Home care services provide a cost-effective alternative to higher cost acute care by enabling shorter hospital stays, earlier discharge, and the use of more cost-effective outpatient procedures (Canadian Home Care Association, 2004). "Home and community care services help people to receive care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the community" (Health Canada, Home and Continuing Care, www.hc-sc.gc.ca). Services are provided for all age groups and are integrated in the home setting with community services including, but not limited to, professional services, transportation assistance, volunteer services, respite care services, day programs, visiting services, meals on wheels, and palliative care (Canadian Home Care Association, 2004).

Home and community care nursing practice occurs within an environmental context that includes individuals, communities, workplaces and legislative frameworks (Canadian Community Health Nursing Standards, 2004). Using the nursing process (assessment, diagnosis, planning, implementation, and evaluation), home and community care nurses interact with vulnerable individuals and families where they live, work, and access social, health, and community services. The goals of home and community care nursing can be preventative, curative, rehabilitative, palliative or supportive. What differentiates home and community care nursing is that the *place of work* supersedes the occupational designation of the care provider. "The sector is defined by where people in the sector work, rather than the work they do" (The Home Care Sector Study Corporation, 2003, 22).

VON Canada Vision, Mission, and Values

Vision: VON Canada will be Canada's leading charitable organization addressing community health and social needs.

Mission: VON Canada, a charity, guided by the principles of primary healthcare, works in partnership with Canadians for a healthier society through:

- Leadership in community-based care;
- Delivery of innovative, comprehensive health and social services; and
- Influence in the development of health and social policy.

Core Values: Caring for Life through:
Respect
Participation
Responsiveness
Courage

Therefore, values and beliefs related to the home and community care sector can be described from both a practice and a system level. The following section outlines several unique features of home and community care nursing and the sector.

To work in the home and community sector, especially rural and isolated areas, nurses must be flexible, creative, willing to learn, capable of independence in practice, able to tolerate uncertainty, and to demonstrate caring in changing circumstances while delivering services to clients, families, and community groups (Boucher, 2005). Home and community care nurses must manage a different set of

risks than their hospital colleagues. These include provision of care in unsanitary conditions, lack of cooperation from the client residing in the home, and verbal abuse from the client, family caregivers. These risks take on growing concern when compared with institutional settings in which providers are able to get assistance from co-workers, supervisors and colleagues. The risk factors are compounded when services are delivered in rural, remote and isolated areas in all kinds of weather. Rural nurses must work at being an accepted member of the community (Boucher, 2005). Reporting on the experiences of home and community care nurses in rural and urban centres in British Columbia, Duncan (1992) concludes that nurses are often not prepared to deal with all the ethical challenges that arise in their practice. She notes that all too often the success of many community health nurses (CHNs) dealing with ethical dilemmas is a result of their own confidence and experience rather than any specific professional training. She underscored the need for education and training to develop the insight to deal with ethical dilemmas that nurses working in rural and remote communities face.

In its 2003 report, the Community Health Nurses Association of Canada (CHNAC) highlighted the values and beliefs of CHNs as:

- Caring;
- Principles of Primary Health Care;
- Multiple ways of knowing;
- Individual/community partnerships; and
- Empowerment.

The CHNAC (2003) identified five interrelated standards of practice for community nursing including:

- Promoting health;
- Building individual/community capacity;
- Building relationships;
- Facilitating access and equity; and
- Demonstrating professional responsibility and accountability.

Knowledge of, and adherence to, these standards is an expectation of every community health nurse working in any of the domains of practice. These standards serve as a benchmark for novice community health nurses and become basic expectations after two years of service. The practice of expert community health nurses will extend beyond these standards.

A comprehensive conceptual model developed by a group of leading researchers and practitioners in the field also underscored the complexity of nurses' working environment with interrelation of numerous components (Griffin, et al., 2003). The model highlighted the need for a systematic approach to develop, implement and evaluate improvements to the work environments of nurses at the individual, organizational and systems levels.

The model suggests that the individual nurse's functioning is mediated and influenced by interactions between the individual and her environment – thus interventions to promote healthy work environments must be aimed at multiple levels and components of the system. The assumptions underlying the model include:

- Healthy work environments are essential for quality, safe patient care;
- The model is applicable to all practice settings and domains of nursing;
- Individual, organizational and external system level factors are determinants of health work environments for nurses;

- Factors at all three levels impact the health and well-being of nurses, quality patient outcomes, organizational and system performance, and societal outcomes either individually or through synergistic interactions;
- At each level there are physical/structural policy components, cognitive/psycho/social/cultural components and professional/occupational components; and
- The professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations (Griffin, et al., 2003, 1).

The Canadian Nursing Experience

As discussed above, numerous recent studies on the state of the health care system in Canada underscore that there are just too few funded nursing hours for too many health care needs - a situation which can seriously threaten patient care (Canadian Nursing Advisory Committee, 2002).

In an effort to redress the damage done to nursing through a decade of reform and develop a blueprint for constructive change, the Canadian Nursing Advisory Committee (2002) commissioned six research/information projects:

- Current perspectives on strategies for healthy workplaces;
- Information on the cost of nurses' absenteeism and overtime;
- Strategies for addressing workload issues;
- Information on factors relating to nurses satisfaction in the workplace;
- Findings of focus group on nurses' definitions of respect and autonomy in the workplace; and
- A discussion of the organizational structures within which nurses, doctors and patients interact.

The findings of these papers and the results of consultation undertaken by the Advisory Committee resulted in the development of 51 recommendations to address the issues identified as central barriers to a quality workplace for Canadian nurses. These include:

- The need to increase the number of nurses;
- The need to improve the education and maximize the scope of practice of nurses; and
- The need to improve the working conditions of nurses.

The Canadian Health Services Research Foundation (CHSRF) commissioned a report to explore the impact of the working environment on the health of the nursing workforce. After conducting an extensive literature review and interviews and focus groups with system managers, nurses, government employees, educators, representatives of nurses associations and unions, Baumann and her colleague's defined the problems facing nurses as issues related to:

- Work pressure;
- Job security;
- Workplace safety;
- Support from managers and colleagues;
- Control over practice;
- Scheduling; and
- The need for stronger leadership roles for nurses (Baumann, A., et al., 2001, ii).

Key messages that emerged from the report underscored that:

- Canada's nursing shortage is due at least in part, to a work environment that burns out the experienced and discourages new recruits.
- The job satisfaction level of nursing staff has been shown to be a strong determinant of the overall satisfaction level of patients. Satisfaction improves with manageable workloads and when employers make it easier to balance work and home life.
- Nurses, greatly stressed and vulnerable to injury, have a higher absentee and disability rate than almost any other profession. This disrupts care, makes planning difficult and costs the healthcare system a great deal of money.

- Increased workloads improve short-term productivity but increase long-term costs, as nurse stress and illness may lead to poor judgment and low productivity, which can harm patients. Delegating more work to aides and unit clerks so that nurses can concentrate on their patients reduces some of that stress.
- Nurses work best and have more loyalty to their employers when their expertise is respected, they have some control over their lives (such as the ability to set their own hours) and they are free to practice to the full scope of their education.
- Keeping staff is easier in a less-stressful, more supportive workplace; and good relations on the care-delivery team benefit patients and may even reduce death rates. Reducing staff turnover and letting nurses practice independently within a co-operative setting could do much to improve the work atmosphere (Baumann, A., et al., 2001, i).

Many other ideas emerge from the report about what can be done. Nurses, like most people, need some basic predictability in their lives. They need a sense of job security and the confidence that the risk of injury and workplace violence has been reduced. Better equipment and more staff can help reduce the risk of injury which increases when there is no one to help turn a patient or when a nurse gets so busy and overextended that she pricks herself with a used needle (Baumann, A., et al., 2001).

The report identified other ways to support nurses. Some ideas are as simple as providing parking spaces close to the building for the safety of night workers; providing hot, nutritious meals 24 hours a day; and providing safe, inviting physical environments. Other ideas that propose multi-year funding for the health care system require co-operation on every level - from employers to the federal government (Baumann, A., et al., 2001).

In the Canadian Policy Research Networks report (Koehoorn, M., et al., 2002), the risks of not taking action to address the quality of worklife of health care workers was identified warning that the worklife has deteriorated to the point where it is impeding the capacity of the system to recruit and retain the staff needed to provide effective patient care. It underlined that finding solutions to these problems starts with the recognition that the performance of any health care organization depends on motivated, knowledgeable, and well-resourced employees (Koehoorn, M., et al., 2002). Finally, it called for a fundamental new approach that includes “treating employees as assets that need to be nurtured rather than costs that need to be contained” (Koehoorn, M., et al., 2002).

Magnet Hospitals: Lessons on Recruitment and Retention

The characteristics of the healthy work environments identified in these recent Canadian reports are similar to the characteristics identified in the Magnet Hospital studies that were conducted in the United States in the early eighties. The term Magnet was coined after a survey of 41 hospitals identified the characteristics through which some hospitals were able to attract and retain professional nurses during a national nursing shortage (Flynn, 2003).

After studying practices at hospitals successful in retaining and attracting nurses, the American Academy of Nursing (AAN) Task Force on Nursing Practice in Hospitals identified three major categories of characteristics that contributed to their success in recruitment and retention. These included:

- Leadership attributes of the nursing administration;
- Professional attributes of the staff; and
- A supportive professional environment (Frazier, S., 2003, 605).

The report described an effective leader as one who is visionary, supportive, knowledgeable, and who values the professional development of all nurses within the organization. Nursing coordinators of magnet hospitals were able to create an organizational culture that encouraged professional growth and enhanced staff satisfaction (Frazier, S., 2003). Important professional attributes of staff were described as:

- Therapeutic relationships with patients;
- Nurse autonomy and control; and
- Collaborative nurse-physician relationships.

Findings from Canadian Studies

Nationally and internationally home care is an increasingly important component of health care systems (Doran, D., et al., 2004). The demand for home health services is expected to rise well into the 21st century as an aging population; early discharges from hospital, and the shifting emphasis on community-based care drive demand. A study by Flynn (2003) estimated that the home care nursing workforce would need to double by the year 2020.

Yet, despite the quickly growing aging population and the fact that so much care is moving to the community, home and community care health nurses are still paid less than those working in hospitals (Baumann, A., et al., 2001).

Recruiting and retaining an adequate supply of nurses in the midst of a severe shortage poses challenges for administrators in all settings. As home and community care leaders grapple with issues of recruitment and retention in their sector many are developing strategies based on lessons learned in other settings. Several recent Canadian studies have examined issues related to recruitment and retention among home and community nurses and explored if and how the characteristics of Magnet Hospitals can be applied to home care agencies.

Similarities/Differences among Nurses in Community and Hospital Settings

Cameron and her colleagues (2004) used selected magnet characteristics to explore the similarities/differences of nurses' perceptions in community and hospital settings.

They mailed surveys to nurses randomly selected from the College of Nurses of Ontario membership list. The sample included equal numbers of community and hospital nurses as well as full and part time workers. A total of 1,248 nurses ranging in age from 23 to 69 responded (42%). The community sample, comprising nurses working in home care, community clinics and public health settings represented 54% of respondents. Hospital nurses, working in a range of units, represented the remaining 46% of respondents (Cameron, S., et al., 2004).

Results of the survey indicated that:

- Community nurses were significantly older than hospital nurses;
- Nurses working full time in community settings had been employed longer as nurses, but nurses working in the hospitals tended to have been employed in their current workplace and position longer; and
- In terms of education:
    - More nurses in hospital settings (77%) had an RN diploma from a college or hospital-based school of nursing than did nurses working in a community setting (50%); and
    - 46% of community nurses vs. 19% of hospital nurses had a baccalaureate.

The survey also explored organizational factors (including organizational and immediate supervisor support, decentralized decision-making, nurse-physician relationships and work group cohesiveness) and job-related factors (including autonomy, job challenge, work demands, fair treatment, work-status congruence; satisfaction with career, salary, and working conditions).

Findings indicated that overall, nurses from both community and hospital settings are less satisfied with organizational than job-related factors. While participation in decision-making was the area where both groups of nurses were most dissatisfied, followed by lack of organizational support, the low scores on all organizational factors indicate that there is room for improvement in the organizational factors surveyed.

Key findings from the survey indicates:

- Community health nurses reported significantly greater degrees of cohesiveness within their work groups;
- Community nurses were more likely than hospital nurses to indicate a greater degree of support from their immediate supervisor in terms of receiving recognition and feedback;
- Community health nurses were more satisfied as they reported significantly more autonomy and control in their jobs.
- Community health nurses were more likely to indicate a higher level of satisfaction with their work demands, work schedule and working conditions than hospital nurses;
- Nurses in both settings reported a moderately high level of job challenge and were relatively satisfied with their careers; and
- Although both groups reported feeling unfairly rewarded for their contributions to their organizations, satisfaction with pay was the only area where community nurses were more dissatisfied than their colleagues in hospitals (Cameron, S., et al., 2004).

Organizational Change and the Health and Well-Being of Home Care Workers

The purpose of this study by the Workplace Safety and Insurance Board was to examine ways to improve the prevention of work-related injuries and illnesses among home care workers. Involving 11 agencies and 7 union locals, researchers interviewed 59 key decision-makers, conducted 29 focus groups with 171 workers, and analyzed responses from 1,313 surveys from field staff (a 70% response rate) (Denton, M., 2003).

On the positive side, workers in all occupational groups in this sector show high levels of self-esteem and mastery. However, a number of physical health problems commonly identified among this workforce are much higher than among a comparable population in the Canadian population. These include back pain; arthritis and rheumatism; musculoskeletal disorders; migraine headaches; high blood pressure; stomach and intestinal problems; and cancer.

Another occupational health problem for this workforce is workplace harassment and violence. Given that these employees work primarily in elderly or sick client's homes, it is common for these workers to experience unacceptable racial/ethnic/sexual comments or harassment.

Workers also have high levels of job insecurity. They are afraid of losing their jobs or that their workplaces will close when their agency contract is not renewed. Still workers are dedicated to their agencies and show low levels of propensity to leave. But within this environment, managers and supervisors are having problems managing an increasingly stressed and dissatisfied workforce.

Many in the field are critical of the restructuring and managed competition process. This study showed that the restructuring and organizational change in the home care sector have contributed to the deteriorating health of the workers. Within this new business-like work environment, cutbacks, lack of resources and perceived decline in quality of care are taking its toll on workers. Burnout and

diagnosed physical health problems are significant issues within the system. The study results conclude that the occupational health problems experienced by workers in this study are preventable (Denton, M., 2003).

Management and Delivery of Community Nursing Services in Ontario: Impact on the Quality of Care and Quality of Worklife of Community-Based Nurses

This study by Doran and her colleagues (2004) examines the impact of the competitive model introduced in Ontario in 1995 in which the Ministry of Health and Long-Term care created 43 Community Care Access Centres. The Centres were responsible for awarding service contracts to both profit and not-for-profit provider agencies using a competitive Request for Proposals process.

The first phase of the study analyzed how the competitive bidding process was being put into operation while the second phase examined relationships between variables in the structure of the contracts and quality of care; client outcomes; cost of care; and nurse outcomes.

Findings indicated that:

- There were few differences in quality of care based on whether the agency was for-profit or not-for profit – variations in quality exist among both types of ownership structures;
- Most access centres and agency managers believed that quality of care and quality improvement initiatives had either remained the same or improved, although some not-for-profit agencies believed the quality of care has declined;
- Clients cared for by for-profit agencies reported slightly higher quality of care and higher satisfaction than clients cared for by not-for profit agencies;
- Clients functioned better on social and emotional levels when more visits were made by registered nurses (as opposed to other classes of nurses);
- Having clients seen consistently by the same nurse was associated with lower nursing costs, but was not related to client health;
- The likelihood that the same nurse would see clients consistently did not depend on whether the agency was for-profit or not-for-profit – rather it was more likely when agencies were awarded longer contracts.
- Nurses who were compensated for their work on an hourly basis reported higher satisfaction with the time available to care for a patient compared to nurses who were reimbursed on a per visit basis.
- Nurses reported moderate work enjoyment and low satisfaction with job security and their time for care. There were no differences based on whether they worked for a for-profit or non-profit agency;
- Policy makers should focus on:
    - Providing opportunities for full-time or regular part-time employment with employment benefits (rather than casual employment); and
    - Providing nurses with more time to provide care. (Doran et al., 2004, i)

Manitoba Worklife Task Force: Renewing our Commitment to Nurses

This report to the Manitoba Minister of Health (Worklife Taskforce, Manitoba Health., 2001) was part of a five-point plan to address issues that affect nurses' working conditions and their workplace environment. These included factors contributing to job dissatisfaction; causes of workplace and personal stress for nurses such as a lack of mentors, limited or no input into decision-making, increased workload demands, and caring for children and elders at home. The report looked at nurses in the full range of clinical settings and the situation of nurses working in the home and the community was also considered.

Responses from the surveys, meetings and written submissions indicated that autonomy and one-to-one client care provide high job satisfaction for home care nurses. However, the lack of permanent positions significantly limits staffing availability and the ability of the Home Care program to take on long term clients. The lack of guaranteed hours for nurses negatively affects nurses' ability to coordinate family responsibilities and personal needs. The large territory and sparse populations in some regions continue to present challenges to a quick response and serving long-term clients. Recommendations included the need to work towards permanent positions in Home Care and expanding home care in rural areas (i.e. The Home Intravenous Program).

Respondents also indicated that the rapid introduction of an increasing number of community health programs in the province is meeting with limited success due to a lack of coordination, infrastructure and resources. The report recommended that there should be a slowing down of new programs until these issues are resolved. The report also highlighted the need to revisit the establishment of a Public Health Nursing Branch to enhance coordination (Worklife Taskforce, Manitoba Health., 2001).

The challenges caused by the physical environment where many community health nurses work were also underscored as a long-term problem. The limitations of substandard buildings with little or no privacy when meeting with clients undermined the professionalism and credibility of the nurses and in some cases meant that they were subjecting themselves and their clients to unhealthy environments. It was recommended that all facilities be reviewed and that secure, adequate, appropriate space should be obtained to house community health programs (Worklife Taskforce, Manitoba Health., 2001).

Healthcare Restructuring and Community-Based Care in British Columbia and Manitoba

Reforming the healthcare system in ways that are cost-effective and meet the current and future health care needs of an aging population is a major concern across the country. Many provinces have attempted to address this through regionalization. This study examines the effects of this policy in six health regions in two provinces (Penning, M., et al., 2002).

Findings indicated:

- A shift in focus and resources toward a more social community-based model of care remains to be achieved;
- Declines in resources and access to hospital and institutional care have not always been accompanied by increases in resources and access to community-based services like home nursing care and home support;
- When allocating health resources, it is important to consider more than medical needs. Assessing only the health care needs of seniors is not enough since many needs are non-medical and require supportive community-based care; and

- Moving preventive care and screening programs out of doctors' offices and into the community may increase the number of people in all socio-economic brackets and increase the number of people receiving screening, immunization and preventive care in both urban and rural areas (Penning, M., et al., 2002, i).

The Canadian Home Care Human Resources Study

The Home Care Human Resource Sector Study (2003) identified eight major themes impacting on the workforce including:

- Changing context of home care;
- Supply of workers;
- Recognition and image of sector and workers;
- Education and training;
- Funding availability;
- Working conditions and the changing nature of work;
- Wages and benefits; and
- The nature of services offered in the home care sector (The Home Care Sector Study Corporation, 2003, 7).

The changing context and trends that impact heavily on the home and community care sector continue to emerge – rising demands in spite of reductions in services, increasing demands on family caregivers, increasing private pay obligations for clients, expanding acute care responsibilities, and increasing demands for use of technology in home and community settings (The Home Care Sector Study Corporation, 2003).

As demand for home and community care services continues to escalate and the number of workers into the sector continues to decline, there is urgent cause for concern in matters of recruitment and retention. While the home and community care sector has enlisted a large cadre of volunteers, there is also cause for concern with that total number of volunteers is dropping within the sector.

In the study, it was noted that there is general lack of valuing and recognition of the role of formal care providers and the family caregivers. More respect for home care providers was identified as one of three ways that working conditions in the sector could be improved for all *formal* workers (The Home Care Sector Study Corporation, 2003). The need for education and training that addresses not only the increasing complexity of client needs, but also the unique characteristics of and challenges in the settings in which care is given. Skilled care providers must have opportunity for advancement and must maintain and further their competence, confidence and comfort levels in environments that change on a day-to-day basis. In addition, the changes in technology and its introduction and/or expansion into home and community care settings requires sensitivity to the matters of client privacy and level of computer literacy of the health care providers (The Home Care Sector Study Corporation, 2003).

The plea for reasonable workloads relates to the emphasis on 'time-per-task' or 'time per visit' service delivery for formal professional staff which creates the perception that the nurse cannot give the quality of care necessary to meet client needs and, therefore, cannot experience job satisfaction and personal feelings of worth and professionalism. "Approximately 60% of home care workers felt that they did not have adequate time to give the appropriate level of care" and family caregivers expressed

an urgent need for "more coordination of informal caregivers with the formal care sector" (The Home Care Sector Study Corporation, 2003, 24).

Nursing Practice in Rural and Remote Canada

The importance of rural health issues is increasingly being recognized – but the reality of health care in Canada (and other Western countries) is that most health policies are developed in urban environments and transplanted to rural and remote areas (Kulig, J.C., et al., 2004).

Recent studies have demonstrated that 18% (41,502) of RNs in Canada are providing care to the 22% (6.6 million) of Canadians living in rural and small town Canada. In most areas of practice RNs in rural and remote Canada face greater demands for an expanded role of practice – in spite of the fact that they have a comparatively lower level of formal education than their urban colleagues. They also have significantly fewer clinical resource supports – with clinical and administrative leaders often located some distance away. Nurses in rural and remote communities also have more difficulty obtaining additional clinical and academic qualifications because of factors related to their isolation (MacLeod et al., 2004).

In this major Canadian study, 13 principal investigators (supported by twenty funders) undertook four streams of research. First, an analysis of the Registered Nurses Database generated the development of a demographic profile of rural RNs generated for the first time in Canada. Second, a systematic review of policy and administrative documents produced a critical view of the policy context in which nurses in rural and remote communities practice. Third, a survey collected comprehensive data on rural nurses' work; quality of worklife; satisfaction with work; perspectives on rurality; and community and practice supports. Finally, a collection of in-depth narratives from nurses who have worked in rural and remote communities permitted an examination of the context of rural practice and nurses' experiences in a variety of settings.

Findings of the study suggest that rural and remote nursing practice is more complex and multi-faceted than previously believed and that the challenges faced by nurses in these areas have been vastly underestimated (MacLeod et al., 2004). Four areas of concern for rural nurses were identified including: maintaining excellent practice; carrying out major responsibilities; addressing the social determinants of health; and fitting in with the community.

Nurses practicing in rural and remote areas have clear advice to new nurses, administrators, policy-makers and educators about the need to listen and learn about the communities they are working in. They have called for the development of a *rural lens* that will allow professionals to understand the realities of rural practice and develop policies, programs, administrative practices and education that reflect these realities. Findings from the report include:

- In small communities, nurses' personal and professional lives are inseparable – a reality that should be reflected in policies and service delivery;
- Because many rural and remote nurses work alone, there are pressing needs for professional support – both in person and through technology;
- Recruitment and retention could be enhanced if done within a realistic context (taking into consideration nurses' perceptions) and in partnership with the community;
- New models of inter-professional practice should be developed which recognize the varied strengths and resources in rural and remote communities;

- Special attention should be paid to the need for culturally-appropriate care in Aboriginal communities including continuity of care and recruitment of nurses;
- Undergraduate and postgraduate education programs (with targeted funding) should be developed to prepare nurses for the realities of practice in rural and remote communities;
- New ways are needed to provide relevant continuing education for rural and remote nurses, including education on site, travel for continuing education, and use of technology;
- New ways to address migration are required (i.e. when nurses leave for education or alternate employment they often do not return.) Migration is perceived as a greater challenge than retirement. Counting on overseas recruitment is not seen as realistic – as only a small percentage of foreign-educated nurses work in rural Canada; and
- The distinctiveness of rural and remote settings and nursing practices can only be adequately captured when nursing databases are improved through the development of unique personal identifiers and rural/urban indicators (MacLeod et al., 2004, v).

Findings from American Studies

As discussed above home and community care is a rapidly increasing field in Canada as well as in the US. Recent research in the US has examined the unique challenges and issues related to human resources in home and community care nurses and explored the hypothesis that the Magnet Hospital literature could provide insight for home and community care leaders seeking to improve nurse recruitment and retention.

They found that the agency traits identified by home and community care nurses in their studies were similar to those reported by hospital-based nurses in the Magnet Hospital studies. The studies also found that these traits reflected many of the recognized components of a professional practice environment and have been associated with increased nurse recruitment and retention as well as positive patient outcomes (Flynn, 2003).

Connecticut Focus Groups

The Ad Hoc Nursing Shortage Committee of the Connecticut Association for Home Care (CAHC) conducted a study in 2003 to identify the factors that attract nurses to and retain them in home care (Anthony A., & Milone-Nuzzo, P., 2005). A survey was circulated to both new and experienced home care nurses in the state. Of the over 500 nurses who responded half had been in nursing more that twenty years; one quarter from 11 to 20 years; and 33% were 51 years of age or older. According to respondents, the most important benefits in working in home care are medical insurance, scheduling flexibility, vacation/holidays, sick time, and short-term disability.

Findings of the survey indicated that, on a positive note, home care nurses find job satisfaction in their ability to practice independently and deliver one-on-one direct patient care in a flexible work environment. They also enjoy the opportunity to teach patients and their families within the home setting.

Anthony and Milone-Nuzzo (2005) also highlighted the high cost of nurse recruitment. Their findings demonstrate that in the US it can cost almost $19,000 for a 12-week training program. So, introducing strategies to retain nurses becomes crucial.

The issue cited as causing the most dissatisfaction among these home care nurses was the amount of paperwork and documentation required in home care. The next highest areas of dissatisfaction were working overtime, or beyond scheduled time, and salary. Dealing with inclement weather and wear on personal automobile also scored a high level of dissatisfaction with about half of all nurses surveyed saying these factors could cause them to leave nursing. Personal isolation and lack of professional peer support were also cited as negative aspects of practice.

The findings of the survey highlighted several areas that individual home care agencies need to address. These include the need to:

- Decrease paperwork and documentation by developing new models of documentation to minimize the real and perceived time required;
- Introduce technology that will assist nurses and decrease paperwork;
- Nurture experienced and new nurses to reduce turnover and improve morale;
- Develop mentoring programs for new nurses to increase confidence and reduce isolation; and

- Help nurses handle physical work demands by introducing job sharing; part-time employment and per diem options which could retain older workers and attract new staff (Anthony, A. & Milone-Nuzzo, P., 2005, 376).

Mid-Atlantic Region Focus Groups

In this study, Flynn and Deatrick (2003) conducted seven focus groups with 58 home health care staff nurses at 6 home care agencies. The nurses were asked to identify the characteristics of home care organizations they considered most important to their professional practice and satisfaction.

Attributes described by home health care nurses were not only similar to those described by hospital-based nurses in the Magnet Hospital studies but also they were also consistent with the key concepts of professional workforce organization. Six categories were highlighted by home care nurses as important to the support of their professional practice and job satisfaction. These included:

- Extensive preceptor-based orientation;
- An organized and supportive office environment with real time phone support and interdisciplinary coordination;
- Reasonable working conditions with a realistic workload, adequate staffing and scheduled time off;
- Accessible field security;
- Competent and supportive management with competent nursing supervisors and supportive administrative practices; and
- A patient-centred mission and vision (Flynn and Deatrick, 2003, 387).

American Nurses Foundation Multiphase Study

Recognizing the increasing importance of home care; the reality that home care is a different practice environment from hospitals; and that little research has been conducted on the characteristics important to home care nurses with regard to recruitment and retention, the American Nurses Foundation sponsored a multi-faceted investigation to identify organizational characteristics that are considered important by home care nurses (Flynn, 2003).

The initial phase of the investigation surveyed 700 randomly selected nurses (from the American Nurses Association and the American Credentialing Centre) asking them to identify organizational characteristics considered important by home care nurses. The characteristics identified in this survey mirrored those identified by the focus groups in the Mid-Atlantic States discussed above.

Researchers in the second phase of the study hypothesized that the *Magnet Hospital* literature could provide insight for home care leaders seeking to improve nurse recruitment and retention. The survey developed in this phase posed three open ended questions (similar to those used in the original Magnet Hospital studies) asking nurses to list home health agency characteristics they considered most important to the support of their practice and job satisfaction. Sixty one percent of nurses from 48 States responded and identified the following 10 traits:

- Support for education;
- A knowledgeable and supportive manager;
- Dedication to quality care;
- A strong, supportive administration;
- Good communication between staff and administration;

- Flexible work schedules;
- A competitive salary and benefit package;
- Reasonable workloads;
- A mechanism that allows staff input into decision making; and
- Adequate nursing staffing (Flynn, 2003, 815).

Although not occurring among the top ten most frequently identified characteristics, other organizational traits considered important included:

- A streamlined documentation system;
- Easy, off-site accessibility to needed supplies and resources; and
- A good agency-community relationship (Flynn, 2003, 815).

The third phase of the multi-faceted investigation was a nation-wide survey in which home care nurses were asked to rate the importance of the specific agency work environment traits (as listed in the Nursing Work Index – Revised) in supporting their home care practice. The key traits identified include:

- A supervisory staff that is supportive of nursing;
- Working with nurses who are clinically competent;
- Not being placed in a position of having to do things that are against my nursing judgment;
- A nurse manager who is a good manager and leader;
- A good orientation program for newly employed nurses;
- Freedom to make important patient care and work decisions;
- An administration that listens to and responds to employee concerns;
- Good relationships with other departments;
- The Plan of Care is accessible and up-to-date for all patients; and
- Enough registered nurses on staff to provide quality patient care (Flynn, 2005, 368).

Through this survey, home care nurses sent very clear and consistent messages about what is important to them. To take the findings one step further and assist home care administrators to develop strategies to enhance their agency's work environment, Flynn and her colleagues classified the characteristics according to Donabedian's 1980 classic quality and outcomes model for health care organizations (Flynn, 2005).

According to the model, structure is defined as those resources needed to deliver care (i.e. staff, training, equipment and setting) while process is defined as the interpersonal activities or interventions related to care delivery. According to the model, adequacy in both structure and process factors is necessary for organizations to achieve positive outcomes.

The structure category included traits related to:

- Working with nurses who are clinically competent;
- A good orientation program for newly employed nurses;
- A Plan of Care is accessible and up-to-date for all patients; and
- Having enough registered nurses on staff to provide quality patient care (Flynn, 2005, 368).

The process category included:

- A supervisory staff that is supportive of nursing;
- Not being placed in a position of having to do things that are against my nursing judgment;
- Nurse managers who are good managers and leaders;
- Freedom to make important patient care and work decisions;
- An administration that listen and responds to employee concerns; and
- Good relationships between nursing and other agency departments (Flynn, 2005, 369).

In an attempt to illustrate how these theories could be operationalized, Flynn (2005) noted that structure traits should focus on programs, resources and people. This could include following the lead of other specialty settings such as ICU that have improved nurse recruitment, job satisfaction and retention by replacing the traditional four week orientation program with a more extensive 12 session program. Another strategy would be to improve access to Plan of Care through the installation of computerized records and electronic communication systems.

Flynn (2005) cautioned that process traits often present greater challenges for home and community care managers and administrators, as these traits require more than a new program or piece of equipment. Process traits require high quality and satisfying interpersonal relationships between agency leaders and agency staff. As noted above, home care nurses in this study rated the presence of supportive supervisory staff as the most important trait in their practice – a trait that requires an underlying structure to support management development programs and support groups and effective communication systems. Reasonable workloads that give managers the time to evaluate, mentor and coach their staff are also key.

While acknowledging the complexity of introducing these characteristics into practice and ensuring an underlying structure to maintain them, Flynn (2005) underscored the centrality of these traits to nurses' job satisfaction and retention and demonstrated the association with positive patient outcomes and higher levels of patient satisfaction.

Finally, the study outlined the following evidence-based recommendations to create a culture of nurse retention strategies in home and community settings.

- Systems and processes that focus on valued work environment traits highlighted above must be established and maintained;
- Administrators should truly comprehend the unique concerns of home care nurses, including personal safety issues and travel-related stressors;
- Nursing administrators should structure opportunities to spend time with staff nurses, experiencing both their accomplishments and concerns; and
- Supporting effective agency manager leadership requires ongoing management development programs, management support groups, effective communication systems, and reasonable workloads (Flynn, 2005, 370).

Flynn (2005) concluded, "Given the challenges that lie ahead, home care administrators must re-evaluate their agency's work environment and renew efforts to create a culture of home care nurse retention."

Developing a Policy Framework

Based on the documents reviewed for this synthesis paper, it can be concluded that home and community care nursing has a long way to go before it reflects the characteristics identified in the literature as necessary for a healthy work environment. The following highlights key issues which illustrate the state of home and community care nursing today and outlines areas that need to be addressed to enhance the health of workplaces for home and community care nurses and improve recruitment and retention in the field.

Key issues highlighting the state of home and community care nursing identified in the literature review include:

- Demographic characteristics of home and community care nurses differed from those of their hospital colleagues.
- Community nurses were significantly older than hospital nurses;
    - Nurses working full time in community settings had been employed longer as nurses, but nurses working in the hospitals had been employed in their current workplace and position longer than community health nurses; and
    - In terms of education:
        - More nurses in hospital settings (77%) had an RN diploma from a college or hospital-based school of nursing than did nurses working in a community setting (50%); and
        - 46% of community nurses vs. 19% of hospital nurses had a baccalaureate.
- Despite the increasing shift of care into the home and other non-hospital settings, nurses in home and community care are often paid less than their hospital colleagues.
- The high cost of nurse recruitment provides a strong rationale to introduce strategies to retain nurses.
- The challenges faced by nurses in rural and remote areas have been vastly underestimated. Their practice is more complex and multi-faceted than previously believed.
    - RNs in rural and remote Canada face greater demands for an expanded role of practice – in spite of the fact that they have a comparatively lower level of formal education than their urban colleagues.
    - RNs in rural and remote communities have significantly fewer clinical supports than urban colleagues.
    - They have more difficulty obtaining additional academic qualifications and professional development because of challenges related to travel and isolation.
    - RNs working in rural and remote areas are highlighting the need to develop a rural lens and underscore the need for new nurses, administrators, policy-makers and educators to actively listen to the communities they are serving.
- On a positive note, home care nurses find job satisfaction in their ability to practice independently and deliver one-on-one direct patient care in a flexible work environment. They also enjoy the opportunity to teach patients and their families within the home setting.
- Dissatisfaction is most often related to the amount of paperwork and documentation required in home care followed by the amount of overtime and salary. Dealing with inclement weather, wear on personal automobile, isolation, and lack of professional peer support are other negative aspects of practice.

As a whole, the literature is calling for a new vision of health human resources that value nurses as assets rather than seeing them as costs that need to be controlled. This new vision calls for significant input at the individual, organizational and system levels to move beyond the traditional parameters of occupational health and safety and develop healthier workplaces that address the full realm of physical and psycho-social factors that affect the overall quality of the work environment – and, ultimately, patient care.

The new vision and associated policies should be based on:

- Adequate long-term funding within a stable policy context;
- Organizational best practice and change guided by comprehensive strategies that ensure:
    - A commitment to recruitment and retention;
    - A long-term vision to allow investments in people to pay off;
    - Integrated human resource information systems and databases;
    - A climate of positive labour relations to rebuild a culture of trust and commitment; and
    - Specific indicators to build and evaluate *a workplace of choice*.
- Quality leadership that:
    - Advocates for home and community care nurses;
    - Ensures that nurses are nurtured, supported and mentored;
    - Encourages the development of policies promoting recruitment and retention; and
    - Encourages the development of policies that build on the unique characteristics of communities.
- Engaged employees working in healthy work environments with positive human resource practices including:
    - Quality of work and work-life balance;
    - Positive supervision and mentoring to increase confidence and reduce isolation;
    - Rewarding of achievement;
    - Pay equity for all nurses regardless of work setting;
    - Jobs designed to increase employees skills, autonomy and participation;
    - Opportunity for employment status of choice including full-time and flexible work arrangements including job sharing, part time employment with benefits and per diem options;
    - Use of technology to support documentation and reduce paperwork;
    - Policies that promote staff development; and
    - Policies that address physical, mental health and safety issues.
- Quality care and positive outcomes for clients and families based on:
    - Accreditation;
    - Standards of practice; and
    - Best practices, monitoring and evaluation.
- A commitment to research, evaluation and documentation to ensure that best practices/lessons learned will be used as the basis to enhance existing workplace models and develop new models.

Moving this vision forward requires commitment from all sectors. Federal and provincial governments, professional associations and unions, management and employees, educators and researchers, and the voluntary sector are all crucial players in designing and building healthier

workplaces that will enhance recruitment and retention of nurses to home and community care settings.

This foundation paper was produced as way to begin a dialogue about how best to create healthy workplaces for nurses working in home and community settings. The paper will be discussed at a national consultation organized by the VON in October 2005 where next steps will be identified to guide the future work of the project.

References

1. Anthony, A. and Milone-Nuzzo, P. (2005). "Factors attracting and keeping nurses in home care," *Home Healthcare Nurse*, Volume 23, 372-377.

2. Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Doran, DI., Kerr, M., McGinnis Hall, L., Vezina, M., Butt, M., and Ryan, L. (2001). *Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system - A Policy Synthesis.* www.chsrf.ca.

3. Blythe, J., Baumann, A., Zeytinoglu, I., Denton, M., and Higgans, A., (2005). "Full-Time or Part-Time Work in Nursing: Preferences, Tradeoffs and Choices," *Nursing Issues*, Volume 8:3, 69-77.

4. Boucher, M.A. (2005). ""Making it": qualities needed for rural home care nursing," *Home Healthcare Nurse*, Volume 23, 103-108.

5. Cameron, S., Armstrong-Stassen, M., Bergeron, S., and Out, J. (2004). "Recruitment and retention of nurses: challenges facing hospital and community employers," *Canadian Journal of Nursing Leadership, 17(3): 79-92*.

6. Community Health Nurses Association of Canada. (2004). *Canadian Community Health Nursing Standards*. http://www.communityhealthnursescanada.org/Standards.htm.

7. Canadian Nursing Advisory Committees. (2002). *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses.* http://www.hc-sc.gc.ca/english/for_you/nursing/cnac.htm.

8. Denton, M. (2003). *Organizational Change and the Health and Well-Being of Home Care Workers*. Workplace Safety and Insurance Board. www.wsib.on.ca.

9. Doran, D., Picard, J., Harris, J., Coyte, P. C., MacRae, A., Laschinger, H., Darlington, G., and Carryer, J. (2004). *Management and Delivery of Community Nursing Services in Ontario: Impact on the Quality of Care and the Quality of Worklife of Community-based Nurses*. Canadian Health Services Research Foundation. www.chsrf.ca.

10. Duncan, S.M. (1992). "Ethical challenge in community health nursing," *Journal of Advanced Nursing*, Volume 17, 1035-1041.

11. Flynn, L. (2003). "Agency characteristics most valued by home care nurses: findings of a nationwide study," *Home Healthcare Nurse*, Volume 21, 812-817.

12. Flynn, L. (2005). "The importance of work environment: evidence-based strategies for enhancing nurse retention," *Home Healthcare Nurse*, Volume 23, 366-371.

13. Flynn, L, and Deatrick, J. (2003). "Home Care Nurses Descriptions of Important Agency Attributes," *Journal of Nursing Scholarship*, Volume 35:4, 385-390.

14. Frazier, S. (2003). "Magnet Home Care Agencies: A Professional Way to Impact Quality and Retention," *Home Healthcare Nurse*, Volume 21, 603-610.

15. Griffin, P., El-Jardali, F., Tucker, D., Grinspun, D., Bajnock, I., and Shamian, J. (2003). *Comprehensive Conceptual Model for Healthy Work Environments for Nurses – Components, Factors and Outcomes* modified from DeJoy, D.M and Southern, D.J (1993). "An integrative perspective on health promotion," *Journal of Medicine*, 35(12), 1221-1230; further modified by Laschinger, MacDonald and Shamian. (2001).

16. Humphrey, C.J. (2004). "Is there something magical about recruiting and retaining home care nurses?," *Home Healthcare Nurse*, Volume 22, 208.

17. Humphrey, C.J. (2005). "Exciting New Research on Recruitment and Retention," *Home Healthcare Nurse*, Volume 23, 208.

18. Judkins, S. and Rind, R. (2005). "Hardiness, job satisfaction, and stress among home health nurses," *Home Health Care Management & Practice*, Volume 17, 113-118.

19. Koehoorn, M., Lowe, G., Rondeau, K., Schellenberg, G., and Wagar, T. H. (2002). *Creating High Quality Health care Workplaces*. Canadian Policy Research Network. *www.cprn.org*.

20. Kulig, J.C., Nahachewsky, D., Thomlinson, E., MacLeod, M.L.P., and Curran, F. (2004). "Maximizing the involvement of rural nurses in policy," *Canadian Journal of Nursing Leadership*, Volume 17, 88-96.

21. MacLeod, M.L.P., Kulig, J.C., Stewart, N.J., Pitblado, J.R., and Knock, M. (2004). "The nature of nursing practice in rural and remote Canada," *Canadian Nurse*, Volume 100, 27-31.

22. MacLeod M.L.P., Kulig J.C., Stewart N.J., and Pitblado J.R., (2004). *Nursing Practice in Rural and Remote Canada*. Canadian Health Services Research Foundation. *www.chsrf.ca*.

23. O'Brien-Pallas, L., Tomblin Murphy, G., White, S., Hayes, L., Baumann, A., Higgin, A., Pringle, D., Birch, S., McGill Hall, L., Kephart, G., and Wang, S. (2004). *Building the Future: An integrated strategy for nursing human resources in Canada. Research Synthesis Report*. The Nursing Sector Study Corporation. *www.buildingthefuture.ca*.

24. Penning, M.J., Roos, L.L., Chappell, N.L., Roos, N.P., and Lin, G. (2002). *Healthcare Restructuring and Community-Based Care*. Canadian Health Services Research Foundation *www.chsrf.ca*.

25. The Home Care Sector Study Corporation. (2003). *Canadian Home Care Human Resources Study: Synthesis Report.*

26. Worklife Taskforce, Manitoba Health. (2001). *Worklife Taskforce: Renewing our Commitment to Nurses A Report to the Manitoba Minister of Health*. *http://www.gov.mb.ca/health/nurses/worklife.htm*.

Other Suggested Reading

Home and Community Care Sector

1. Anderson, M., and Parent, K. (2000). *Care in the home: Public responsibility - private roles?* http://www.utoronto.ca/hpme/dhr/pdf/Anderson_Parent.pdf.

2. Baranek, P.M., Deber, R.B., and Williams, A.P. (2004). *Almost home: Reforming home and community care in Ontario*. University of Toronto. http://www2.m-thac.org.

3. Canadian Association for Community Care and Canadian Home Care Association. (2004). *Sustaining Canada's health care system: The role of home and community care*. www.cacc-acssc.com.

4. Canadian Home Care Association. (2004). *Portraits of home care: A picture of progress and innovation*. www.cdnhomecare.ca.

5. Caplan, E. (2005). *Realizing the potential of home care: Competing for excellence by rewarding results. A review of the competitive bidding process used by Ontario's Community Care Access Centres (CCACs) to select providers of goods and services.* http://www.health.gov.on.ca/english/public/pub/ministry_reports/ccac_05/ccac_05.pdf.

6. Canadian Home Care Association. (2004). *Realizing the Potential of Home Care: A Movement from Statements to Action.* www.cdnhomecare.ca.

7. Chappell Neena L. (2000). "Maintaining the Integrity of Home Care," *HealthcarePapers* (Fall 2000), 1(4): 91–96. http://www.longwoods.com.

8. Hall, R. and Coyte, P. (2001). "Determinants of home care utilization: who uses home care in Ontario?" *Canadian Journal on Aging, 20 (2),* 175-192.

9. Hollander,M.J. (2004). *Unfinished Business: The Case for Chronic Home Care Services, A Policy Paper*. Victoria: Hollander Analytical Services Ltd. www.hollanderanalytical.com.

10. Hollander, M.J. and Chappell, N. (2002). *The National Evaluation of the Cost-Effectiveness of Home Care: Overview of the national evaluation of the cost-effectiveness of home care*. http://www.homecarestudy.com.

11. Hollander, M.J. (2002). *"The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families*. Victoria: Hollander Analytical Services Ltd.

12. Hollander,M.J. (2001). *Evaluation of the maintenance and preventive model of home care*. Victoria: Hollander Analytical Services Ltd.

13. MacAdam, M. (2000). "Home Care: It's time for a Canadian model." *HealthcarePapers* (Fall 2000) 1(4): 9-37. http://www.longwoods.com/home.php?cat=335.

14. Premiers' Council on Canadian Health Awareness. (2002). *Strengthening home and community care across Canada: A collaborative strategy*. Report to the Annual Premiers' Conference, August 2002. Ottawa.

15. Preto, N. and Mitchell, I. (2004). *Ethical Issues In Home Care: Summary and Overview of presentations and discussions at the Annual Meeting of the Canadian Bioethics Society October 28-31, 2004.* Prepared for Health Canada. http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2004-ethi-homedomicile/index_e.html.

16. Shapiro, E. (2002). *Sharing The Learning: The Health Transition Fund, Synthesis Series Home Care,* Health Canada. www.hc-sc.gc.ca.

17. St Elizabeth Health Care. (2004). What is Home Care? www.saintelizabeth.com.

18. VON Canada. (1999). *Report on the National Roundtable on Home and Community Care*, February 10, 1999. Health Canada. www.hc-sc.gc.ca.

19. Woodward, C.A., Abelson, J., and Hutchison, B. (2001). *My home is not my home anymore: Improving continuity of care in homecare*. Canadian Health Services Research Foundation and Ontario Ministry of Health and Long Term Care. http://www.chsrf.ca/final_research/ogc/pdf/woodward_e.pdf.

Home and Community Care Nursing

20. Canadian Institute for Health Information. (2004). Workforce Trends of Registered Nurses in Canada. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_396_E&cw_topic=396&cw_rel=AR_20_E.

21. Canadian Institute for Health Information. (2004). Workforce Trends of Licensed Practical Nurses in Canada. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_397_E&cw_topic=397&cw_rel=AR_365_E.

22. Canadian Nurses Association. (2003). *The value of nurses in the community*. www.communityhealthnursescanada.org/Documents/ValueNursesCommunityEnglishApril03.pdf.

23. Community Health Nurses' Initiatives Group (CHNIG) of the Registered Nurses Association of Ontario (RNAO). (2000). *Understanding Home Health Nursing: A Discussion Paper*. http://www.rnao.org/html/pdf/HomeHealthNursingPaper.pdf.

24. Decter, M. (2003). "The Health Council of Canada: a speculation on a constructive agenda," *Canadian Journal of Nursing Leadership*, Volume November 2003, 16, 46-50.

25. Decter, M. (2002). "Canadian healthcare: time to plan for the providers," *Healthcare Papers*, Volume 2002, 3, 76-79.

26. Decter, M. and Villeneuve, M. (2001). "Repairing and renewing nursing workplaces," *Hospital Quarterly*, Volume Fall 2001, 5, 46-49.

27. Slepkov, M and Mildon, B. (2004). *RNAO Practice Page: Home Health Nursing*. Volume 4, Number 2. www.rnao.org.

Healthy Workplaces/Environments

28. Canadian Nurses Association. (2002). The quality of worklife indicators for nurses in Canada: Workshop Report. www.cna-aiic.ca.

29. Duxbury, L. and Higgins, C. (2001). *"Work-Life Balance in the New Millennium: Where Are We? Where DoWe Need to Go?"* Discussion Paper No. W|12. www.cprn.org.

30. Ellenbacker, C.H. (2004). A theoretical model of job retention for home health care nurses. *Journal of Advanced Nursing*, *47*(3), 303-310.

31. Health Canada (1999). *Human resource issues in home care in Canada: A policy perspective. Section 4.0: Recruiting and retaining home care workers.* http://www.hc-sc.gc.ca/homecare/english/pub.html.

32. Laschinger, H.K.S. and Finegan, J. (2005). "Using empowerment to build trust and respect in the workplace: a strategy for addressing the nursing shortage." *Nursing Economics*, 23, 6-13.

Appendices

VON Canada, *Healthy Workplaces for Home and Community Care Nurses Consultation Meeting*, October 14, 2005.

- List of Participants
- Summary Notes

Workplaces for Home and Community Nurses Project

CONSULTATION MEETING

PARTICIPANT LIST
OCTOBER 14, 2005

Anitta Robertson, Director of Special Projects, Registered Nurses Association of Ontario

Barb Mildon, Immediate Past President, Community Health Nurses Association of Canada

Carol Sinclair, Organizational Development Manager, VON Canada

Cynthia Morris, Registered Nurse, Aboriginal Nurses Association of Canada

Isabelle St. Pierre, Doctoral Student, School of Nursing, McGill University

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Luba Shumsky, Accreditation Specialist, Canadian Council on Health Services Accreditation

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Major Joanne Plemel, Specialist Services Coordinator, Canadian Forces Medical Group Headquarters

Marlene Slepkov, President, Community Health Nursing Initiatives Group, Registered Nurses Association of Ontario

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Beth Allan

Regrets:

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Kathie Paddock, Policy Advisor, Health Canada, Office of Nursing Policy

Healthy Workplaces for Home and Community Care Nurses Project CONSULTATION MEETING SUMMARY NOTES

Friday, October 14, 2005
9:00 A.M. – 4:00 P.M. EST.
Location: Radisson Hotel
Facilitator: Beth Allan

This summary is of the VON Canada National Consultation Meeting for the Healthy Workplaces for Home and Community Care Nurses. Twenty-two stakeholders participated in the meeting (see list of participants). The following summary provides an overview of the meeting purpose, review and validation of the Synthesis Paper, large group discussion – identified themes, small group discussion – barriers, knowledge gaps, and strategies, and final feedback. The VON Healthy Workplaces Project Team wishes to thank all the participants for their time and input into this process to build on the work of the project.

Meeting Purpose

The purpose of the consultation meeting was to:

1. Review, discuss and approve the Synthesis of Learning Paper;
2. Identify lessons learned from and knowledge gaps in the Paper;
3. Position the Comprehensive Conceptual Model as part of the project's context and framework;
4. Determine the need for knowledge dissemination; and
5. Evaluate the consultation meeting.

The meeting promoted both general and small group discussion around the Synthesis Paper, the identified key issues and six themes, and strategies that could be considered useful in moving the issues to action, policy and implementation.

Review and Validation of the Synthesis Paper

After presentations on both the Conceptual Model and the key highlights of the Synthesis Paper, participants were asked the following questions during a facilitated discussion:

1. Does this Synthesis Paper reflect your experience?
2. Are we building on current knowledge?
3. Are there gaps?

Participants agreed that the Synthesis Paper was a foundation for the future work of the project. Participants approved the Paper in principle, with some recommended changes including the addition of the unique characteristics of practice in the home and community care sector. It was suggested to describe the unique characteristics of the home and community care practice environment in more detail.

Large Groups Discussion – Identified Themes

During the discussion on gaps, several themes were identified as a priority to the project including:

- First Nations and Inuit Communities;
- Collaboration;
- Wages;
- Technology;
- Leadership Development;
- Rural and Remote Communities including the Northern Experience;
- System Issues – Model of Care Delivery; and
- Unique Qualities and Features of the Home and Community Care Sector.

Small Group Discussions – Barriers, Knowledge Gaps and Strategies

Following lunch, small groups were formed to discuss the above mentioned theme areas. Using a discussion guide, the groups were asked to answer and report on the following questions:

1. What are the barriers to addressing the issues related to the themes identified?
2. What needs to be further studied/looked at in more detail with respect to healthy workplaces and recruitment and retention of home and community care nurses?
3. What are the three key strategies for the project team you would suggest to further explore these issues?

The following is a summary of the key points raised by participants. Some sections are better developed then others and is no fault of the participants. We either acknowledged areas we needed more information on particular areas or felt that we had enough to move forward on the key barriers, gaps and strategies. For brevity, have captured the key points from the discussion below. The additional information was captured during the discussion will inform the project team.

First Nations and Inuit Communities

The barriers to recruiting and retaining nurses to work with First Nations and Inuit communities were identified as:

- Geography (difficult access and remoteness);
- Lack of work-life balance (burnout and mental health stresses);
- Lack of resources to provide care and services needed;
- Lack of incentives to attract nurses to the sector; and
- The scope of practice required by the nurse in providing care (combination of generalist and extended practice skills).

Issues that need examination include:

- Jurisdictional relationships (federal/provincial/local);
- Differences in compensation (local/FNIHB);
- Access to educational opportunities;
- Feasibility of gaining HR support service;
- Resolution of safety and mental health concerns; and
- Incentives for recruitment for travel costs, and accommodation for nurses.

In terms of strategies that might be helpful to address the issues, the participants suggested:

- Determine what is currently being done to address the barriers;
- Review the literature (similar process to that used in the preparation of the Synthesis Paper);
- Complete interviews with focus groups;
- Promote inter-sectoral collaboration; and,
- Consider job sharing for nurses for these communities.

Collaboration

Issues relate to federal, provincial, territorial and municipal relationships and jurisdictions. The major strategy is one of building collaboration based on a non-competitive environment. To promote collaboration, stakeholders will need to recognize the importance of partnerships, of crossing boundaries, and of building linkages.

Wages and Compensation

The barriers identified in the matter of compensation for services provided included

- The perception of the community nurse as not being as skilled or needing to be as skilled as the hospital nurse;
- Lack of funding;
- Lack of wage parity;
- Lack of full-time positions; and
- Lack of payment for gas and car travel when personal vehicles are used.

Strategies that may be useful include seeking out information about the differences in wages/benefits/perks and more intense political action and lobbying. Participants also indicated that community nurses were being devalued by being paid less than their hospital colleagues.

Suggestions are to

- Examine the impact of paying hourly versus salary based wages;
- Discern the practice of employers paying differing pay for similar work (e.g. community versus pay by FNIHB); and
- Address the scope of practice and expectations of nurses in home and community care.

Technology

The barriers discussed in terms of technological resources and support included

- The need for sustainable technology support in documentation systems and care plans;
- Access to client information databases; and
- The provision of cell phones for nurses.

The barrier to uptake of technology by nurses needs to be studied – what factors prevent nurses from taking up technology? What are the expectations of "newer" and "experienced" nurses in this regard? How can an appropriate response be made to the fact the long service nurses often present with less experience and skill in terms of computer/technology use? Ultimately, it is necessary to determine what is needed and who needs it.

Leadership Development

Participants urged the realization of good succession planning and the need to benefit from the expertise of nurse in the sector for a long time. Other questions raised were:

- What does a great nursing leader in the home and community sector of care look like?
- What are the characteristics that make leaders successful?

Rural and Remote Communities including the Northern Experience

Several barriers were identified for the home and community care sector:

- The importance of capacity development need to be addressed for nurse certification,
- Training opportunities, and
- Access and time for continuing learning to build confidence and competence in clinical practice.

We need to know the types of programs available to support community capacity, development and care in rural and remote communities. There are issues related to the nurse's need for cultural competency as well as coping strategies when working in isolated areas with limited or no resources.

System Issues - Model of Care Delivery

Participants asked, "What is needed to support care?" Measures suggested included the need to determine "productivity indicators," a system for tracking client outcomes, and implementation of strategies to assure that the nurse has built in thinking/reflecting time during a workday.

Unique Characteristics of Home and Community Care

Participants indicated that this sector has its own distinctive practice, context, and character that need to be recognized and considered. These included

- Unique practice, clinical, and ethical issues;
- A different control of the work environment – providing care in a clients home;
- Differences in how time is assigned and managed; and
- Nursing practice that is more autonomous and independent.

There is a clear need for nurse orientation about legal issues, legislation and documentation. It was further noted that nurse empowerment at the bedside in home and community care nursing requires a "different mindset." How does the new nurse become attracted to the setting and its expectations as well as the unknowns that await her "behind the door of a client's home?"

Final Feedback

In closing the day, participants provided the Healthy Workplaces Project Team with some focused feedback. The Team was urged to focus its work on the key issues, to build on the knowledge we already have, and to learn from the experiences of others about what works. In addition, participants provided some of the following advice:

- There is so much – focus, prioritize and concentrate on doing a couple of things well;
- Make the work tangible and doable;
- We know the barriers to a healthy workplace – we now need a tool to show us the "how to";

- Carry out consultations with people who deliver the services and determine whether their work is valued (keep in mind the aboriginal sector);
- Consider extending the project beyond the three years;
- Regarding the case studies – keep the work focussed, bring science to it, make one of the 5 sites one that delivers services and care to aboriginal people, frame the profiles within the Comprehensive Conceptual Model, and build the profiles as the process evolves.


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