



Working together to make health workplaces healthier

Within Our Grasp

A Healthy Workplace Action Strategy
for Success and Sustainability in
Canada's Healthcare System

2007



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**A Healthy Workplace Action Strategy for Success and
Sustainability in Canada's Healthcare System**

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“A fundamental way to better healthcare is through healthier healthcare workplaces. It is unacceptable to work in, receive care in, govern, manage and fund unhealthy healthcare workplaces.”

QWQHC, 2006

The 10 National QWQHC Health Partners

Canadian Council on Health Services Accreditation (CCHSA)
Academy of Canadian Executive Nurses (ACEN)
Association of Canadian Academic Healthcare Organizations (ACAHO)
Canadian College of Health Service Executives (CCHSE)
Canadian Federation of Nurses Unions (CFNU)
Canadian Healthcare Association (CHA)
Canadian Health Services Research Foundation (CHSRF)
Canadian Medical Association (CMA)
Canadian Nurses Association (CNA)
National Quality Institute (NQI)



Letter to Canada's Health Leaders & Stakeholders

Across our country, many Canadians are seeing signs of a struggling health system; some are even questioning its sustainability. Canadians are raising questions because one of their key concerns continues to be – will I be able to get the care I need when I need it? Most people believe an effective and sustainable health system is an important part of Canada's current and future success. They also know through their own experience that there is a direct link between effective healthcare and a healthy workplace. Our elected and appointed leaders also know our health system is a key competitive advantage with our main trading partner, the United States, because our system costs nearly 40 per cent less as a percentage of gross domestic product, has better health outcomes and is universally available to all citizens.

In October 2005, the leaders of 10 national health organizations partnered to develop an evidence-informed framework and action strategy to make Canada's public health workplaces healthier and to improve the quality of care provided. The partners asked more than 45 healthcare experts to join the Quality Worklife – Quality Healthcare Collaborative (QWQHC) to develop the action strategy that is presented in this document.

The members of the Collaborative recognize that many healthcare workplaces are not healthy, our valuable health providers are struggling, and the quality of patient care is being threatened. The Collaborative believes our health providers deserve and require a healthy workplace. We believe a fundamental way to better healthcare is through healthier healthcare workplaces and that it is unacceptable to work in, receive care in, govern, manage and fund unhealthy workplaces.

To support these fundamentals, the QWQHC has identified several evidence-informed strategies to provide leaders with ideas on where to begin and how to achieve success. The Collaborative has also identified ways that its partners can join with other key national stakeholders to work together to support organizations on this improvement journey. The culmination of these ideas, tools and strategies for change is presented in this document *Within Our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System*. The national health partners support this action strategy and are committed to join with other health stakeholders to bring the ideas in this document to life.

This is a call for immediate action and courage by Canada's healthcare leaders to commit to improve the quality of worklife for all Canadian health providers to ensure the success and sustainability of our healthcare system. In this document, we provide a "healthy healthcare leadership charter". We ask all groups and leaders in our health system to endorse this charter, and make a commitment to actively propel positive change in the health workplace.

During this next year, the Collaborative will continue its efforts to champion the importance of building healthier healthcare workplaces. For example:

- The leaders of partner organizations will introduce the Charter to their organizations, governing bodies and to their provincial colleagues to demonstrate their commitment to building healthier healthcare workplaces.
- We will assist health leaders in understanding and implementing this action strategy.
- We will explore with other national groups the development of a Pan-Canadian database of performance information.
- We will facilitate the exchange of knowledge and experience.
- We will report on the extent to which Canada's health organizations are implementing this action strategy.

In closing, we would like to thank the leaders of our partner organizations, the over 45 experts who worked directly in our Collaborative and the many groups and individuals across Canada who provided their advice and support to help us develop this framework. We also thank Health Canada for funding this important work and finally, we thank the Canadian Council on Health Services Accreditation and our capable secretariat, Ms. Melissa Barton for their invaluable support.

Now is the time for action and for courage to put in place and bring to life the changes required to build healthier healthcare workplaces for our valuable health providers and for the people they serve each and every day throughout Canada.



Wayne Strelloff, FCA
Chair
Former Auditor General of British Columbia
Former Provincial Auditor of Saskatchewan



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March 20th, 2007

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Within Our Grasp

A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System

Key Components

The Quality Worklife – Quality Healthcare Collaborative (QWQHC) grew and evolved out of an overwhelming and widely-held recognition that urgent action was needed to coordinate, integrate and share learning aimed at more effectively and more expeditiously improving the quality of worklife (QWL) in healthcare. The QWQHC operates from a shared belief that it is unacceptable to fund, govern, manage, work in or receive care in an unhealthy healthcare workplace. To support these fundamentals, the QWQHC has identified several evidence-informed strategies to provide leaders with ideas on where to begin and how to achieve success. The culmination of these ideas, tools and strategies for change is presented in *Within Our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System*.

The QWQHC believes success can be achieved in the short term if health leaders and their organizations commit to:

1. Making QWL a strategic priority and putting in place appropriate performance expectations and accountability practices

All publicly funded health organizational leaders and system leaders are challenged to take up the call to action and to signal their commitment by adopting and signing the **Healthy Healthcare Leadership Charter**.

2. Measuring QWL

Organizations and systems are challenged to measure and report on the QWQHC's **Standard QWL Indicators** with common definitions to facilitate Pan-Canadian benchmarking and monitoring.

3. Implementing one or more strategies to improve QWL and evaluating these initiatives

Four priority actions for health organizations and four priority actions for health system leaders are provided along with menus of leading practices and an overall recommended change process to aid in the focused implementation of QWL initiatives.

4. Building good internal and external knowledge exchange to continue to share, learn and improve

The **QWQHC Knowledge Network** aims to actively connect explicit (formal) knowledge (e.g. research findings) and tacit (informal) knowledge (e.g. frontline experiences); and plans to provide a one-stop shopping approach for frontline QWL champions/ change agents, organizations, policy-makers and researchers to connect on QWL issues in healthcare.

Executive Summary

The health and well-being of the health workforce and the quality of the healthcare work environment has a profound impact on the effectiveness and efficiency of healthcare services. In recent years, there have been numerous reports listing hundreds of recommendations for improvement to healthcare work environments; however there has not been enough concentrated action and outcomes. The ability to reduce wait-times and ultimately, the sustainability of the Canadian healthcare system depends on a strong supply of healthy healthcare providers. With staffing shortages affecting more health professions, coupled with evidence that shortages will only get worse in the near future, there is a broad consensus that leaders must do more to support and develop their current employees.

In June 2005, 10 national healthcare organizations partnered to form the Quality Worklife – Quality Healthcare Collaborative (QWQHC). They shared a view that Canada’s health system must do more to retain our health human resources through the development of healthy and supportive work environments. By working together to support and implement a pan-Canadian action strategy the Collaborative aims to improve both patient/client and system outcomes through the improvement of the health of the healthcare workforce and their workplaces.

The QWQHC mandate is to develop a pan-Canadian Quality Worklife – Quality Healthcare Framework and Action Strategy. To achieve this, a National Steering Committee and four working groups with more than 45 Quality of Worklife (QWL) experts were formed. The shared belief among all QWQHC members is that a fundamental way to better healthcare is through healthier healthcare workplaces; and it is unacceptable to fund, govern, manage, work in or receive care in an unhealthy healthcare workplace.

The Strategy

The QWQHC action strategy identifies three focused areas of immediate action that embrace evidence-informed management and accountability practices. These include QWL measurement and reporting, implementation of improvement strategies and knowledge exchange. The action strategy supports collaboration among all health stakeholders (funders, governors, managers, providers, and researchers) to build healthy workplaces to improve patient/client, provider and system outcomes. To achieve success, all stakeholders must actively engage in the sustainable uptake and implementation of the action strategy well beyond the end of the QWQHC mandate. The action strategy is based on sound change management principles for implementing quality of worklife initiatives (see Appendix A).

I. QWL Indicators

The QWQHC has identified standard QWL indicators that all health organizations should build into their management information systems, performance agreements and accountability reports. A national benchmarking report of these QWL indicators will help organizations identify areas for focused improvement and set annual targets. It will also allow the identification of potential leading practices to develop, share and translate to other organizations across the country. This parsimonious group of indicators was selected because they are practical and feasible to collect, applicable to all health organizations and workers, and have evidence to support that they are related to QWL and patient/client-care.



The Standard Pan-Canadian QWL indicators with standard definitions include:

- **Two system level indicators:** QWL indicators built into performance/accountability agreements, and QWL indicators integrated into Federal/Provincial/Territorial Health Human Resources Plans
- **Seven organizational level indicators:** turnover rate, vacancy rate, training and professional development, overtime, absenteeism, workers' compensation lost time, and provider satisfaction.

II. QWL Knowledge Exchange Framework

The QWQHC has set out a framework to exchange and apply knowledge, leading practices and research on healthy workplace strategies between all health organizations across Canada. To know where to begin and then how to succeed in implementing positive change, health organizations need easy access to research, advice and leading practices. The knowledge network would actively connect explicit (formal) knowledge (i.e. research findings) and tacit (informal) knowledge (i.e. frontline experiences) and provide a “one-stop-shopping” approach for individual change agents, organizations, policy-makers and researchers to connect on QWL issues in healthcare. The QWQHC identifies existing knowledge exchange vehicles/initiatives wherever possible, and establishes the basis for a clearinghouse for key target knowledge users where the knowledge would be presented in a format that allows users to find explicit and tacit knowledge for key areas that they have prioritized for action.

III. QWL Priority Action Items

The QWQHC has identified priority actions that are known to improve the workplace and that can be implemented quickly and efficiently. The actions focus on both system wide and organizational performance improvement on specific areas relating to QWL. Leaders at both levels should identify one or more of these key areas to focus their attention on.

The four system-level priority actions are the creation/implementation of:

- *A national QWL database and support for reporting of standard QWL indicators*
- *Enhanced performance/accountability agreements and accreditation standards*
- *A pan-Canadian QWQHC knowledge network to recognize and share leading practices*
- *A national workplace health promotion program for healthcare.*

The four organizational-level priority actions are the creation/implementation of:

- *A strategic management system for QWL*
- *A comprehensive and integrated HR, Health & Safety and Organizational Development strategy (leading practices relating to this activity have been themed into 8 key areas)*
- *Measurement of QWL and linking it to other organizational performance management systems*
- *Enhanced internal and external knowledge exchange capacity regarding QWL.*

Implementation

The QWQHC recognizes that committed leadership and sustainable efforts are required to realize our shared vision, where Canadian health providers achieve optimal health and work in settings that demonstrate healthy workplace leadership, management and accountability practices. **The Healthy Healthcare Leadership Charter** was developed to assist health leaders in signalling their commitment to action. The QWQHC will encourage all health leaders to join their colleagues across the country and actively engage in improving QWL to retain health providers and improve patient/client care.

The Collaborative anticipates that if health organizations implement the strategies outlined in this document, QWL will undoubtedly improve. The cost of inaction (e.g. fewer healthy providers, less effective and safe care, and

increased illness, disability and recruitment costs) comes at too high a price. Success can be achieved with greater efficiency if all stakeholders collaborate to improve the health of healthcare across the country.

A draft of this strategy was shared broadly, first through a pan-Canadian QWQHC stakeholder summit of 80 delegates, followed by email distribution through the National Health Partners. Stakeholders were also asked to respond to a short online survey. The survey data showed 100 per cent of the 80 respondents believe the QWQHC's action strategy supports the building of healthier health workplaces. This shows incredible level of support for the work that the QWQHC has accomplished to date.

There is also momentum across the country for a pan-Canadian approach to addressing the nation's Health Human Resources (HHR) issues, as described in the Advisory Committee on Health Delivery and Human Resources' (ACHDHR) Framework for Collaborative Pan-Canadian HHR Planning. The QWQHC's action strategy should be integrated into this broader HHR framework since this strategy lays out an evidence-informed framework for achieving one of ACHDHR's major goals relating to HHR recruitment and retention. This step would therefore support the sustainability of the QWQHC's efforts while at the same time advancing the ACHDHR's efforts.

Health Canada and the National Health Partners of the Collaborative will support the continuation of the QWQHC Secretariat for an additional year to coordinate the uptake of this action strategy. Ongoing collaboration will also be facilitated and supported by the National Health Partners as each will continue to bring this strategy to life. For example:

- Canadian Health Services Research Foundation is well-positioned to offer the expertise and support to create and maintain a comprehensive, up-to-date repository of evidence (research and leading practices) relevant to quality of worklife issues.
- Canadian Council on Health Services Accreditation through the development of new standards will contribute in a powerful way to moving this agenda forward. The CCHSA's surveyors and clients can be

supported to identify leading practices relating to QWL during the accreditation survey process.

- Canadian College of Health Services Executives, Canadian Healthcare Association, Association of Canadian Academic Healthcare Organizations, Academy of Canadian Executive Nurses, and the National Quality Institute will provide leadership through education, knowledge exchange and awards for health leaders to take a strategic and comprehensive approach to healthy healthcare workplaces.
- Canadian Nurses Association, Canadian Medical Association, and Canadian Federation of Nurses Unions will provide support for health providers to become more involved in making improvements to the quality of their own working lives and the quality of care they are providing.
- All National Health Partners will play a large role in the strategic communication and promotion of the QWQHC action strategy and its key deliverables through their wide-reaching distribution networks. The partners will also "lead by example" by working to incorporate the principles outlined in the QWQHC action strategy into the way they operate.

Conclusion

Anyone knowledgeable about Canada's current healthcare environment realizes that the quality of worklife for health providers is a significant and serious issue. **The cost of inaction is potentially staggering.** We cannot simply focus on today's challenges and ignore the problems that are emerging. The consequences could threaten the very sustainability of the health system that is synonymous with our Canadian way of life. Commendable steps are being taken across Canada, however the impacts are marginal. A coordinated and effective effort is essential if we are to make a marked improvement in QWL in healthcare. The good news is we do not have to wait – we can choose to act now and expect to see positive results in both the near and long term. **All stakeholders in our health system have the power to choose – the power to act.** Together we can accomplish great things – for ourselves and our children. It is truly Within Our Grasp – reach for it!

The Issue

The health and well-being of the health workforce and the quality of the healthcare work environment both have a profound impact on the effectiveness and efficiency of health service delivery. Our health system is a strategic competitive advantage over our main trading partner, the United States; our system costs about 40 per cent less as a percentage of GDP, and yields better health outcomes while being universally available to all citizens. To maintain this advantage, we must continue to innovate and improve how we deliver care in this country; we must support our health human resources to thrive, not merely survive.

The ability to reduce wait-times and ultimately, the very sustainability of the health system depends on a strong supply of healthy providers. In its interim report on the state of the health system in Canada, the Standing Senate Committee on Social Affairs, Science and Technology observed that “10 years of downsizing the Canadian healthcare system have only exacerbated the situation for nurses by producing unhappy patients, horrific workloads for nurses across the system, destruction of organizational loyalty and decaying morale among healthcare workers.”¹

Recently, a startling study of Canadian physicians found that 46 per cent are in advanced stages of burnout.² Further qualitative research commissioned by the Canadian Medical Association and the Institute of Neurosciences, Mental Health and Addiction showed the link between work organization and mental health problems among physicians.³ Another study found that 66 per cent of new nurses (less than 2 years into the job) were experiencing symptoms of burnout, including emotional exhaustion and depression and many are leaving their jobs within two years of graduation.⁴ Burnout is related to work overload, a perceived lack of recognition for the employee’s contribution to the organization, a lack of congruence between their own values and organizational values, and a disempowering work environment.⁵

With staffing shortages affecting more health professions every year and evidence that shortages will get worse in the near future, there is a broad consensus that employers must do more to support and retain their current employees. Across all health occupations, the

average age in 2003 was 41.6 years.⁶ The Canadian Institute for Health Information reports that compared to other workers, more health professionals retire early and it projected that in 2006 if nurses who are 55 years of age retire, Canada would lose 28 per cent of the nursing workforce. The challenge is to create positive work environments that encourage older health providers to delay retirement while at the same time retains younger health professionals throughout the course of their careers.

Health sector employees are absent from work as a result of illness or disability more than any other worker in Canada (on average they reported 13.1 sick days per year compared to 7.8 days for all Canadian workers in 2005).⁷ With over 1.5 million people working in Canada’s Health and Social Services sector (which equals roughly one in every 10 employed)⁸, this high rate of absenteeism represents a tremendous cost. For example, illness and disability in Ontario hospitals⁹ and British Columbia health authorities¹⁰ cost an estimated one billion dollars each, annually. High levels of absenteeism also amplify the burden placed on units that are already trying to operate with staffing shortages.

In 2002, the Canadian Nursing Advisory Committee noted that after 20 years of research on health provider job satisfaction and retention, we know what needs to be improved.¹¹ Across the country, many initiatives are underway which improve the quality of worklife for health providers; however, they are often isolated due to a lack of coordination, integration and shared learning. Collaborative efforts are required to ensure we can increase the pace and effectiveness of our efforts. National and provincial human resource initiatives have focused mainly on managing the dynamics of the supply and demand of health providers. Now a broader focus and coordinated effort is needed, so that health providers are viewed – and treated – as core long-term assets of the health system. This will only happen by embedding higher standards for health human resources and work environments within strategic plans at organizational and governance levels. The business case is strong; the cost of inaction is substantial. More concentrated investment is needed to support health providers to be healthy and productive.

Background to the QWQHC

A few years ago, the Canadian College of Health Service Executives convened a broad group of national health stakeholders to discuss health human resource issues. This group unanimously agreed that “Canada’s health system needs a comprehensive and collaborative approach to workplace and workforce renewal that does not pit one organization against another in a zero-sum quest for recruitment”. The ideas that were born out of this stakeholder workshop set the stage for the principles of this Quality Worklife-Quality Healthcare Collaborative (QWQHC).

The Canadian Council on Health Services Accreditation received \$349,000 of funding to support the work of the QWQHC Coordinating Secretariat. This two year funding is from Health Canada’s Healthy Workplace Initiative (which came out of the 2003 First Minister’s Accord on Health Care Renewal – Recruitment and Retention Strategy). Health Canada has allocated more than four million dollars to support a number of healthy workplace interventions across Canada. This Collaborative aims to fill an identified gap in the lack of knowledge sharing for healthcare organizations nationally. Please visit the website, www.hc-sc.gc.ca to find out more information about Health Canada’s work in this area.

In June 2005, 10 national healthcare organizations partnered to form the QWQHC with consensus that the Canadian health system must urgently do more to retain its health human resources in healthy and supportive work environments. By working together to support and implement a pan-Canadian action strategy to improve the health of the healthcare workforce and their workplaces, the Collaborative aims to also improve patient/client and system outcomes.

The 10 National Health Partners include:

- Canadian Council on Health Services Accreditation (CCHSA) (Coordinating Secretariat)
- Academy of Canadian Executive Nurses (ACEN)
- Association of Canadian Academic Healthcare Organizations (ACAHO)
- Canadian College of Health Service Executives (CCHSE)

- Canadian Federation of Nurses Unions (CFNU)
- Canadian Healthcare Association (CHA)
- Canadian Health Services Research Foundation (CHSRF)
- Canadian Medical Association (CMA)
- Canadian Nurses Association (CNA)
- National Quality Institute (NQI)

The partners selected a 15 member National Steering Committee from a group of recognized experts in Quality of Worklife issues from across the country. The National Steering Committee for the QWQHC considered the quality of work environments from a broadly-based and collaborative approach. The key deliverable of the Committee was the national framework and action strategy on quality of worklife to address a broad range of human resources challenges and to improve healthcare delivery and patient/client outcomes.

The QWQHC Mandate

The Quality Worklife-Quality Healthcare Collaborative is a national coalition of health leaders working together to develop an integrated pan-Canadian action strategy that will improve the health of health workplaces in order to improve patient/client care.

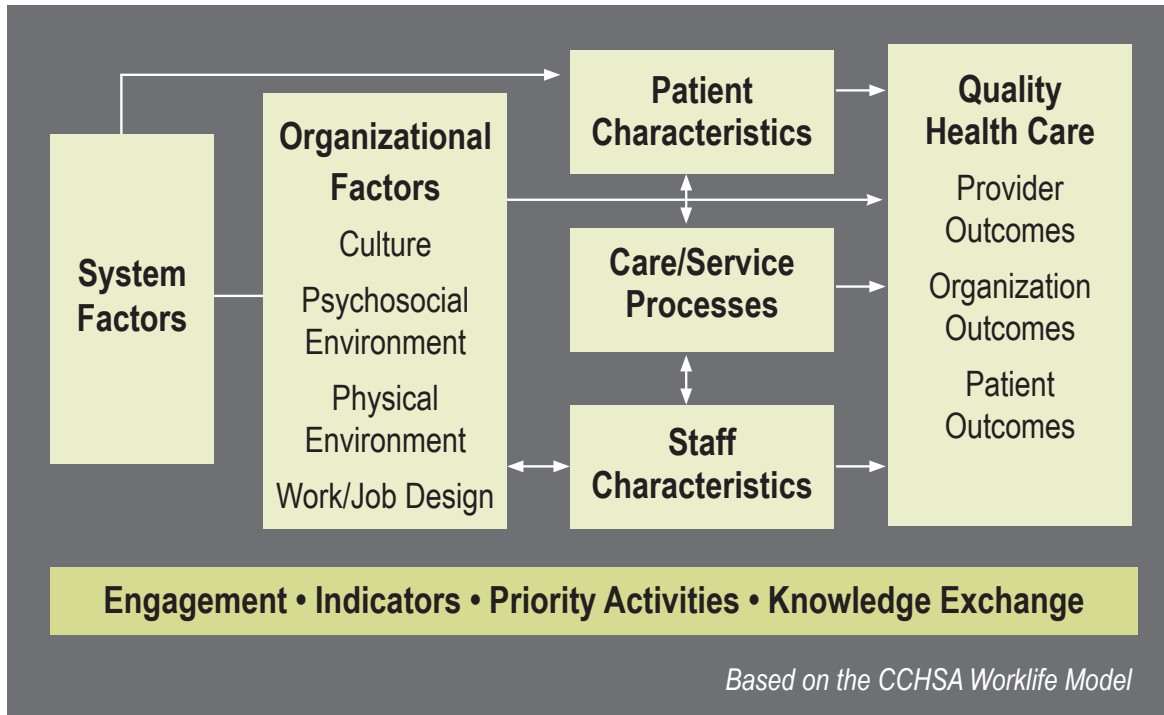
Our Vision: Canadian health providers achieve optimal health; and work in health settings that demonstrate healthy workplace leadership, management and accountability practices.

Our Shared Belief: A fundamental way to better healthcare is through healthier healthcare workplaces; it is unacceptable to work in, receive care in, govern, manage and fund unhealthy healthcare workplaces.

Our Definition of a Healthy Healthcare Workplace: A work setting that takes a strategic and comprehensive approach to providing the physical, cultural, psychosocial and work/job design conditions that maximize health and wellbeing of health providers, quality of patient/client outcomes and organizational performance. (Adapted from Registered Nurses Association of Ontario (RNAO) definition)



Guiding Conceptual Framework



Guiding Principles for the Development of the QWQHC Integrated Action Strategy

- Promotes a cultural shift (seeks transformative change and recognizes the complexity of the challenge)
- Comprehensive (addresses the full spectrum of human resource practices)
- Strategic (embeds workplace and workforce renewal goals into strategic plans)
- Inclusive (for all types and sizes of health organizations and types of workers)
- Practical, feasible and flexible (encourages a customized approach)
- Evidence-informed (using benchmarks and evaluation tools to monitor and report work environment determinants, as well as HR and organizational performance outcomes)
- Collaborative (based on partnership among diverse stakeholders)
- Sustainable (the work will outlive the life of the current mandate)

Overall QWQHC Shared Goals

1. **Create an appetite for change** and increase awareness and engagement for addressing QWL issues in health workplaces in a sustainable way. *(Increasing Awareness & Engagement Working Group)*
 2. **Develop indicators and a measurement framework** that health organizations agree to publicly report on for focused improvements to QWL. *(Indicators and Measurement Working Group)*
 3. **Identify and support specific strategies for improvements** to key priority QWL issues. *(Priority Strategies Working Group)*
 4. **Coordinate mechanisms to develop, transfer and apply knowledge** on research and leading practices. *(Knowledge Exchange Working Group)*
- **The Indicators and Measurement Group** provided advice on standardized working definitions, conceptual model, key indicators, and measurement processes/tools.
 - **The Priority Activities Group** provided advice on how health organizations should begin to transform into healthy workplaces and addressed internal and external barriers to this transformation.
 - **The Knowledge Exchange Group** developed optimal processes for knowledge exchange of research and leading practices related to QWL to improve health system delivery and patient/client outcomes. This group also supported the connection of champions involved in QWL interventions.

QWQHC Structure

The QWQHC was created on a shared leadership model. The structure included the Partners Group, The National Steering Committee, four working groups and a Coordinating Secretariat. Over 45 healthcare experts were recruited and volunteered their time to develop the QWQHC action strategy. Appendix B lists the experts involved.

- **The Partners Group** supported the ongoing work coming out of the QWQHC's action strategy and modeled and promoted the action strategy to their respective membership.
- **The Coordinating Secretariat** coordinated and supported the work of the various committees and subcommittees of the QWQHC.
- **The Steering Committee** synthesized the work from its four working groups into the integrated pan-Canadian action strategy.
 - **The Awareness and Engagement Group** developed key messaging to explain the purpose of the Collaborative, the importance of healthy workplaces and the current state of health workplaces; and provided advice on engaging key stakeholders in the uptake of the pan-Canadian action strategy.



Within Our Grasp

A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System

1. Increasing Awareness and Engagement

Health providers are a highly valued Canadian resource. Healthcare remains a top priority for Canadians, particularly patient safety, wait-times and access to quality healthcare services. Retaining health providers is vital to delivering positive results in all of these areas. The link between the quality of worklife (QWL) for health providers and our collective ability to move forward on these key system issues must be well understood to create our case for change and the corresponding call for action.

Several earlier reports provide recommendations on how to improve QWL for health human resources (HHR) but nationally we have not experienced concentrated, focused and sustained action on these recommended improvements. The challenge is to effectively engage those individuals responsible for making a positive difference in the working lives of health providers, encouraging them and supporting them to act. To begin, commitment is needed from funders, governors, managers and providers to work together to take a strategic and comprehensive approach to improve QWL. The following summarizes some challenges for each target stakeholder group.

Funders

Health human resources have not always been viewed as a core long-term asset of the system. As a result, the need to invest in maintaining and protecting this asset has not been universally recognized. Funders need to understand that the risk of inaction is substantial and the negative consequences are both predictable and formidable. Decision-makers need to commit to action to transform this situation. To accomplish this, funders must be aware of the issues and know what solutions are available. They need support and encouragement to

challenge the status quo. Funders need to understand that they have a responsibility to act – a fact that must also be reflected in their accountability to support the needed changes. Actions which improve and enhance system sustainability need to be valued and reflected in management incentives and not traded off for short-term budget goals.

Governors and Managers

You can not successfully govern that which is not measured or monitored. Leaders in health organizations must be held accountable for evidence-informed management practices. We have been successful at creating a culture in healthcare where evidence-informed clinical decisions are becoming the norm; we need to create this same culture for management decisions.

Healthcare Providers

Communications with health professionals must build hope and demonstrate through evidence that we are taking concrete action to improve their QWL. We need to build a labour relations environment that is more flexible and allows for shared agreements on common goals – especially when it comes to improving the QWL for all providers. For example, British Columbia made gains through tri-partite policy tables (including government, unions and employers) prior to formal bargaining where all parties discussed challenges and proposed solutions. The government provided the funding and process for a number of QWL initiatives which were put in place both in and outside the collective agreements.

Patients/Clients and the Public

The media continues to focus on patient safety, wait times and access to care. To date, the media has not been fully engaged in the QWL in healthcare issue and how it connects with patient/client care. The Canadian Broadcasting Corporation recently aired two award-winning news series “Out of Sync” and “Dying for a Job” that draw attention to the health of healthcare work environments; which will hopefully inspire other media outlets to do the same. The media needs to be educated to better position their role as an effective channel to help the public make the connections between the quality of worklife for providers and high quality, safe and timely care.

A 2006 Ipsos-Reid survey conducted on behalf of the Health Action Lobby (HEAL) shows that the majority of Canadians (63 per cent) are not confident that in 10 year’s time that Canada will have enough health professionals to meet its future needs.¹² In this same survey, 60 per cent of Canadians said that to improve access to the health system in Canada and reduce wait times, what the health system needs most is more health professionals (while only 28 per cent said the system needs more money, or 9 per cent said the system needs more technology).

The Healthy Healthcare Leadership Charter

The initial step for the QWQHC action strategy is to encourage leaders (at provincial and organizational levels) to sign-off on both the principles behind addressing QWL and to commit to action. The Healthy Healthcare Leadership Charter (see the next page) should be signed by government (i.e. Premiers, Ministers and Deputy Ministers of Health), and organizational leaders (Board Chairs, CEOs, and other senior leaders representing the shared commitment from unions, patient/client-care, HR and managers, and health and safety leaders to work together).

The Charter provides healthcare leaders a tangible and compelling way to demonstrate their shared commitment to actively creating positive change in the health

workplace. The Charter relates to the key components of the QWQHC action strategy (indicators, priority activities, and knowledge exchange) and states that if organizations put these activities into place, there is a shared expectation that QWL will improve. The second page of the Charter provides a mechanism for leaders to further demonstrate their commitment by indicating more specifically how they will prioritize one or more actions to bring about this positive change. It also provides leaders the opportunity to identify that their organizations have potentially developed leading practices in these key areas.



Healthy Healthcare Leadership Charter

This Charter is intended to support the continuous improvement of the health of all Canadian healthcare workplaces and providers. It is founded on the principle that a fundamental way to better healthcare is through healthier healthcare workplaces; and it is unacceptable to work in, receive care in, govern, manage and fund unhealthy healthcare workplaces.

A healthy healthcare workplace is a work setting that takes a strategic and comprehensive approach to providing the physical, cultural, psychosocial and work/job design conditions that maximizes the health and wellbeing of health providers, quality of patient/client outcomes and organizational and system performance.

Health human resources should be viewed and treated as core assets of the health system. A high quality of worklife is required for the retention of our finite number of resources. Quality of worklife is also important for the delivery of effective, efficient and safe patient/client care.

Our vision is for Canadian health providers to achieve optimal health and work in healthcare settings that demonstrate healthy workplace leadership, management and accountability practices. Canada’s health system needs a comprehensive and collaborative approach to workplace and workforce renewal that does not pit one organization against another in a zero-sum quest for recruitment. By working together to build, implement, evaluate and share healthy workplace leading practices, we will achieve this vision.

We agree with these principles and will act now to ...

- **Make quality of worklife a strategic priority.**
- **Assess, monitor and report on quality of worklife indicators including the standard QWL indicators identified by the QWQHC.**
- **Identify one or more priority action strategies that we will implement and evaluate.**
- **Identify and build knowledge on leading practices related to healthy workplaces.**
- **Exchange knowledge and network with other health leaders on healthy workplace practices.**

<i>Signature</i>	<i>Title</i>	<i>Date</i>
Organization:		
Province:		

Healthy Healthcare Leadership Charter Follow-Up Self-Assessment for Health Organizations

Priority Areas of Improvement	Specific Organizational Activity (see Menu of Priority Actions for descriptions of leading practices associated with each activity)	Score	One or More Priority Areas of focus
Create strategic leadership and management system for QWL	Build a strategic foundation for QWL initiatives		
Implement a comprehensive and integrated human resources, healthy workplace and organizational development strategy	Implement an integrated disability prevention & management system		
	Introduce a more comprehensive support system for employee wellness		
	Build a healing environment		
	Provide healthy leadership support and development program		
	Implement structures and processes that facilitate collaborative working practices		
	Implement opportunities and paid time for training and development		
	Implement a fatigue management policy and program		
	Implement new and innovative approaches to workload and staffing systems		
Link QWL to performance management systems	Implement data systems to track and analyze QWL and support increased accountability		
Develop internal and external knowledge exchange capacity	Support QWL champions to build knowledge exchange relating to priority areas for improvement		

Scoring System

1. **“Not Much Yet”** = discussion is starting to occur on the need for the activity, any actions that have been implemented so far have not been done in a strategic or coordinated way.
2. **“Getting Started”** = the activity is guided by a shared vision and is linked to the organization’s strategic goals. Commitment from top management is visible and champions are identified throughout the organization. A broadly represented participative team or committee has been identified to ensure direct employee involvement in the activity.
3. **“Activity Underway”** = the activity has clear objectives for the short-term and longer term. The committee has developed an action plan with clear goals, timelines and outcome measures. The activity has been implemented in a systematic way and is based on good planning.
4. **“Potential Leading Practice”** = the outcomes of the activities have been consistently evaluated, organizational leaders are kept informed about the impact of the initiative, multiple channels are used to communicate progress to employees. Ongoing reflection and learning occurs and involves continuous feedback loops and adjustments to the initial plan throughout the implementation of the initiative. Ongoing support and resources have been attained to ensure the success of the activity can be sustained. Knowledge is shared with other departments and organizations.

2. Standard QWL Indicators

The Collaborative was formed to inspire action on improving quality of worklife (QWL) in healthcare workplaces. There is enough evidence to support the need to improve and there are some good ideas about what needs to be done. The role of the Indicators and Measurement Working Group was to increase activity by developing a common set of indicators and measurement framework to drive this action. The following indicators were identified because every health organization should be able to track and report on them in the short term. These standard indicators have evidence to support their connection to key outcomes (for staff, organization and patients/clients). Even if organizations cannot track every one of these indicators, they should begin working with what they currently have and put a plan in place for the measurement of the others.

The Collaborative recognizes the burden on health organizations for data collection. To reduce this burden, we must all work together to streamline the data collection and reporting process. To this end, the Collaborative has proposed some standard definitions for each of the key QWL indicators. There are no flawless pan-Canadian QWL indicators and it will take much further collaboration across the pan-Canadian health system to achieve standardization of the definitions. The indicators presented in this action strategy represent the beginning of the QWL performance measurement development work, not the end.

Health organizations need and want valid comparable indicators to benchmark against their previous results, other organizations, and future ideal targets. They need to be able to use the comparable indicators to begin to ask themselves – why are we better or worse in

certain areas? What can we do to improve? A national benchmarking report of these standard QWL indicators would help organizations to identify areas for focused improvement and to set annual targets. It would also allow for the identification of potential leading practices to develop and share across the country. Organizations like the Health Council of Canada, the Canadian Institute for Health Information, Canadian Healthcare Association, or the Canadian Council on Health Services Accreditation are well positioned to take the lead on this benchmarking report.

The Collaborative also supports the urgent need for a national database for collecting and reporting on standard QWL indicators. Organizations like the Canadian Institute for Health Information, Statistics Canada or the Canadian Council on Health Services Accreditation are well-positioned to take the lead on the development of this database, and hence take the lead on the process for the standardization of the indicator definitions as well the future development of the standard basket of QWL indicators.

It is important to note that the standard QWL indicators that are proposed by the QWQHC only represent the “tip of the iceberg” of indicators that organizations need to consider. Organizations are encouraged to develop more robust and in-depth indicators to complement the ones presented here in order to understand their own unique challenges and opportunities for improvements to the health of their workplaces. Where there is organizational capacity to do so, it is important for them to collect and connect these QWL indicators with patient/client and system outcome measures.

System Factors
(Indicators of Funding and Governing Healthy Healthcare Workplaces)

Rationale	Potential Definitions	Notes
Indicator 1: QWL Indicators Built into Performance/Accountability Agreements		
Building capacity for sustainable improvements requires accountability for a strategic and comprehensive approach.	The extent to which each jurisdiction has QWL indicators in Performance/Accountability Agreements	
Indicator 2: QWL Indicators and Improvement Strategies Integrated into HHR Plans		
Building capacity for sustainable improvements requires accountability for a strategic and comprehensive approach.	The extent to which each jurisdiction has QWL built into HHR Plans	Include work of First Nations & Inuit Health Branch's HHR plan.



**Organizational Factors and Outcomes
(Indicators of Managing Healthy Healthcare Workplaces)**

Rationale	Potential Definitions	Notes
Indicator 1: Turnover Rate		
<p>Work force instability, as demonstrated by high rates of staff turnover result in workflow inefficiencies, delays in delivering patient care, and dissatisfaction among patients and staff, all of which can have significant negative effects on quality of care and patient safety.¹³</p>	<p>a. Number of employees who have permanently left this location between April 1, 2006 and March 31, 2007, separated by reason:</p> <ul style="list-style-type: none"> A. Resignations (No special incentives) B. Lay-offs (No recall expected)* C. Special workforce reductions** D. Dismissal for cause E. Retirement (No special incentives) <p>Then divide the number of employees leaving by the average level of employment observed between April 2006 and March 2007</p> <p><i>Source:</i> Stats Canada, Workplace Employer Survey (WES)</p>	<p>* Involuntary lay-offs with enhanced severance packages should be included with "Lay-offs".</p> <p>** Special workforce reductions include resignations and early retirements brought on by special financial incentives (i.e. where employees voluntarily leave).</p>
	<p>b. Labour Stability Rate = percentage of staff at the beginning of a fiscal year and were also employed a full year before</p> <p><i>Source:</i> Trillium Health Centre, ON</p>	<p>Focused on retention as opposed to turnover is a good approach. Need to define for all active employees (i.e. include those that are on maternity leave, disability leave, etc.) or define the exceptions (as listed above in a.) Also determine if we need to control for changes in total number of employees over a year.</p>
Indicator 2: Vacancy Rate		
<p>Work force instability, as demonstrated by high rates of staff turnover result in workflow inefficiencies, delays in delivering patient care, and dissatisfaction among patients and staff, all of which can have significant negative effects on quality of care and patient safety.¹³</p>	<p>a. number of positions vacant longer than 6 months/total number of budgeted positions</p> <p><i>Source:</i> Sask Health Workforce Action Plan</p>	<p>Evidence is not clear on the appropriate length of time to indicate a "hard to fill" vacancy, note the UK uses 3 months.</p>

**Organizational Factors and Outcomes
(Indicators of Managing Healthy Healthcare Workplaces)**

Rationale	Potential Definitions	Notes
Indicator 3: Training and Professional Development Opportunities		
Supporting health professionals to learn and develop leads to better staff retention and improves the quality of patient/client care.	<p>a. Average training hrs per employee</p> <p>b. Average training hours per full-time equivalent (FTE)</p>	Define what is included (in-house and offsite).
	c. Percentage of employees participating in in-service training session and/or off-site education and training programs annually	
	<p>d. Phase 2: broken down by the average number of hrs for each type of session reported annually</p> <p>Source: CNA</p>	
Indicator 4: Overtime		
High rates of overtime (OT) may reflect inadequate staffing or high levels of absenteeism and may result in workload issues and increased costs.	<p>a. Paid overtime rate = total # OT hours/Total paid hours</p> <p>Phase 2: also Total unpaid Overtime rate = total # unpaid OT hours/Total paid hours</p>	Recognize problems with tracking OT through the payroll system. Some collective agreements allow staff to take time in lieu of pay – difficulty capturing this banked time consistently.
Indicator 5: Absenteeism		
Absenteeism is a measure of QWL and well-being of providers. Absenteeism diverts essential resources away from patient/client care.	<p>a. Percentage paid sick hrs = paid sick leave hrs for eligible employees/total paid hours for eligible employees *100</p> <p>Phase 2 aims to further develop this indicator to capture the reasons why people are away from work.</p> <p>Source: Adapted from BC Performance Agreement and Ontario Hospital Association Absence Survey</p>	Recognized problems with tracking sick time for employees that are not eligible for benefits (i.e. part-time (PT) or casual staff in various jurisdictions), therefore only include hours for those who are eligible.
Indicator 6: Workers Compensation Lost Time Incidents Rate		
Safe work environments lead to healthier staff and safer patient/client care.	a. Average lost time claims accepted per 100 FTEs on an annual basis (frequency)	Not all provinces report per 100 FTE (or 200,000 hrs) but can easily be converted.
	b. Average number of days lost per 100 FTE on an annual basis (severity)	
	Source: WCB	

Worker Factors and Outcomes (Indicators of Working-In Healthy Healthcare Workplaces)

Rationale	Potential Definitions	Notes
Indicator 7: Health Provider Satisfaction		
Provider satisfaction with key “upstream factors” such as leadership, working conditions and individual and organizational health factors relate with outcomes such as turnover and quality of care.	Employee feedback survey questions on key QWL factors <i>Source: CCHSA – OHA Pulse Survey)</i> (see <i>CCHSA-OHA Pulse Survey Questions</i> below for the list of recommended standard questions)	Scales for questions a-k are a 5 point likert scale (strongly agree to strongly disagree) * QWQHC suggests replacement to original question to reflect a stronger focus on measuring leadership.

CCHSA-OHA Pulse Survey Questions

- a. I am satisfied with communications in this organization.
- b. I am satisfied with communications in my work area.
- c. I am satisfied with my supervisor.
Or
* I believe that my supervisor....
 - i. Is competent and knowledgeable.
 - ii. Communicates honestly with employees.
 - iii. Cares about the best interests of employees.
 - iv. Does not withhold important information from employees.
 - v. Can help solve important problems faced by our organization.
- d. I am satisfied with the amount of control I have over my job activities.
- e. I am clear about what is expected of me to do my job.
- f. I am satisfied with my involvement in decision making processes in this organization.
- g. I have enough time to do my job adequately.
- h. I feel that I can trust this organization.
- i. This organization supports my learning and development.
- j. My work environment is safe.
- k. My job allows me to balance my work and family/personal life.
- l. In the past 12 months, would you say that most days at work were (choose one) not at all stressful, not very stressful, a bit stressful, quite a bit stressful, extremely stressful.
- m. In general, would you say your health is... excellent, very good, good, fair, poor.
- n. In general, would you say your mental health is... excellent, very good, good, fair, poor.
- o. In general, would you say your physical health is... excellent, very good, good, fair, poor.
- p. How satisfied are you with your job? Very satisfied, somewhat satisfied, not too satisfied, not at all satisfied.
- q. In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day)
- r. During the past 12 months, how many days did you work despite an illness or injury because you felt you had to (counting each full or partial day as 1 day)?
- s. How often do you feel you can do your best quality work in your job? (Never, rarely, sometimes, often, always).
- t. Overall, I am satisfied with this organization (5 point likert scale).
- u. Working conditions in my area contribute to patient safety (5 point likert scale).

Patient/Client Outcomes

(Indicators of Receiving Care In a Healthy Healthcare Workplace)

Note these indicators may not be included in the QWL database or benchmarking report, however we will identify a strategy to allow for meaningful correlation between these datasets.

Rationale	Potential Definitions	Notes
Indicator: Patient/client Satisfaction		
QWL indicators need to be reported alongside Patient/client Satisfaction indicators to allow for meaningful analysis and continuous improvement.	<p>Population aged 15 and over receiving health services in the past 12 months who rate their level of satisfaction with those services</p> <p><i>Source:</i> Stats Canada Canadian Community Health Survey</p>	Health services are broken down as follows: Overall healthcare services; hospital care; physician care, community-based care; and telephone health line or tele-health services. Provided by province/territory.
Indicator: Patient/client Safety		
QWL indicators need to be reported alongside Patient/client Safety indicators to allow for meaningful analysis and continuous improvement.	Influenza Immunization rates for healthcare workers (<i>Source:</i> BC Performance Agreement)	
	Employee survey question regarding working conditions contributing to patient/client safety <i>Source:</i> CCHSA – OHA Employee Pulse	
	Adverse Events <i>Source:</i> CPSI	



3. QWL Knowledge Exchange

Health system stakeholders are fortunate to have a large collection of research and leading practices across the country that relate to quality of worklife (QWL) and its correlation to improvements in health system delivery and patient/client safety/outcomes. However there is also a large gap in the ability of the health system to efficiently and effectively spread these ideas across the country to facilitate change.

The aims of this working group were to favour the connection of key individual and organizational contributors/champions involved in QWL initiatives and identify implications for clinical, educational, organizational and policy supports.

The Collaborative used the following definition of Knowledge Exchange (KE) as a guide:

Effective knowledge exchange involves interaction and linkage between stakeholders and results in mutual learning through the process of planning, producing, disseminating, and applying and evaluating existing or new research and leading practices in decision making on quality of worklife to improve health system delivery and patient/client outcomes.

This knowledge exchange will result in evidence-informed decision making (where evidence includes both scientific and experiential evidence). (Adapted from CHSRF definition).

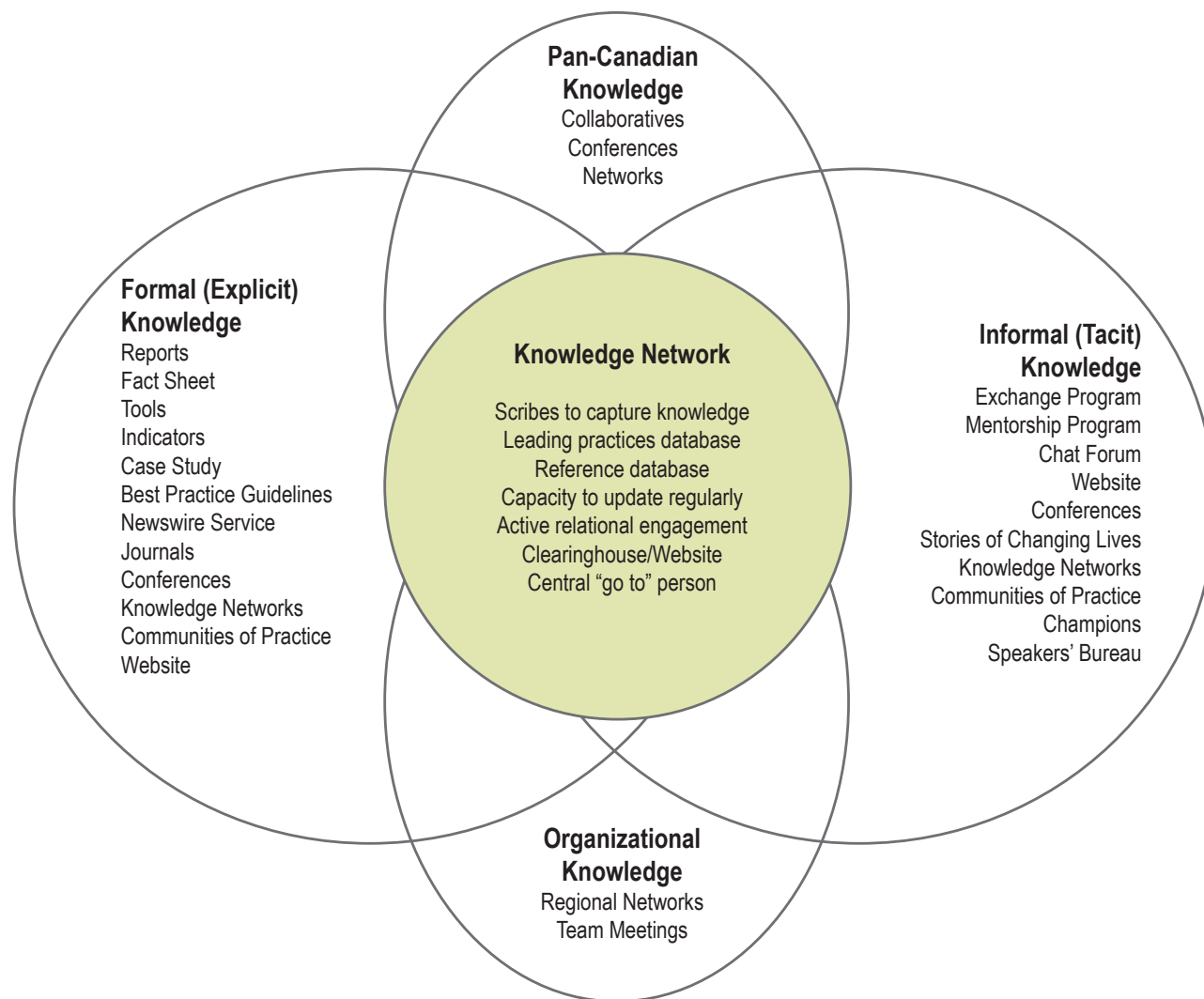
The QWQHC in partnership with the CHSRF funded an environmental scan to research the optimal processes for knowledge exchange of research and leading practices

related to QWL to improve health system delivery and patient/client outcomes.⁴⁴ See Appendix C for the Executive Summary of this Environmental Scan. This scan provided a series of recommendations for the QWQHC's Knowledge Exchange in Research and Leading Practices Working Group to consider as they developed the pan-Canadian QWL knowledge exchange framework and action strategy. See Appendix D for a summary of proven KE vehicles and tools. These were founded in a literature review of nationally significant synthesis documents and a review of activities and initiatives underway in all Canadian jurisdictions. The input from a diverse set of experienced and knowledgeable individuals from across Canada was invaluable.

The pan-Canadian QWL knowledge exchange framework and action strategy is based on the combination of formal (or explicit) and informal (or tacit) knowledge to support the use of strategic knowledge on quality worklife and its relation to quality healthcare. **Explicit Knowledge** includes highly relevant documentation and customized knowledge products such as journal articles, reports, fact sheets, etc. **Tacit Knowledge** includes sharing individual and organizational experience on quality worklife and quality healthcare initiatives; for example, through stories, mentorship programs, chat forums, etc.

The Collaborative recommends identifying existing knowledge exchange vehicles/initiatives wherever possible, and provide a clearinghouse for key target knowledge users to enhance their practices. The knowledge presented in this clearinghouse will be in a format that allows users to find knowledge or information for key areas that they have prioritized for action.

QWQHC Knowledge Exchange Framework



QWQHC Knowledge Exchange Action Strategies

1. Develop a sustainable infrastructure to keep people working together and sharing knowledge through the creation of a pan-Canadian KE network.

There is a well-established need for national coordination of QWL and related KE activities. One recommendation is the creation of a pan-Canadian KE network that would take on some of the knowledge related national coordinating functions. The focus would be to maximize learning and application of knowledge in developing, implementing and evaluating QWL initiatives. It would provide support for a range of knowledge exchange activities to bring people and knowledge together using a range of methods that hold promise or have been proven to work as effective knowledge transfer vehicles.

Key activities of the KE Network should include:

- Developing an actively updated central clearinghouse/website that provides links to relevant existing knowledge exchange initiatives (see Appendix D).
- Supporting Communities of Practice. Bring together and support the development of QWL champions in health organizations; support knowledge exchange relating to priority areas for improvement. Stakeholders at all levels must take ownership and feel empowered to become part of the knowledge exchange process.
- Providing a “go-to person” for providing active relational engagement between stakeholders.
- Keeping the inventory of the research for QWL up to date by building on the current RefWorks Database on published literature and “grey literature” documents to ensure easy access to current and relevant information.
- Developing an easy to access database of leading and promising practices in quality worklife and quality healthcare. Leading practices will be identified through the Healthy Healthcare Leadership Charter, CCHSA accreditation surveys (where CCHSA surveyors and clients can identify leading practices during the accreditation survey process), national conference abstract submission

processes (i.e. the National Healthcare Leadership Conference, CMA Physician Health Conference, Registered Nurses Association of Ontario Healthy Workplaces in Action Conference, or the Healthy Hospital Innovative Practices Symposium of the Ontario Hospital Association, etc.) and through the efforts of the KE clearinghouse members. We will also look outside the health work environment context for broader sharing of leading practices, ideas and tools.

- Explore linkages with existing leading practice electronic knowledge management tools, e.g., NurseONE, (the Canadian nurses portal developed by the Canadian Nurses Association in partnership with the First Nations and Inuit Health Branch, Health Canada.)
- Developing the capacity to respond to organizational and individual requests for “just in time” customized knowledge products such as briefing notes, background documents, research syntheses, multi-media presentations, overviews of specific leading practices and organizational QWL options. These products should target each key stakeholder audience.
- Providing skilled “scribes” that codify informal (tacit) knowledge into formal (explicit) knowledge by seeking out and sharing leading practices on how organizations create success in improving QWL and share knowledge and skills internally.
- Partnering with other federal/provincial/territorial knowledge exchange initiatives to provide linkages between relevant areas of interest.
- Providing templates for individuals to tell their own stories in a way that captures the highest quality of information possible.

2. All organizations to include QWL, knowledge exchange and change management as part of the existing learning and skills development initiatives that are already taking place.

Both KE and QWL must become a part of the full range of the educational experience; including academic institutions, training programs, colleges, etc. Development and documenting of tacit knowledge should be part of all formal educational experiences.

- 3. All organizations to develop policy/advocacy strategies and initiatives to support increased organization and system capacity for knowledge exchange regarding QWL for Quality Healthcare.**

See Appendix D for examples of key knowledge exchange vehicles.

- 4. All organizations to support the development and maintenance of a pan-Canadian QWL network and contact list.**

Develop and support QWL champions to actively participate and contribute in knowledge exchange networks. This should be inclusive of all job functions and levels of responsibility.

- 5. All organizations to support the evaluation of QWL and KE activities.**

Determine the level of involvement in KE activities, and the outcomes of this involvement.



4. Priority Organizational and System Actions

The QWQHC sets out several organizational and system actions to help the health community work together to build healthy workplaces and link improvement to patient/client care outcomes. We recognize that many health leaders are committed to improving the health of their work environments but that it is often difficult to determine where to begin in this complicated process. There are many good initiatives already in place across the country but more concentrated and integrated action is needed to achieve measurable success. The QWQHC has identified a menu of action strategies that are known to improve the workplace and the health of providers; that relate to improved patient/client care; and that can be quickly put into place.

Much of the study into the effects of the work environment on QWL and its effects on quality healthcare has focused on nursing and much of the evidence provided in the QWQHC action strategy reflects this focus. With the high numbers of nurses in the system (approx. 1/3 of the healthcare workforce) it has often been suggested that as nursing goes, so goes the rest of the system. Future solutions need to use this nursing specific evidence and build a broader base that includes the entire healthcare workforce. That said; this body of evidence gives us a great starting place to improve the QWL for all providers.

We must respect the complexity of the issue and understand that the improvement process will not likely occur in a linear fashion. Organizations need to be able to adapt recommended practices to meet their unique needs and so prescriptive methods are not practical or effective for sustainable change. For each of these priority action areas, evidence-informed “menus” of leading practices are provided. These leading practices do not represent an all-inclusive list, but provide some evidence-informed ideas to help health organizations prioritize their activities. Leaders at both organizational and system levels should identify one or more of these key areas for their focused attention.

Many of the leading practice activities at the organizational level do not require extra funding; they simply involve doing things differently and giving people more control over their working lives. For the activities that require upfront investments such as the training and development of providers, leading practices show these investments can be recouped through more effective care and by reducing costs for recruitment, sick pay and overtime.

As with any program that aims to change the culture of systems or organizations, leaders must pay attention to the change management process. For example, it is important that each initiative is implemented with a strategic and continuous quality improvement approach (by teams with representation from unions, providers and management); initiatives are evaluated and communicated; and knowledge is widely spread. See Appendix A for an overview of change process for implementing all QWL initiatives.



Menu of Organizational Priority Actions

(Organizations should implement one or more of the following action strategies)

Priority Action 1: Create Strategic Leadership and Management System for QWL

Activity A: Build a Strategic Foundation for QWL Initiatives

Rationale

A healthy and supportive work environment is the crucial factor in creating robust employment relationships. This includes physical, social, and psychological aspects of the workplace.¹⁴

A comprehensive systems approach to promoting a climate of health and safety, which includes taking into account workplace organizational factors and physical and psychological hazards is the best way to improve the healthcare workplace and thereby patient safety.¹⁵

Menu of Leading Practices

- Show senior leadership involvement (show they support and reinforce the importance of QWL issues, identify a senior champion for regularly reporting to the Board on progress of the initiative, expect all senior leaders be accountable for QWL and model healthy leadership styles).
- Ensure mission, vision and/or values statement acknowledges that people are the health organization's greatest asset.
- Ensure you have a highly functioning joint health and safety committee and consider asking them to implement the QWL/Healthy Workplace Initiative.
- Ensure the needs of all providers and volunteers working in health facilities (including physicians and others who may not receive remuneration directly from the organization) are taken into consideration, and offer access to QWL/Healthy workplace programs and services regardless of the employment relationship.
- Ensure the organization's Health and Safety policy (or a separate policy) includes a focus on the promotion of mental, physical and social well-being in the workplace; and that it outlines clear roles and responsibilities for action.
- Identify the most relevant healthy workplace model for your organization that approaches health from a comprehensive and broad perspective.
- Integrate HR, QWL, disability prevention and management system, wellness programs, safety (patient/client and employee), organizational development and environmental initiatives into an overall healthy healthcare workplace plan. Identify goals, timelines and outcome measures. Link with other quality improvement initiatives aimed at improving organizational performance and patient/client care processes.
- Develop a strong client focus for the healthy workplace plan. Include the needs of both internal and external clients. Determine employee QWL needs and key safety (employee and patient/client) risks. Survey employees using a tool that will allow for comparisons across units within organizations and also will allow for benchmarking with similar organizations.
- Prioritize QWL issues and link these priorities to the organization's strategic direction and business operating plans. Involve health, safety, human resource and risk management professionals in the organization's strategic planning processes.
- Evaluate and communicate continuously throughout the initiative
- Share what you have learned and diffuse the successful practices to other parts of the organization and externally.



Priority Action 2: Implement a Comprehensive and Integrated Human Resources, Workplace Health and Organizational Development Strategy

Activity A: Implement an Integrated Disability Prevention and Management System

Rationale

Organizations must move beyond regulatory compliance and responding to the current health and safety crisis, to create a positive health and safety culture in a system of care.¹⁶

Worker safety relies on the precautionary principle that reasonable action to reduce risk should not await scientific certainty.¹⁷

Violence prevention is a key area for focus as providers are at a relatively high risk of violence in the workplace. The risk of health providers experiencing violence may be 16 times greater than the risk for other service workers. Health providers are more likely to be attacked at work than prison guards, police officers, transport workers, retail or bank employees.¹⁸

Menu of Leading Practices

- Employ specialists to create a management system approach to building a culture of health and wellness to prevent and manage disability (i.e. Certified Disability Management Professional, Certified Return to Work Coordinator, Occupational Health Nurse, Ergonomist, etc).
- Conduct a workplace health and safety risk assessment. Ascertain major injury trends, conduct needs assessment; analyse indicators.
- Work with Health and Safety Committee to develop and implement a comprehensive risk management program that integrates organizational measures – patient/client, employee, public, environmental, quality, and fiscal.
- Link real-time health and safety measures within a balanced scorecard and provide progress reports to the board.
- Create an open non-punitive risk reporting culture and create user-friendly reporting processes to encourage reporting by all stakeholders and to quickly analyze and communicate risks. Provide a variety of methods such as anonymous reporting (i.e. telephone, web).
- Implement tools to manage disabilities using evidence-informed disability duration guidelines.
- Develop a workplace violence prevention program that includes client aggression management programs. Measures to include hazard prevention controls, methods of reporting, investigating and responding to incidents of violence. All settings should implement policies to address violence, abuse and harassment in the workplace.³⁰
- Develop and implement a Critical Incident Stress Management Program.¹⁹ Include dealing with adverse events.
- Reduce variability through standardized equipment and operating procedures.
- Implement mode effect analysis – an assessment process to examine steps in processes where there may be undesirable variation resulting in employee and/or patient/client risks.
- Educate risk managers, safety personnel and QWL/Safety team members in root cause analysis.

Priority Action 2: Implement a Comprehensive and Integrated Human Resources, Workplace Health and Organizational Development Strategy

Activity B: Introduce a Comprehensive Support System for Employee Wellness

Rationale

Having healthy employees is important to achieving excellence, as 70 per cent of ill health is preventable and good levels of health can be maintained when the workplace environment provides support and does no harm.²⁰

Increased worker stress leads to fatigue which leads to increased risk of adverse events and health problems for providers (e.g. burnout, drug & alcohol abuse).²¹

Menu of Leading Practices

- Determine individual health needs – via survey, analysis of benefits/drug utilization, focus groups. Involve unions up front to assist with development and promotion of survey.
- Build onsite health promotion initiatives based on employee health and wellness needs and that address the wide range of health determinants.
- Implement integrated chronic disease management programs for employees and patients/clients.
- Evaluate initiatives – link with QWL indicators.
- Provide EAP (employee assistance program) and introduce an approach that normalizes and de-stigmatizes mental and emotional health issues.
- Offer critical incident debriefing as a normal response to all critical incidents.
- Create positive and healthy relationships (self esteem to improve relations with co-workers, family).
- Offer assistance and programs regarding eldercare for employees.
- Visit the Canadian Centre for Occupation Health and Safety's website for a list of tips and tools on creating healthy workplaces.
www.ccohs.ca/healthyworkplaces/employers/tools.html

Activity C: Build a Healing Environment

Rationale

The “ambience” of a space has an effect on people using the space. The hierarchy of environments range from simply non-toxic to safe (both physically and psychologically) to providing a positive context to being actively healing (promote calmness, reduce stress and strengthen coping resources and healthful processes).²²

Menu of Leading Practices

- Go beyond basic legislative requirements to create the place, space and time for people to connect and build healthy working relationships.
- Allow grass-roots ideas to be brought to life to support this in a participatory approach.
- Ensure a solid foundational support for safe and secure physical working conditions (see activity A).
- Include health and safety personnel (including an ergonomist) and staff who will be working in the area in design decisions when renovating or building new spaces.
- Pay attention to lighting, temperature, air quality, colour and flow of movement through the space to maximize healing potential of the environment.²³

Priority Action 2: Implement a Comprehensive and Integrated Human Resources, Workplace Health and Organizational Development Strategy

Activity D: Provide Healthy Leadership Support and Development Program

Rationale

Front and mid-level managers play an important role in implementing system change, encouraging front-line workers to adopt change and facilitating change at upper management or leadership levels. Yet these managers are assuming so much of the responsibility for implementing change that they are burning out in the process.

Managers with positive leadership styles (i.e. who develop, stimulate, and inspire followers to exceed their own self-interests for a higher purpose), had more satisfied staff, lower levels of employee turnover, higher patient/client satisfaction. Where managers have a large number of staff reporting to them, patient/client satisfaction is lower, and there are higher levels of staff turnover. No leadership style will overcome having a large number of staff reporting to the managers.²⁴

Menu of Leading Practices

- Implement best practice leadership development guidelines developed by professional associations (e.g. RNAO Nursing Leadership Best Practice Guidelines.)²⁵
- Promote latitude in decision-making related to professional practice.
- Implement management training programs to develop positive leadership styles.
- Give immediate support (including sufficient time and resources) middle and frontline managers to ensure the health system retains and develops strong middle management capacity.²⁶
- Develop guidelines regarding the optimum number of staff who should report to front line managers. (Span of control).
- Provide mentoring for new managers and provide skill development and education for all managers in relation to quality worklife factors and their relation to patient/client care.
- Hire front line managers with relevant clinical experience and strong leadership abilities.³⁰
- Integrate health professionals into organizational hierarchy through management positions, clinical laddering and meaningful participation in governance.²⁷
- Require managers to be certified in a recognized leadership development program (that includes a focus on their role in creating a healthy work environment) as part of hiring conditions.
- Ensure that QWL is included in the performance appraisal of all senior and frontline managers.
- Increase amount of time spent each day by senior and middle management on addressing issues related to culture and QWL.
- Encourage sabbaticals for all leaders to increase knowledge of other systems (medical and non-medical, national and international).
- Create autonomy for appropriate decisions at the unit level. Empower leaders and ensure the system is ready to respond to and support front-line decisions.

Priority Action 2: Implement a Comprehensive and Integrated Human Resources, Workplace Health and Organizational Development Strategy

Activity E: Implement Organizational Structures and Processes that Facilitate Collaborative Working Practices

Rationale

There is growing consensus that interprofessional and collaborative patient/client-centered practice – across all health sectors and along the continuum of care – will contribute to the following:

- improved population health/patient/client care;
- improved access to healthcare;
- improved retention and recruitment of healthcare providers;
- improved patient safety and communication among healthcare providers;
- more efficient and effective employment of health human resources;
- improved satisfaction among patients/clients and healthcare providers.²⁸

Menu of Leading Practices

- Engage health professionals in the discussion of distinct and shared responsibilities among team members to promote effective collaborative practice.²⁹
- Provide clarity on the role of all providers working within team environments; foster respect for the contributions of all providers.
- Engage employers, regulatory bodies, educators, practitioners, unions, and policy makers in dialogue about strategies for improving the utilization of all health professionals.²⁹
- Employ effective change management strategies when introducing new staff mix models.²⁹
- Promote inclusiveness (for all health providers), create working conditions and positive working relationships that enable and support collaborative practice from a broad perspective.
- Collaborate with policy makers and agencies responsible for monitoring and reporting on health system performance to address the current inadequacy of databases that allow linkage of unit or program level staff mix and contextual data to patient/client, provider, and system outcomes.²⁹
- Put in place policies that will allow each regulated profession to function to the maximum of her or his professional practice abilities according to the respective provincial/territorial licensing body.³⁰
- Create leaders to foster collaborative practice in all healthcare settings (provide technical/process assistance in team functioning, education, information, resources, feedback).
- Develop collaborative/multidisciplinary teams and provide dedicated time for direct dialogue to address factors that influence team function and increase its capacity for effectiveness (e.g. factors at the practice level, organizational factors and social factors that can affect teamwork).
- Consider the influence of financial incentives/rewards for teamwork.
- Educate team members in factors that influence team effectiveness (include: knowledge of health professional roles, ability to communicate effectively, ability to reflect on the effect of health professional's roles/attitudes related to mutual trust, and willingness to collaborate).
- Optimize staff participation in clinical decision making (within and across disciplines) and develop new models of care that involve patient/client advocacy groups to address the role of patients/clients, families and caregivers.
- Reduce the amount of time health professionals spend on tasks that do not require their specific skills and competencies.
- Implement a diversity program to address and celebrate intergenerational, cultural, language, etc. differences.



Priority Action 2: Implement a Comprehensive and Integrated Human Resources, Workplace Health and Organizational Development Strategy

Activity F: Implement Opportunities and Paid Time for Training and Development

Rationale

Health providers want professional development opportunities, time to be involved in developing professional practice and research initiatives, and demonstrated support from leaders. This leads to improved patient/client-centred care and provider retention.

Preliminary analysis of the 80:20 professional development pilot project at University Health Network (UHN) shows that there is no use of agency staff, reduced sick time, reduced overtime, and increased staff and patient/client satisfaction on the study unit.³¹

Menu of Leading Practices

- Initiate pilot projects where 20 per cent of salary budgets are shifted to allow for professional development activities (including paid time for training and professional development, committee work for Quality Improvement, QWL, Health and Safety, etc.)³¹ Include strategies to ensure providers who often fall outside the traditional employee/ employer relationship (e.g. physicians, physiotherapists, etc.) also have access to these paid time development activities.
- Implement a staff development program with annual allotment per employee.
- Work with managers, staff and unions to devise schedules and replacement strategies that allow staff to take full advantage of education opportunities and guarantee their replacement during education leaves.³⁰
- Implement a Learning Management System to track types of programs, staff hours, costs and outcomes of training and development initiatives.
- Ensure that the work environment is a learning environment, support performance evaluation.²⁷
- Provide an annual QWL education budget - annual programs for all staff including: Illness and Injury prevention (MSIP, slips & falls, violence, infection control), work life balance/ Health and Wellness, and team and leadership development, etc.
- Evaluate and improve orientation, mentorship programs.
- Offer interdisciplinary training and development.

Activity G: Implement a Fatigue Management Policy and Program

Rationale

The chain of evidence shows direct correlations between work overload and worker stress which causes fatigue. Fatigue is linked to risk of adverse events and health problems for providers and both of which impact the overall quality of care provided.³²

Evidence shows linkages between fatigue among clinicians and the safety of patients³³, the working hours of hospital staff nurses and patient safety³⁷; and the incidence of preventable adverse events related to hours of work.³⁴

Menu of Leading Practices

- Embed a fatigue management policy and program within patient safety expertise but have an interdisciplinary advisory team and clear interdisciplinary focus.
- Define organizational and personal responsibilities and interventions to increase awareness of fatigue and to implement strategies to reduce risk associated with fatigue in the workplace.
- Identify and measure risk associated with fatigue for key tasks and professional groups. Analyse impacts of mandatory overtime, 12 hour shifts, shift rotation and hours of work on patient/client, provider and organizational outcomes.
- Address fatigue issues from a shared responsibility approach (system, organizational, and individual).
- Reduce work-overload and overtime through staffing strategies that guarantee the number of health professionals required instead of using overtime. Where overtime hours are being worked, employers should work with their managers and front-line staff to minimize and, where possible, eliminate overtime hours.³⁰
- Educate on strategies to improve quality of sleep.
- Identify risks of and strategies for addressing compassion fatigue/spiritual fatigue and psychological fatigue (due to cognitive dissonance and moral residue issues).
- Define the “line” for decision-makers between operational efficiency and too great a negative impact on the fatigue and stress levels of staff.
- Conduct a multi-disciplinary study and evaluation of models of management of fatigue further.

Priority Action 2: Implement a Comprehensive and Integrated Human Resources, Workplace Health and Organizational Development Strategy

Activity H: Implement New and Innovative Approaches to Workload and Staffing Systems

Rationale

Current staffing conditions demand immediate attention, as they have become increasingly inadequate and can result in unacceptable compromises to patients/clients and providers.³⁵

Unit productivity/utilization levels should target 85 per cent plus or minus five per cent. Levels higher than this lead to higher costs, poorer patient care, and poorer nurse outcomes.³⁶

The odds of an adverse event are three times higher when RNs work shifts longer than 12.5 hours.³⁷ Every additional patient beyond an average hospital nurse's workload of four patients increases the risk of death following common surgical procedures by 7 per cent.³⁸

Strategies to reduce workload among health professionals will likely lead to improved patient outcomes.^{39,40,41}

RNAO advocates for a 70:30 FT/PT staffing model.⁴²

Menu of Leading Practices

- Implement effective, formal staffing plans. Such plans should be specific to the unit, ward, or program and the needs of its constantly changing patients; the experience levels of staff who work there, and which other professionals and support services the organization can provide. The plan needs to address staffing needs required for quality healthcare delivery; be formed in consultation with staff, using a shared governance model; and should spell out options, repercussions, and alternatives when staffing goals are not met.³⁵
- Consider overstaffing by a small margin in anticipation of absences; this strategy is known to result in decreased overall cost compared to traditional staffing methods.³⁰
- Link staffing initiatives with management concepts that create quality work environments that encourage and sustain: transformational leadership structures; collaborative work among all healthcare team members; professional autonomy and control over practice; use of technology, innovation, and research to improve work processes and patient/client outcomes; and research to generate evidence for “best” practices.
- Create more full-time positions to increase team stability.
- Ask staff what their preferable work status is and build strategies for maximizing employee satisfaction with their employment status.
- Respect collective agreement language and work towards complementary structures and processes to support innovative approaches.



Priority Action 3: Link QWL and Workplace Health to Performance Management Systems

Activity A: Implement Organizational Data Systems to Track and Analyze QWL and Support Increased Accountability (See the Standard QWL Indicators Section for more information)

Rationale

Integrated human resource information systems are an essential management tool, helping to make the case for specific human resource interventions – as well as showing the costs of inaction.⁴³

Total salary and benefit expenditures to deliver services encompass approximately 70-75 per cent of every dollar spent. We spend millions to track and manage inventory to ensure we get the best value for the money spent for something that is a fraction of the HR costs.

Menu of Leading Practices

- Include QWL indicators within performance/accountability agreements for all leaders within health organizations.
- Collect the pan-Canadian standard QWL indicators using the standard definitions and participate in the pan-Canadian QWL benchmarking report.
- Implement a comprehensive human resources information system that tracks key QWL indicators and allows for the integration of HR and health and safety information at the individual employee level and unit level (costs, hours, etc. should be collected to understand the return on investment for QWL interventions).
- Ensure the HRIS system allows for the integration of information with patient/client care reporting and workload measurement systems, at similar unit level. Implement a training management system to track training hours/costs at the individual employee level and unit level. Build this within the HRIS system.
- Implement a balanced scorecard that can be drilled down to the unit level to provide real-time information and allow analysis on the causal impacts of QWL indicators on financial and patient/client outcomes.
- Create leaders for the analysis and translation of the data into practice, facilitate team discussions on continuous quality improvement of results, evaluate interventions, and share evidence with other units and organizations.

Priority Action 4: Develop Internal and External Knowledge Exchange Capacity

Activity A: Support QWL Champions to Build Knowledge Exchange Relating to Priority Areas for Improvement (See the Pan-Canadian Knowledge Exchange Framework Section of this report for more information)

Rationale

In moving forward, it is important to build on existing relationships, capacity and fully utilize existing organizations, professional networks and QWL initiatives underway across the country⁴⁴.

Menu of Leading Practices

- Support QWL Champions to actively participate in/contribute to knowledge exchange networks.
- Develop KE processes across the organization that are linked and integrated with frontline employee involvement. Look beyond organizational silos which may also involve allocating resources differently.
- Utilize evidence to support employees and managers to make ethical decisions in practice environments i.e. support colleagues and management facing difficult situations due to the complexity of care and staff shortages, among other pressures.
- Contribute to the development of a national database that would provide easy access to highly relevant documented information (on literature and practice) to support more efficient search for evidence.
- Invest in mechanisms to take your work in knowledge development, dissemination, translation and exchange and connect it to organizational action in the areas of strategic planning, workplace policy, program and practice development, implementation and evaluation.
- Support the development of “dual practitioners” in both operations and research. Academic researchers without a background in operations may be hesitant to fully engage in projects led and dominated by operational issues and processes. On the other side, staff and consultants from the public or private sector may not be comfortable engaged in academic research. In order to bridge these two realities, the development of individuals educated and experienced in “both worlds” would be helpful⁴⁴.



Priority Actions for the Health System (Federal/Provincial/Territorial Levels)

To support health organizations to achieve success in implementing priority action strategies to improve quality of worklife and patient/client care, the QWQHC has also identified priority areas for system leaders to focus attention on. F/P/T Ministries of Health and non-governmental health organizations across Canada are encouraged to work together to build support for health organizations in their own jurisdictions; and also to support pan-Canadian knowledge exchange activities. The four system-level priority action areas include putting in place:

Priority Action	Rationale	System Level Practices
<p><i>Create and support a national QWL database and support mandatory reporting of standard QWL indicators</i></p> <p>(see Standard QWL Indicators section for more information)</p>	<p>National benchmarking allows for the identification of leading practices and leads to the further development of targets for QWL measures. Public reporting will increase engagement and awareness of the importance of the issue.</p>	<ul style="list-style-type: none"> • Reach consensus of indicators for inclusion in Pan-Canadian QWL Benchmarking Report. • Identify the secretariat responsible for building and maintaining the database and facilitating database research. • Identify the key bodies that can make reporting mandatory and/or create incentives for wide participation.
<p><i>Enhance performance/accountability agreement and accreditation standards</i></p>	<p>People are the healthcare system's greatest asset and it is critical that decision-makers are held accountable for effective management of these assets.</p>	<ul style="list-style-type: none"> • Set targets for process and structure indicators linked to evidence supporting organization's achievements in building a healthy foundation for a strategic QWL initiative. • Set targets for improvement to key QWL outcomes indicators (link with Standard QWL indicators). • Link monetary incentives to achievement of QWL targets by health leaders and organizations.
<p><i>Create a pan-Canadian QWQHC knowledge network to recognize and share leading practices</i></p> <p>(see Knowledge Exchange section for more info)</p>	<p>This is a well-recognized gap and leaders across the country have expressed great interest in being able to connect with others across the country to learn and share more about QWL practices.</p>	<ul style="list-style-type: none"> • Build a centre of policy/research excellence in healthy workplaces (partners could include CHSRF, all levels of governments, CIHR, etc.). • Identify a "new initiative per year" and promote across the country. • Promote a national award to draw out and recognize leading practices. • Offer scholarship/research/fellowships and project funds in this area. • Develop/promote a nationally recognized certification training program for healthy leadership development for frontline, middle and executive management roles. • Identify a national program for certification/education for integrated disability management and prevention systems in health workplaces. • Create communities of practice across the country and include mentorship opportunities for managers, QWL champions.

Priority Action	Rationale	System Level Practices
<p><i>Focus a national workplace health promotion program that starts within the health community</i></p>	<p>The health workplace is a key health promotion setting and should be a focus because of its strong health promotion influences on providers, patients/clients and their families.</p>	<ul style="list-style-type: none"> • Link with population health and public health initiatives focusing on health promotion and workplace wellness programs. • Partner with the CMA Centre on Physician Health and Well-Being, Canadian Physician Health Network to allow for application of program to the physician population. • Establish pan-Canadian program, provide leadership, budget, and develop a strategic plan for a workplace health promotion initiative. • Create a national collaborative, multi-modular “health professional health and well being” program (expand on CMA’s physician health program).

Appendices

Appendix A

Overview of the Change Process for Implementing Quality of Worklife Initiatives

- 1. Guided by vision and values:** Creating and maintaining a high quality work environment should be guided by a shared vision of what this looks like. Actions to achieve this vision should demonstrate the organization's values.
- 2. Leadership:** Commitment from top management is critical, and must take the form of visible leadership on work environment issues. Employees judge commitment by the actions of the organization's leaders. Cultivate champions throughout the organization, especially among middle managers and front-line supervisors.
- 3. Participative team approach:** Implementing a QWL strategy requires an integrated approach, guided by a team or committee that includes representatives from management, health and safety, human resources, employees and unions. Direct employee involvement in all stages is critical to success.
- 4. Define scope and objectives:** The committee charged with developing a QWL initiative needs to identify opportunities for change by assessing the needs of employees, organizational priorities, current strengths in people practices, and related initiatives that can be built upon. Set clear objectives that can be achieved in the short-term and longer-term. Consider starting small, with a pilot site, to learn and build internal support.
- 5. Link to strategic goals:** Clearly link QWL issues and outcomes to the organization's strategic goals. Integrated employee health and well-being objectives into the organization's business planning process so that, over time, all management decisions take these factors into account.
- 6. Customized plan:** Collaboratively develop an action plan with clear goals, timelines and outcome measures. Get feedback on a draft plan from key stakeholders, and revise accordingly. The plan must be tailored to the organization's current context and strategic direction.
- 7. Evaluate and communicate:** Open and continuous communication is a key success factor in any organizational change initiative, and QWL is no different. Consistently evaluate outcomes, keep organizational leaders informed about the impact of the initiative, and use multiple channels to communicate progress to employees.
- 8. Learning:** Successful change requires ongoing reflection and learning by the committee and other change champions. This dynamic approach involves continuous feedback loops and adjustments to the initial plan. Avoid taking a "paint-by-numbers" approach, where change is viewed as a linear, step-by-step method of implementing a program.
- 9. Ongoing support:** Allocate resources that ensure that QWL actions can be sustained. Managers and supervisors may require training, time and other support and incentives to enable ongoing improvements in work units.
- 10. Diffusion:** Expand the initiative to include other groups and work sites over time using the process described above to engage people through the organization so that the vision, and the actions needed to achieve it become theirs, too. Realistically, transforming the work environments of nurses and other health system workers can be achieved incrementally with persistence over several years.

From: Making a Measurable Difference: Evaluating Quality of Worklife Interventions. CNA, 2006⁴⁶

Appendix B

List of experts on the QWQHC

Coordinating Secretariat

Melissa Barton and supporting staff at the Canadian Council on Health Services Accreditation (including Kristina Van der Veer, Ileana Belanger, Paula Cecchetto, Ginette Laplante, Denise Seveny)

The following experts have volunteered their time and energy to develop the Quality Worklife-Quality Healthcare action strategy.

National Steering Committee

Wayne Strelloff (chair), Melanie Lavoie-Tremblay, (deputy chair), Derek Puddester, Edgardo Perez, Gaye Hanson, George Tilley, Jeanne Besner, John Perry, Joshua Tepper, Judith Dyck, Marie-France Maranda, Marlene Smadu, Pamela Fralick, Vicki Squires, Wendy Hill

Increasing Awareness & Engagement Working Group

Marlene Smadu (co-chair), Linda O'Brien-Pallas (co-chair), Steven Lewis, Glenn Hildebrand, Adam Somers, Mary Ferguson-Pare, Tanya Dunn-Pierce, Lisa Nowlan, Marla Fryers, Victor Trotman, Judith Dyck, Liane Craig

Indicators and Measurement Working Group

Jeanne Besner (co-chair), Linda McGillis Hall (co-chair), Vicki Squires, Robin Carriere, Evangeline Danseco, Emily Gruenwoldt, Bev Mathers, Greta Cummings, Heather Laschinger

Priority Strategies Working Group

Derek Puddester (co-chair), Michael Cuddihy (co-chair), Pamela Fralick, Larry LeMoal, Larry Myette, Irmajean Bajnok, Patricia Boucher, Jaclyn DesRoches.

Knowledge Exchange Working Group

Melanie Lavoie-Tremblay (co-chair), Janet Helmer (co-chair), Mylene Dault (co-chair), Gaye Hanson, Andrew Taylor, Della Faulkner, Heather Laschinger, Irmajean Bajnok, Todd Watkins, Leanne Campbell, Katrina Loeffler

Appendix C

Executive Summary of QWQHC Environmental Scan

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

- *Shared vision and values between all levels in healthcare delivery.*
- *Use existing networks and capacity as a foundation to move forward.*
- *Use experience from other sectors and professionals as quality worklife is an issue for many economic sectors, both private and public and a variety of professional and occupational categories.*
- *Create opportunities for innovation and new ideas in management and governance as well as new models of healthcare delivery.*
- *Horizontal and vertical integration to move beyond silos and “turf” and ensure frontline investment.*
- *Ethics in decision-making in practice environments and supporting individuals facing difficult choices.*
- *Responsiveness to a range of organizational and provider groups ensures an inclusive approach.*

The recommendations developed based on the research activities include:

Knowledge Exchange

- *Storage and access to documented knowledge resources;*
- *Collection, storage, exchange of leading and promising practices;*
- *Customized knowledge products;*

- *Knowledge exchange options;*
- *Internal and horizontal knowledge transfer and skill development.*

Quality Worklife

- *National promotion and awareness;*
- *National action strategy;*
- *Governance and senior management leadership and accountability;*
- *Access to information on leading practices;*
- *Identification and use of QW indicators;*
- *Worklife survey tools, specific indicators and data systems;*
- *Education and training;*
- *Research and organizational impact assessment;*
- *New knowledge generation;*
- *Collaboration and partnership;*
- *Quality worklife funding programs;*
- *Link to Health Human Resources (HHR) planning and implementation; and*
- *Moving knowledge to implementation.*

National Coordination

- *National coordinating functions related to QW and related KE activities.*

For more information, please consult the Full report (www.chsrf.ca): Hanson et al. 2007 *Quality Worklife Quality Healthcare Collaborative (QWQHC) Environmental Scan*.



Appendix D

Examples of Key Knowledge Exchange Vehicles from the QWQHC Environmental Scan (Gaye Hanson et al, 2007)⁴⁴

Explicit Knowledge

- **“Newswire” Services Electronic Journals, Newsletters, E-bulletins**, – this e-bulletin or newsletter service would be a brief synopsis of new publications, resources and initiatives that would be delivered to subscribers weekly with up to three pages of brief descriptions with embedded web links for more information. This provides an opportunity to scan for new information, knowledge and initiatives without spending a lot of time.
- **List serves**
- **Media Relations and Press Releases**
- **Website** – a website could house a number of searchable databases, electronic reports/documents/resources, customized information or knowledge products, web streaming of multi-media segments or presentations, downloading of pod casts, a place for networking or meeting of members of specific groups or communities of practice etc. The website would have to be actively managed to ensure it is up-to-date and changing regularly to keep visitors interested. Respondents also underlined the need for a website to have capacity to support dialogue between users.
- **Internet and Intranet** – both Internet and Intranet (internal to the organization) support information access and exchange as well and Intranet based chat rooms, forums, teleconferences, videoconferences and other applications.
- **DVD – Written Documents or Reports**
- **Combination Methods** – for improved uptake, combining methods may be more effective. For example, sending an email announcing a report that has been released followed up by a web link to the report in the email or a mailed hard copy to follow by mail.

- **Brief Information on Leading Practices and other Initiatives – Research Fact Sheets – Best practices guidelines**
- **Ready to Use Materials** – for creating customized posters, brochures and newsletters. A gallery of photos, graphics, articles and stories could be easily uploaded and used in developing internal communication tools.
- **Case Studies** – case studies may be researched and published in the healthcare Management Forum or alternative publication. A variety of case studies can be used to support education and training processes as well as informing QWL implementation.
- **Tools and Indicators** – identify and support access to worklife surveys and other monitoring tools such as specific indicator development, survey instruments, data system development and support for analysis and reporting of data collected.

Tacit Knowledge

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

- **Facilitating Relationship Building and Knowledge Exchange** – a matching or electronic introduction service could assist in connecting people with useful information, knowledge and experience with those that need to know.
- **Organizational Visits or Exchange Programs** – providing representatives from one organization to talk to, visit and do work exchanges with a “sister” organization could be a very effective vehicle for sharing information and knowledge within the context of professional relationships.
- **Organizational QWL Surveys and Feedback** – information created by the collection and analysis of data is very relevant to an organization and can be used to develop interventions. The sharing or comparison process between units or departments within one organization or with other organizations can be a foundation for relationships and knowledge exchange related to interventions and sharing success.
- **Mentorship Programs** – mentorships could be established on an individual or organizational level. If provided with financial support, visits and communication between mentors and mentees could be facilitated.
- **Formal Education and Training** – quality worklife and quality healthcare curriculum needs to be included in undergraduate and graduate programs that educate healthcare workers at all levels. In addition, ongoing professional and other education and training needs to be targeted toward all levels of decision makers and care providers. Key external organizations such as unions and professional regulatory organizations need access to training as well.
- **Face-to-Face Dialogue Opportunities** – meetings, seminars, workshops, conferences, national roundtable/forum and leadership gatherings all provide opportunities for dialogue in person, which is a very important vehicle for establishing relationships

and opening channels of communication and sharing of information and knowledge. Bring together researchers, academics, employers, employees, regulatory bodies and other decision makers to work through a process of knowledge exchange.

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



List of References

- ¹ Standing Senate Committee on Social Affairs, Science and Technology (2002a). *Interim Report on the State of the Healthcare System in Canada*, Volume 4. Ottawa. ON
- ² Canadian Medical Association, CMA Study on Physician Burnout. CMA Centre for Physician Health and Well-Being, November 2003.
- ³ Maranda, M.F. Gilbert, M.A., Saint-Arnaud, L. and Vezina, M. (2006) *La Détresse des médecins : un appel au changement*. Québec : Les presses de l'Université Laval.
- ⁴ Cho, J., Laschinger, H. K. S. & Wong, C. (Under review). Workplace empowerment, work engagement and organizational commitment of new graduate nurses. *Canadian Journal of Nursing Leadership*
- ⁵ Greco, P., Laschinger, H.K.S. (2005). The effects of leader empowering behaviours on staff nurses' empowerment and work engagement.
- ⁶ Canadian Institute for Health Information. *Health Care in Canada 2004*. Ottawa: CIHI (www.cihi.ca) 2004: 76.
- ⁷ Statistics Canada. *Work Absence Rates 2005*.
- ⁸ Canadian Institute for Health Information. *Health Care in Canada 2006*.
- ⁹ Ontario Hospital Association *Absence Survey, 2004*.
- ¹⁰ BC Auditor General Report: *In Sickness and In Health, 2004*
- ¹¹ Health Canada, Office of Nursing Policy. *Our health, our future: Creating quality workplaces for Canadian nurses*. Final report of the Canadian Nursing Advisory Committee. Ottawa: Health Canada, 2002.
- ¹² HEAL, *Canadian Views on National Strategy for Health Human Resources*, April 2006.
- ¹³ Voluntary Hospitals of America. *Business Case for Workforce Stability*. 2002.
- ¹⁴ Lowe, G., Schellenberg, G. (2001). *What's a Good Job? The Importance of Employment Relationships*. CPRN.
- ¹⁵ Yassi, A., Hancock, T. *Patient Safety – Worker Safety: Building a Culture of Safety to Improve Healthcare Worker and Patient Well-being*. *Healthcare Quarterly* Vol. 8, Special Issue. October, 2005.
- ¹⁶ Yassi, A., Gilbert, M., & Cvitkovich, Y, 2005. Trend in injuries, illnesses and policies in Canadian healthcare workplaces, *Canadian Journal of Public Health*, 96(5), pp. 333-339
- ¹⁷ Campbell, A. *Spring of Fear. The SARS Commission Final Report*. January 2007.
- ¹⁸ Kingma, M. (2001). Workplace violence in the health sector: A problem of epidemic proportion. *International Nursing Review*. 48, 129-130.
- ¹⁹ Flannery R. B., & Everly, G. S. Jr. (2004) *Critical incident stress management (CISM): updated review of findings, 1998-2002*. *Aggression and violent behaviour*. 9, 319-329.
- ²⁰ The Health Communication Unit, University of Toronto. *"The case for comprehensive workplace health promotion – Making "Cents" of a Good Idea"* www.thcu.ca/Workplace/documents/business%20case%20v102.pdf accessed Feb 2007
- ²¹ Tattersall, Bennett, Pugh (1999). *"Stress and Coping in Hospital Doctors."* *Stress Medicine*, 15(2) 109-113.
- ²² Schweitzer, M., Gilpin, L., Frampton, S. *Healing Spaces: Elements of Environmental Design that Make and Impact on Health*. *The Journal of Alternative and Complementary Medicine*. Vol. 10, Supplement 1, 2004, pp. S71-83.
- ²³ <http://www.planetree.org/about/welcome.htm>
- ²⁴ Doran, D., Sanchez McCutcheon, A., Evans, M.G., MacMillan, K., McGillis Hall, L., Pringle, D., Smith, S., Valente A. *Impact of the Manager's Span of Control on Leadership and Performance*. Canadian Health Services Research Foundation, September 2004.
- ²⁵ Registered Nurses' Association of Ontario (2006). *Developing and Sustaining Nursing Leadership*. Toronto, Canada: Registered Nurses' Association of Ontario.

- ²⁶ Golden-Biddle K., Hinings C.R., Casebeer A., Pablo A., Reay P. *Organizational Change in Healthcare with Special Reference to Alberta*. Canadian Health Services Research Foundation, April 2006.
- ²⁷ *Commitment and Care*, Canadian Health Services Research Foundation, 2001.
- ²⁸ Health Canada, IECPCP framework.
- ²⁹ Besner J., Doran D., McGillis Hall L., Giovannetti P., Girard F., Hill W., Morrison J., Watson L. *A Systematic Approach to Maximizing Nursing Scopes of Practice*. Canadian Health Services Research Foundation, 2005.
- ³⁰ *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses*. Final Report of the Canadian Nursing Advisory Committee, 2002.
- ³¹ Bournes, D., Ferguson-Paré. Innovations in Nurse Retention and Patient Centered Care. Change Foundation Grant #05033. Progress Report 2: November 2005-May 2006
- ³² Firth-Cozens, Greenhalgh (1997). "Doctors' Perceptions of the Links between Stress and Lowered Clinical Care." *Social Science Medicine*, 44 (7), 1017-1022
- ³³ Gaba D.M, Howard S.K. *Fatigue among Clinicians and the Safety of Patients*. *New England Journal of Medicine*, 16 (347), 1249-1255. October 2002.
- ³⁴ Lockley S. et al. *Effect of Reducing Interns' Weekly Work Hours on Sleep and Attentional Failures*. *New England Journal of Medicine*, 18 (351), 1829-1837. October 2004.
- ³⁵ Ellis, J., Priest A., MacPhee, M. and Sanchez McCutcheon, A. *Staffing for safety: A synthesis of the evidence on nurse staffing and patient safety*. Canadian Health Services Research Foundation. 2006.
- ³⁶ O'Brien-Pallas, L., Thomson, D., McGillis Hall, L., Pink, G., Kerr, M., Wang, S., Li, X. & Meyer, R. *Evidence-based Standards for Measuring Nurse Staffing and Performance*. Canadian Health Services Research Foundation, September 2004
- ³⁷ Rogers, A. E., Hwang, W.-T., Scott, L. D., Aiken, L. H., & Dinges, D. F. (2004). The working hours of hospital staff nurses and patient safety. *Health Affairs*, 23 (4), 202-212.
- ³⁸ Aiken, L.H., Clarke, S.P., and Sloane, D.M. (2002) Hospital staffing, organization, and quality of care: cross national findings. *International Journal for Quality in Health Care*, 14(1), 5-13.
- ³⁹ Hickam DH, Severance S, Feldstein A, et al. The Effect of Health Care Working Conditions on Patient Safety. Evidence Report/Technology Assessment. Agency for Healthcare Research and Quality. April 2003.
- ⁴⁰ Baldwin D.C. Jr, S.R. Daugherty, R. Tsai et M.J. Scotti Jr. (2003). A National Survey of Residents' Self-Reported Work Hours: Thinking Beyond Specialty. *Academic Medicine* 78 (11), p.1154-1163
- ⁴¹ Arnetz B.B. (1997). Physicians' view of their work environment and organization. *Psychotherapy and psychosomatics*, 66(3), p. 155-162.
- ⁴² Registered Nurses Association of Ontario. *The 70 per cent Solution: A Progress Report on Increasing Full-time Employment for Ontario Nurses*. 2005.
- ⁴³ Koehoorn, M., Lowe, G., Rondeau, K.V., Schellenberg, G. (2002) *Creating High Quality Healthcare Workplaces*, Canadian Policy Research Network.
- ⁴⁴ Hanson G., Fahlman J., Lemonde M. *Quality Worklife-Quality Healthcare Collaborative Environmental Scan*. 2007.
- ⁴⁵ Canadian Physiotherapy Association. *Position Statement: Health Human Resources Planning*. February 2006.
- ⁴⁶ Lowe, G. *Making a Measurable Difference: Evaluating Quality of Worklife Interventions*. Canadian Nurses Association. 2006.



