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Introduction

The Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU) appreciate the opportunity for national nursing associations and nursing unions to share information, explore trends and identify priorities. Again, we look forward to working with others to develop strategies for global nursing workforce issues.

CNA is a federation of 11 provincial and territorial nursing organizations. In Canada, provincial/territorial organizations tend to perform both professional and regulatory functions. CNA’s mission is to advance the quality of nursing in the interest of the public. Its vision is to see registered nurses collectively contributing to the health of Canadians and the advancement of nursing.

CFNU represents 123,000 Canadian nurses, including registered nurses, licensed practical nurses and registered psychiatric nurses working in hospitals, long-term care facilities, our communities and in our homes. CFNU has every provincially based nurses union, except Québec, as a member. Its mission is to give voice to nurses’ and patients’ concerns when they are discussed on Parliament Hill and in the national media. It also takes very seriously the protection and improvement of Canada’s health care system, which has served Canadians so well.

1. SEW Developments

Demographic Influences

Canada is a country of more than 31.7 million people. Its land mass totals almost 10 million km² and is divided into 10 provinces and three territories. The responsibility for health policy is shared among national and provincial/territorial governments. However, the responsibility for workplace and labour issues falls to provincial and territorial governments.

Canadian demographics for 2003 show 31.9 per cent of the population is under 25 years, 38.1 per cent is between 25 and 50 years, and 30 per cent is 50 years or older. Life expectancy is approximately 81 years for women and 76 years for men.

In 2001, average earnings for full-year, full-time Canadian workers was $35,258 Cdn for women and $49,250 Cdn for men. The national unemployment rate as of April 2004 was 7.3 per cent. The major Canadian employers in 2003 are the manufacturing industry, the retail trade industries, health and social service industries and other service industries.¹

Nurses, like other health professionals, are employed by the government, hospitals, nursing homes, privately owned organizations or as independent contractors. Provincial legislation defines scope of practice for all health professions. Licensure, credentials and standards of performance are established and monitored by national or provincial professional regulatory bodies. The regulatory bodies are publicly accountable for the appropriateness of these standards and for ensuring that those individuals awarded a licence to practise have the necessary skills, abilities and competencies to meet the standards.

¹ All statistics were derived from Statistics Canada’s website: http://www.statcan.ca
Health Care in Canada

The structure of Canada’s health system includes both publicly (government) and privately funded services. The publicly funded component of the system ensures universal access to physician and hospital services, regardless of an individual’s income. The publicly funded component accounts for 70 per cent of health system expenditures. Public opinion polls confirm that the majority of Canadians remain committed to Canada’s public health care system.

In most provinces, privately owned organizations deliver particular health services, such as dietetics and nutritional counselling, diagnostic laboratory services, physiotherapy, speech therapy and rehabilitative services. Privately owned organizations also offer services directly to Canadians and through employers’ insurance plans, thus covering the costs of various health services.

During the last decade, governments in Canada reduced their investments in the system of publicly financed, publicly administered and universally available health care. Some provincial governments concurrently allowed greater participation in the system of for-profit entities. This trend includes contracting out nursing services.

There has been some action taken over the past year in response to various reviews and studies of the health care system. This action, however, has been fragmented and sporadic with no national framework for most issues. In December 2003, Canada saw the retirement of the leader of the governing Liberals and the instalment of a new leader, Paul Martin. On May 25, 2004, the prime minister unveiled a detailed, comprehensive plan to preserve and enhance health care for Canadians. He notes that health care must be based on need and not income and that the task is to preserve and enhance our publicly funded and administered system of health care. The plan for health care renewal includes new funding and detailed measures for reform that must be implemented working in concert with the provinces and territories. The results of the latest federal election, held June 28, 2004, leave the Liberal party in a position to form a minority government with 135 seats won. To form a majority government, a political party must win 155 seats. In this election, no one party won enough seats to form the majority. To advance the political agenda, the government will have to negotiate alliances with members of Parliament of all political stripes, who will act according to the priorities they see as necessary to get them re-elected. The possible political priorities will be:

- health care and reduction of waiting lists
- investing in infrastructure and direct support to municipalities – large and small
- support for manufacturing and agricultural sectors
- accountability

Major initiatives underway, or proposed to the health system, include: primary health care reform; a national public health agency; a national patient safety institute; a national pharmacare strategy; reduction of waiting times in targeted areas of cancer, heart disease, diagnostic imaging, joint replacement and sight restoration; a national homecare program; and a national immunization strategy. Improving access to care, addressing all illnesses (including mental illness), patient safety and public vs. private funding remain the contentious issues.

While health human resources remain a fundamental issue to the sustainability of the health system, no national health human resource strategy exists despite calls from the nursing and medical community.
Developments in Pay and Working Conditions

In 2002, the federal government released the Canadian Nursing Advisory Committee report which clearly articulated the issues of concern for Canadian nurses and laid out a series of recommendations to address those concerns. In 2003, the federal government released the *Report on the Nursing Strategy for Canada*, which describes the level of implementation of those recommendations. The report shows that for a few recommendations, such as increasing the number of education seats, implementation has been widespread. The report fails to note, however, that the number of seats still remains much lower than it was 10 years ago. On most issues, progress appears to have been made in pockets. Numerous barriers to implementation are noted, including accountability, resources, and collective bargaining. On a positive note, a number of policy-level supports have facilitated and would continue to facilitate implementation including targeted funding, monitoring mechanisms, evidence to support decision-making, and leadership positions for nursing. The report does acknowledge the difficulty in knowing the impact of these actions.

A separate report, *Trends in Illness and Injury-Related Absenteeism and Overtime Among Publicly Employed Canadian Registered Nurses*, released this year finds the impact of working conditions on nurses has worsened significantly between 2001 and 2002. The number of FTEs lost to absenteeism increased by 1,800 between 2001 and 2002 to the equivalent of 10,808 full-time, full-year nursing jobs. Between 1997 and 2002, the rate increased from 6.8% to 7.9% – a 16.2% rise in absenteeism rate over five years.

The federal government is initiating a national survey on the health of nurses as it relates to working conditions. It will be conducted in 2005. CNA is a member of the national advisory committee for this study.

CNA continues its partnership with Health Canada’s Office of Nursing Policy (ONP) and the Canadian Council on Health Services Accreditation (CCHSA) in its work on quality work life indicators for nurses in Canada. CCHSA will reflect the results of the feasibility study in the subsequent version of its national indicators list. CNA and CFNU both participate on the national advisory committee for this research.

Parallel work began in 2003, led by CCHSA and funded by ONP. CNA collaborates on two of the CCHSA work life initiatives. CNA participated in the second national consensus meeting (March 2004) on work life indicators. CNA also participates on the Work Life Advisory Committee. Its mandate is to advise CCHSA on the further development of the work life dimension of CCHSA quality framework and accreditation products.

Because Canadian nurses have increasingly expressed concern about the ability to deliver safe care in today’s work environments, much energy continues to be directed to the nurses’ role in patient safety. CNA hosted a think tank, *Patient Safety: Developing the Right Staff Mix* (December 2003), in order to review the increasingly difficult context in which staff mix decisions for RNs and licensed/registered practical nurses (LPNs) are made, to describe related policy and research initiatives, as well as to identify gaps and challenges. A position statement was developed in January 2004 on patient safety (see Appendix A). A discussion paper, *Nurses and Patient Safety: A Discussion Paper* (May 2004) was published to address the nursing perspective on patient safety, including the impact of staffing levels and staff mix. This was followed by another significant collaborative initiative with several partners to develop a joint

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3 Depending on where they are located in Canada, licensed practical nurses (LPNs) are also known as registered practical nurses (RPNs). In general, in this document, they are referred to as LPNs.
evaluation framework for RNs, LPNs and registered psychiatric nurses to determine the impact of staff mix decision-making (March 2004). Because research indicates that the professional practice environment of RNs directly affects client health outcomes, the professional practice environment for RNs in Canada continues to be a priority for CNA.

In September 2002, a National Steering Committee on Patient Safety issued a report\(^4\) identifying problems similar to those of other countries. The report outlined several recommendations, the first of which was for a national institute outside government to provide information and advice on patient safety issues. CNA advocated for nursing involvement in the creation of the Canadian Patient Safety Institute, established in December 2004, which will play a strong advisory and coordinating role in building a safer health care system. Two nurses were appointed to the nine-member founding board.

In May 2004, the first Canadian research\(^5\) on adverse events in acute care hospitals was released with results very similar to what was found in studies in Australia, New Zealand and the United Kingdom. CNA led and supported nursing organizations in responding to the new research. CNA welcomed the research results because they provide important information and will support the Association’s work and the work of others to improve the quality of practice environments. For further information, refer to Appendix B.

The British Columbia Nurses Union has issued the Patient’s Bill of Rights, which proposes significant improvements in what patients can expect when they go to an emergency room, require surgery, seek community health services such as home care, need a bed in a nursing home, require palliative care in the last days of their lives and want access to information about their care.

With British Columbians struggling to cope with hospital overcrowding, bed closures and the elimination of long-term care nursing homes, the Patient’s Bill of Rights represents both a challenge and an opportunity for the provincial government to engage in a dialogue with the general public and with health care providers about the resources needed to ensure patients get the care they need in British Columbia.

CNA and CFNU are exploring a Canadian patient’s bill of rights.

The proposed patient’s bill of rights would include, for example:

- for residents of urban and rural communities, the right to access an emergency department within a maximum of one-half hour travel time;
- the right to subsidized travel for patients who cannot get emergency hospital treatment in their own community; and
- the right of palliative patients to choose whether they want to die at home, in a hospice or in a hospital palliative care bed.

From a recent wave of positives gains, the pendulum swings again toward difficult negotiations.

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The United Nurses of Alberta (UNA), representing 21,741 nurses, has been involved in negotiations since January 2003. The employers outlined the following major concessions:

- the right to schedule permanent evening or night shifts
- the right to provide only 30 per cent day duty for those employees on rotating shifts
- the right to re-assign employees to facilities or cities on a permanent/temporary basis
- legislation of the UNA Collective Agreement.

The Newfoundland and Labrador Nurses’ Union (NLNU), representing 4,475 nurses, was informed by their employer that no money will be available for salary increases for this upcoming round of bargaining. In addition, the following issues were raised:

- All compensation areas, along with wages, were frozen in the Collective Agreement.
- There will be a possible reduction of statutory holidays by three days and sick days by one day a month, as well as changes to severance pay.
- There was no commitment for a joint trusteeship of the pension plan.
- Funding for indexing of the pension plan will be reduced, which means less money for retirees.

The British Columbia Nurses Union represents 24,974 nurses. The Nurses’ Bargaining Association has reached a framework agreement with the Health Employers Association of BC, which stipulated how bargaining discussions will be conducted. These discussions will deal with key professional practice concerns of RNs i.e. ways to improve patient care by addressing nursing issues during the continuing shortage of nurses.

This framework agreement guarantees the public that the health care system will not suffer disruption from nurses’ bargaining. It also gives nurses the assurance that their working conditions (patient ratios and full-time positions) will be a bargaining priority. To achieve this, nurses had to agree to a wage freeze and no concessions in the Collective Agreement for two (2) years.

The Ontario Nurses’ Association (ONA) is beginning legal action for 30 ONA members and their families against the Ontario Government in relation to the nurses’ contraction of SARS.

The Government mandated that health care workers comply with inadequate precautions. Nurses claim the Ontario government failed to properly enforce occupational health and safety standards in hospitals. Nurses also claim that in forcing them to risk their health, the government breached the Canadian Charter of Rights and Freedoms.

QUESTIONS FOR DISCUSSION

SEW Developments

☞ What are the trends in working conditions?
☞ What programs and strategies have been successful in improving the health of nurses?
2. Ethnicity and Diversity in the Nursing Workforce

Canada is becoming more diverse in terms of culture and religion than it has ever been.

While Canadians do not routinely collect national statistics on race or culture of health professionals in this country, it is widely accepted that our health professional population is not representative of the general public.

Immigration continues to be the main reason for diversity. The most recent census of 2001 indicates that the proportion of foreign-born Canadians is at its highest in 70 years. The number of visible minorities has increased three-fold since 1991.

Forty-nine per cent of Canada’s population is male; however, the proportion of males in nursing remains at five percent of the 239,957\(^6\) registered nurses employed in Canada. CNA commissioned a study, Men in Nursing (unpublished to date), exploring gender difference with respect to nursing to raise awareness of the issue and develop strategies to address this issue. A literature review was conducted, followed by Canada-wide focus groups with male high schools students and male nursing students. Male nursing students were attracted to nursing through direct experience with the profession and learning about nursing while in another field of study. The majority of both groups felt that the perceptions of society at large about the profession of nursing act as a deterrent for men to enter the profession. For the most part, participants felt that society at large does not know what nurses do. Sexual stereotypes are still seen as a major deterrent. The majority of young men in high school had not considered nursing as a career since they felt that the profession lacked prestige and recognition; the job tasks were not appealing to men; the work is too stressful and nurses are not paid enough for this level of stress. Overall, participants in both types of groups did not feel that the media portrays nurses in a positive light, nor does it portray what nurses can really do. The majority of young men did not receive information regarding nursing in high school. The profession was not identified by counsellors as one relevant to young men; counsellors did not know much about it; and if young men raised the profession as an option with counsellors, they were often deterred from pursuing it. These findings were validated through a national consultation.

There is a strong trend in Canada toward a representative workforce, where aboriginal workers are represented at all occupational levels (entry level, middle and senior management) in proportion to their numbers in the provinces’ populations. There has been some progress in increasing number of dedicated aboriginal nursing educational opportunities. Student attrition for aboriginal students and those whose first language is not English remains an issue. Many nursing schools are exploring innovative educational and support programs for aboriginal students. The achievement of a representative workforce requires changes in the workplace, improvements in the knowledge/skill attainment of potential aboriginal workers, and a comprehensive and focused employment development initiative.

A position statement on cultural competence was developed in March 2004 and is included in Appendix C.

Opportunities, Challenges and Strategies for a Diversified Nursing Workforce

Nursing regulatory bodies face the challenge of assessing internationally educated nurses for registration, a process that is becoming increasingly difficult. Language proficiency is a significant issue. Further, there is the challenge of facilitating the integration of these nurses into Canadian culture and the nursing workforce. Researchers studying the nursing workforce are challenged to work with privacy laws when gathering data that is culturally sensitive and may stigmatize cultural groups even with the de-identified personal information.

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CNA is co-leading a national taskforce on the integration of internationally educated nurses and is leading a project to better understand the registration and integration issues facing nurses immigrating to Canada. CNA is developing a line of web-based tools and resources to support internationally educated nurses in making informed decisions about working as an RN in Canada before they come to Canada. The first tool, the LeaRN CRNE Readiness Test, was released earlier this year (see Appendix D).

Several educational programs are providing dedicated seats for minorities. CNA will be developing a strategy to increase the level of diversity in the nursing workforce, including the number of men. CNA is also part of a working group with the Aboriginal Nurses Association of Canada, the Canadian Association for Schools of Nursing, and the First Nations and Inuit Health Branch, looking at strategies to increase educational opportunities for aboriginal nursing students. Earlier this year, Saskatchewan Union of Nurses (SUN) signed the Aboriginal Employment Development Program (AEDP) agreement with the Saskatchewan Association of Health Organizations and Saskatchewan Government Relations and Aboriginal Affairs regarding a representative workforce strategy. The goal of this agreement is to create specific cooperative initiatives to prepare and develop the aboriginal workforce and facilitate the integration of aboriginal people into Registered Nurse and Registered Practical Nurse positions in Saskatchewan.

Considerable cooperative work is required for this strategy to be effective. There will need to be outreach in the secondary school system to encourage aboriginal students to enrol in math and science classes throughout high school. Aboriginal nursing students will need access to nursing seats in culturally sensitive programs. In order to recruit and retain nurses in a manner that reflects the changing demographics of this province, we will need to work towards raising awareness and building bridges between nurses.

The partnerships contain the following common goals:

- to develop a bilateral or multilateral process that promotes fairness, equity, trust, respect, dignity and consistency;
- to work with the aboriginal community, unions and employees;
- to develop programs to facilitate constructive cultural and race relations;
- to promote aboriginal employment and career development;
- to build links to the aboriginal labour force;
- to develop programs promoting employment opportunities for aboriginal people; and
- to build business development initiatives for further employment opportunities.

**QUESTIONS FOR DISCUSSION**

**Ethnicity and Diversity**

What strategies have been successful in creating a diverse workforce?

For countries with a high percentage of males, what strategies were successful for them in achieving this goal?
3. Migration

At this time, a person interested in immigrating to Canada as a registered nurse must apply to one (or more) of the 12 nursing regulatory bodies. The regulatory bodies assess each applicant’s professional qualifications, educational credentials, and language proficiency, among other criteria. This process may involve reviewing and assessing the curriculum of foreign nursing schools. It can take up to 18 months to process each application. If an applicant applies to more than one jurisdiction, the process is repeated.

CNA recognizes the need to develop a national, standardized approach to facilitate the integration of internationally educated nurses (IENs) into the Canadian nursing workforce.

As of 2002, 6.9% of the RNs employed in nursing graduated from a foreign nursing program. Since 1998, the proportion of foreign graduates in the workforce has remained between 6 and 7%. However, the intent to migrate has risen greatly over the years as evidenced by the number of foreign applicants and the number writing the licensing exam. The number writing the CRNE for the first time has increased greatly over the last 5 years from 560 in 1998 to 2402 in 2003. The number of foreign-educated nurses applying for RN registration in Canada is increasing rapidly, as reported by provincial/territorial RN regulatory bodies. In 2002, over 4,000 international nursing graduates applied for licensure as a RN in Canada. Of those, only ~1400 or 35% met the educational and language requirements to be eligible to write the Canadian Registered Nurse Examination (CRNE). There is also an issue of successfully passing the exam. Between 1998 and 2003, the average pass rate for foreign applicants writing the CRNE for the first time was 58%, compared to 93% for Canadian applicants.

Opportunities and Challenges

Canadian nursing regulatory bodies report increasing difficulty in assessing the credentials and education of foreign applicants. They would prefer to assess competencies and will be determining how best to do so. This will include the role of Prior Learning Assessment Recognition. Employers report integration problems, primarily in the areas of language proficiency, cultural integration and understanding of the health system. The challenge is to accurately track the migration of nurses. No sources are complete at this time.

Recruitment and Retention Strategies

CNA has undertaken a number of initiatives on this issue. They include:

- co-leading a national taskforce on the integration of internationally educated nurses;
- leading a project to identify and assess the current practices and policies with respect to licensure of international applicants for each of the three regulated nursing groups;
- developing a regulatory framework diagram for international applicants to guide this work (see Appendix E);
- developing a principles-based approach to immigration with the following characteristics: transparent, competency-based, fair, national and ethical.
- developing key concepts for a position statement on International Nurse Applicants (will be presented at the November 2004 CNA Board)
- membership on advisory committee for Prior Learning Assessment Recognition research specific to nursing; and
- developing a web-based readiness test to allow foreign applicants to assess their readiness to write the CRNE.
QUESTIONS FOR DISCUSSION  
Migration

What kind of system is being put in place to accurately track migration?
What international efforts are being taken to manage migration?

4. Pay Equity
Québec has actively pursued pay equity since 2001 and is the only province to do so. Since that time, the inter-union body composed of the several unionized organizations representing public sector employees worked with the Treasury Board to define a plan free of sexist bias. The evaluations have been completed, evaluated and harmonized. Over 10,000 employees participated and as of May 10, 2004, the unions are still asking government to support the work of the inter-unions and make pay equity a reality in Québec.

QUESTIONS FOR DISCUSSION  
Pay Equity

Are pay equity initiatives part of the bargaining agenda (total compensation package)? Or should they be?

5. Impact of Technology on the Nursing Profession
Technology continues to grow in the health care field and is seen as both a help and a risk. During the SARS outbreaks, there was a disturbing lack of equipment for appropriate isolation and for the protection of nurses and other health care workers. Two nurses who contracted SARS through occupational exposure died in the months following this public health crisis. Many government commitments were made to attend to these concerns, task force reports were written and organizations are attempting to better prepare for all types of infectious outbreaks.

Technology is also seen as a cost driver in the health care system and the federal government is developing a strategy in collaboration with the provinces and territories to guide technology assessment and growth based on values including population benefits. CNA was represented in the consultations on the strategy but nothing concrete has emerged. The Canadian Coordinating Office for Health Technology Assessment leads health technology assessment in Canada and has received increased funding in recent years.

There continues to be a strong interest among Canadian ministers in health information technology. Presently, the national health information system, Canadian Institute for Health Information (www.cihi.ca), aggregates various kinds of data on human resources (e.g. numbers, categories, ages of personnel by province or health care setting), illness or chronic conditions of Canadians and health service delivery information (length of stay, type of facility). While this system provides a growing and valuable source of information, the vast majority of the clinical care data is physician centred. The data which is abstracted from each patient chart is taken only from the physician records.

Given the upsurge in developments around electronic health records, and the government investment in making them interoperable, CNA is advocating for national clinical care data standards. Many clinical data systems for nurses and other care providers are in use but are different from one organization to another even in the same city block. We are promoting multidisciplinary clinical care data standards to be developed at the national level and are promoting the ISO standard 18104, which establishes ICNP® as a
reference terminology model that can connect the clinical care data of many nursing vocabularies and possibly those of other disciplines.

This work is just beginning, and we cannot report much uptake at this time. We feel that the inclusion of nursing in future pan-Canadian electronic health care records is under threat, and we will continue to encourage nurses to participate in informatics projects at all levels. The majority of nurses are not well acquainted with this issue or its potential value to enhancing knowledge creation, building the evidence base for nursing and patient safety. CNA is currently seeking funding to develop resources which could address these issues.

QUESTIONS FOR DISCUSSION
Technology and its Impact

Is nursing care and its impact reflected in health care records (electronic or paper) and in national health care data?

6. Nurse/Patient Ratios

Workload has historically been an issue of concern for registered nurses. Conflicts may arise between nurses’ duty to obey their employer and accept all patient assignments given to them and their duty to the patients and the profession of providing appropriate care to each one.

It is now accepted that workload problems have been exacerbated (nursing shortage and shorter length of stay). While it is widely recognized that reducing workloads by adopting minimum nurse/patient ratios would solve the problem, to date no decision has been made on following this route in Canada’s provinces. However, Ontario, Saskatchewan and British Columbia are currently considering the issue.

CNA has identified scope of practice as an emerging strategic issue, expressing concern over whether changes to staffing patterns are being made safely. CNA has developed two position statements as a framework to address these complex issues: *Scopes of Practice* (2003) – a joint statement with the Canadian Medical Association and the Canadian Pharmacists Association, and *Staffing Decisions for the Delivery of Safe Nursing Care* (2003). These two position statements are included in Appendixes F and G. The position statements provided a basis for a CNA think tank, *Patient Safety: Developing the Right Staff Mix* (December 2003). Participants included over 70 clinical nurses, educators, researchers, government representatives and policy-makers, nurse administrators, employers and union representatives. Registered nurses, licensed/registered practical nurses and registered psychiatric nurses from almost all the provinces and territories were represented.

The purpose of the think tank was to review the increasingly difficult context in which staff mix decisions for registered nurses (RNs) and licensed/registered practical nurses (LPNs) are made, describe related policy and research initiatives and identify gaps and challenges. General agreement emerged on the following points:

- Errors in nursing staff mix can lead to clinical errors that may result in adverse patient and organizational outcomes.
- Decisions about nursing staff mix must be evidence-based.
- Decisions about nursing staff mix must consider the core competencies of RNs and LPNs, the acuity and complexity of patient care needs and the available environmental supports.

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7 In this context, nurse means both RN and LPN.
• Many RNs and LPNs are concerned that the increased use of unregulated health care workers, without appropriate role definition, threatens patient outcomes.

There was also general agreement on several issues related to research and knowledge transfer. Following recommendations from the think tank, CNA undertook a successful collaborative project to develop a joint evaluation framework to determine the impact of staff mix decisions (March 2004). Representatives from the Canadian Nurses Association, the Canadian Practical Nurses Association and the Registered Psychiatric Nurses of Canada participated in the project. The purpose of this project, funded by Health Canada, was to support employers to maximize the scope of practice of nursing staff. Staff mix can be defined as: “the combination and number of regulated and unregulated persons providing direct and indirect nursing care to clients in all settings where” regulated nursing groups (RNs, LPNs, RPNs) practice. This project relates to recommendation No. 19 from the final report of the Canadian Nursing Advisory Committee (CNAC), *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses* (2002), which addresses maximizing nurses’ scope of practice. Based on a literature review and the results of a national web-based survey, a framework was developed to address patient outcomes, nurse outcomes and system outcomes. After each of the national associations conducts an internal consultation of this working document, a collaborative consultation of a revised draft will be undertaken with external stakeholders.

7. Non-Hospital Work Environments

One of the major issues in non-hospital work environments in Canada over the past decade has been the drastic cuts to public health infrastructure, including the elimination of many registered nurse positions. This became evident during the SARS experience here in Canada last year. Nurses working in public health report that their work is unrecognized and undervalued. They also report that their voices are not heard in the decision-making process.

CNA commissioned the report *The Value of Nurses in the Community* to highlight the role of community nurses and their contribution to the health system. This paper has generated much discussion.

In 2004, post-SARS, the federal government announced funding to rebuild public health infrastructure, including the creation of a Canadian public health agency and support for capacity building among health professionals in public health.

Home-based Nursing

In 2002, 4 per cent of those RNs employed in nursing in Canada worked in home care. Last year marked the release of a national home care sector study which CNA supported. Key findings showed the following:

- Wage differentials between home care and other health care settings make it difficult to attract and retain home care workers, particularly in professions already facing shortages.
- High staff turnover means that home care workers are often not as experienced as those they are replacing. This “experience gap” has emerged alongside the need for more specialized skills necessary to handle more complex care needs and greater use of medical technology.
- Home care workers report noticeable workload increases over the past five years.
- The need to work long hours to make a decent living is cited by many home care workers as a key stress, as is the reality that many home care workers operate in virtual isolation from peers.
- Nurses raised a range of concerns about supervising and assigning tasks to unlicensed personnel, including accountability, delegation of regulated acts, and maintaining standards of practice.

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**Nursing Homes**

In 2002, 8.8 per cent of RNs employed in nursing in Canada work in long-term care. Due to fiscal restraints, many RN positions in nursing homes have been eliminated and replaced by practical nurses. This matter has raised concerns over patient safety including the issue of abuse/neglect in nursing homes. The acuity of patients in nursing homes is also increasing. Some monies are beginning to be introduced back into nursing homes to create more nursing positions as a result of these issues.

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**QUESTIONS FOR DISCUSSION**

**Non-Hospital Work Environments**

- How are others dealing with the broadness of public health as opposed to just the timely components of public health such as bioterrorism and communicable diseases?
- How are others dealing with insufficient community resources to support people in the management of chronic disease?
- How is the issue of substitution, especially in non-hospital environments, being addressed?

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8. **Working Hours**

**Part time vs. Full time**

Budgets cuts to health care over the last decade resulted in the loss of many full-time nursing jobs. The CNAC report identified an optimal goal of 70% of nurses working full time. Current statistics show that 54.1% of RNs work full-time, 33.8% part-time and 11.8% casual. It’s a difficult goal to achieve because so many nurses have no desire to work full time, citing unhealthy working conditions, family responsibilities and a lack of flexibility in scheduling, among other issues. Temporary, full-time positions specific for new graduates were secured to support their integration into the workforce.

**Overtime**

The situation of overtime for RNs in Canada is worsening. The report, *Trends in Illness and Injury-Related Absenteeism and Overtime Among Publicly Employed Canadian Registered Nurses*, finds overtime has increased significantly between 2001 and 2002:

- One in five part-time nurses (18.7%) worked overtime each week.
- Full-time nurses were more likely to report overtime hours (28.4%).
- Weekly overtime increased for full-time nurses from 15.9 % to 28.4 %.

**Overtime trends provincially:**

**Newfoundland and Labrador**

- Employers are reverting back to an increased use of casuals.
- There is an increase in part-time positions.
- New graduates have secured full-time, permanent work. A large number of the graduating class of 2004 is planning to leave the province. The main reasons are the lack of permanent work and the wage freeze.

**Manitoba:**

- A committee was struck to study ways to increase the number of full-time positions.
- 34% of nurses work full time as compared to 56% nationally.
- About 1300 nurses work at two to four jobs to earn a living.
The recommendation of Manitoba’s Provincial Joint Committee is to increase full-time nursing positions to be implemented through attrition.

**Ontario:**
- The Minister of Health and Long-Term Care indicated a need for employers to create 8000 new full-time nursing positions by reducing agency and overtime costs.

**British Columbia:**
- 41% of the nursing jobs in 2002 were full-time positions.
- The British Columbia Nurses Union and health care authorities are trying to bring full-time nursing positions up to 51% by March 31, 2006.
- Casual positions are to be reduced by 20%.

### QUESTIONS FOR DISCUSSION

#### Working Hours

- Have other countries defined goals for full-time/part-time nursing? Have they achieved these goals, and if so, how?
- What strategies are being used to secure full-time positions for new nursing graduates?

### 9. Job Design and Programs for the Older Nurse

Demographic information clearly shows a potential labour and nursing shortage for the future. This trend is happening when the aging Canadian population will likely be in need of more health care services.

If retention programs for older workers are to be optimal, a closer examination of pension legislation is needed. Collective agreement language should be strengthened to include: the reduction of work hours; the creation of mentoring positions; respect for shift work preferences – allowing the refusal of night shifts; and added bonuses for older workers, such as maximizing retirement allowance beyond the services threshold and increased vacation.

### 10. Future Options and International Strategies

It is a pleasure for CNA and CFNU to be able to exchange information, ideas and strategies on nursing excellence and workforce issues. In closing, we would like to pose the following questions:

- What are the global implications of these trends?
- Where should national nursing associations collectively invest their energy over the next year? Over the next five years?
- What links might be made between the outcomes of this workforce forum and the health care meetings and conferences staged during 2003-2004 in other international forums?
- Are there any future strategies that should be considered related to the WHO Strategic Directions for *Strengthening Nursing and Midwifery Services*?
- Should ICN collaborate with WHO (to create a meta-database of information sources on health care staff) and attempt to establish an international nursing workforce data set (including the same information collected by each country using the same definitions) so we can perform international comparisons?
APPENDIX A:

Position Statement

PATIENT SAFETY

Canada’s health care system is thought to be among the safest in the world. However, as large studies in several countries have shown, health care systems are prone to error and failure, and the risk of adverse events is significant. Problems with patient safety are seen as being driven by systemic factors such as rapid changes in the health care system, increased use of technology, restricted resources including shortages of qualified professionals and the quickening pace of work.

Canadian nurses have increasingly expressed concern about the ability to deliver safe care in today's health care system. Given the commitment of nurses expressed in the first value of the Code of Ethics for Registered Nurses to provide “safe, competent and ethical care,” nurses are experiencing increasing moral distress as they continue to work in environments that are not able to support quality professional practice. Much work has been done by nurses to address concerns for patient safety, as evidenced by the growing body of research on best practices and the Canadian Nurses Association’s (CNA) promotion of quality practice environments and appropriate human resource planning in the health system, but much remains to be done.

CNA POSITION

Patient safety is the prevention and mitigation of unsafe acts within the health care system. For nursing it must mean more than that. It means being under the care of a professional health care provider who, with the person’s informed consent, assists the patient to achieve an optimum level of health, while at the same time ensuring that all necessary actions are taken to prevent or minimize harm. Patient safety is fundamental to nursing care and health care across all settings and sectors. It is not merely a mandate; it is a moral and ethical imperative in caring for others.

Providing safe, competent and ethical care to patients within the health care system is a shared responsibility of all health care professionals, health care organizations and governments and requires the involvement of the public.

CNA believes that providing for patient safety involves a wide range of actions at the level of the individual nurse, the profession, the multidisciplinary team, the health care organization and the health care system. These actions must include adequate clinical support for nurses by nurse managers. It is also critical to patient safety that nursing care data are collected and interpreted at the national level to support research on best nursing practices.

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1 Studies in the United States, United Kingdom, Australia and New Zealand indicate that adverse events occur in the range of 3.7 - 16.6 percent of all hospitalizations, summarized in Nursing: AGRotence Outcomes (Down, 2000). Canadian rates of adverse events in acute care are being investigated and are expected to be released in early 2004.
2 An adverse event is an unintended injury or complication that results in disability, death or prolonged hospital stay and is caused by health care management. This is the definition being used by researchers in the CIHI-CHHR research on Adverse Events in Canadian Hospitals (Canadian Institute for Health Information, 2002).
3 Nurses refer to registered nurses, throughout.
5 (CNA, 2001).
6 (CN, 2002).
7 (CNA, 2000).

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CNA further believes that the escalating shortage of registered nurses, the use of inappropriate staffing practices and the understaffing and underskilling of health care services pose a significant threat to patient safety and contribute to incidents of failure to rescue. Present workloads are at times so heavy that nurses are unable to develop therapeutic relationships, make the comprehensive assessments needed and seek nursing or other expertise as required. Such workloads also prevent experienced nurses from being available to guide less experienced nurses. The casualization of the nursing workforce over the last decade, in the interest of cost-reductions, has also contributed to decreasing the availability of nurses to mentor other nurses and, at the same time, reduced the continuity of care, which in and of itself is a threat to patient safety.

Human health resource issues impacting on patient safety, such as those indicated above, must be addressed on a system level and be evidence-based. An appropriate balance must be sought between full-time nursing personnel and part-time, casual and temporary personnel. In terms of staff mix, an evidenced-based approach must be central to decisions on the nursing competencies: therefore, the level and mix of nursing staff required for a particular patient population in a particular setting. Even with the right numbers of nurses and the right mix of nursing competencies, nurses in clinical leadership and unit management roles must have a span of control that reasonably permits them to provide supervision and support for nurses that will ensure patient safety.

Patient safety cannot be achieved without system accountability and system competence. Efforts to analyze and reduce adverse events in the provision of health care are most effective when such events are viewed as system failures. This concept represents a paradigm shift from a culture of individual blame to a culture of safety in which reporting adverse events is required and promoted. While individual competency may be a contributing factor, and individuals remain accountable for their own actions, it is increasingly evident that system competency plays a major role in patient safety. Only when adverse events and near misses are reported can they be analyzed collaboratively to identify and address problems in the system.

Patients have the right to know when an adverse event has occurred in their care and to have appropriate treatment to address the problem as fast as possible. When such an event results in injury or even death, there must be open and honest communication with the patient or the family as soon as possible. The implementation of clear agency policies on the reporting of adverse events and near misses, and on disclosure of adverse events to the patient and family, are necessary to support good clinical practice and to the overall improvement of patient safety in the system.

Nurses must advocate for an environment in which nurses and other health care workers are treated with respect and support when they raise questions or intervene to address unsafe or incompetent practice. Whistleblowing legislation should be enacted in all jurisdictions so that, after all avenues of addressing the problem have been tried, nurses who speak out publicly in good faith can be protected from reprisals.

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8 (Needleman, Buerhaus, Matke, Stewart, & Zelevansky, 2001).
9 (Aiken, Clarke, Cheung, Sloane, & Silber, 2003).
10 (Cloise & Aiken, 2003).
11 “Nurses must be committed to building trusted relationships on the foundation of meaningful communication, recognizing that building this relationship takes effort. Such relationships are critical to ensure that a patient’s choice is understood, expressed and advocated” (CNA, 2003, p. 11).
12 (CNA, 2003).
13 (National Steering Committee on Patient Safety, 2002).
14 “Nurses must strive to prevent and minimize adverse events in collaboration with colleagues on the health care team” (CNA, 2002, p. 9).
16 Whistleblowers are people who expose negligence, abuses or dangers, such as professional misconduct or incompetence, which exist in the organization in which they work. In health care institutions, nurses may be the first to recognize unsafe practices or to identify actual or potential hazards (CNA, 1999).
17 (CNA, 2003, p. 17).
18 (Sinclair, 2001, chap. 10).
The practice environment enables or hinders nurses and other health care professionals in their ability to provide safe care. Developing and supporting quality professional practice environments is a responsibility shared by practitioners, employers, governments, regulatory bodies, professional associations, educational institutions, unions and the public.\(^{19}\)

Strong leadership across the nursing profession is essential to moving forward the cultural reform that is required to ensure the delivery of safe quality care in professional practice environments.\(^{20}\) The number of first-line managers should be sufficient to allow reasonable levels of contact with nurses in the practice environments. In settings where the majority of the staff are nurses, the first-line manager should be an experienced nurse with strong leadership abilities.\(^{21}\)

Nurses have a significant contribution to make in protecting and improving patient safety. As the principal health care providers with the patients, overseeing, co-ordinating and providing care 24 hours a day, seven days a week, nurses are ideally positioned to strengthen the safety net for patient care. The nursing perspective on reducing errors and improving systems must be part of a collaborative approach involving the public, other professions, employers and governments. Adequate resources must be made available to undertake this work at all levels of the health care system.

**BACKGROUND**

Studies in the United States, the United Kingdom, Australia and New Zealand have shown that adverse events may occur in anywhere from 3.7 per cent to 16.6 per cent of all hospital admissions and a significant portion of these may be preventable.\(^{22}\) Canadian rates of adverse events in acute care hospitals are being investigated through research funded by the Canadian Institute of Health Information and the Canadian Institutes of Health Research.\(^{23}\)

Nursing has always given the highest priority to patient safety. Nursing associations at the provincial, territorial and national levels have centred their work around patient safety and promoting excellence in nursing practice in the interest of the public. CNA, over many decades, led the development of standards of nursing practice, education, administration and the Code of Ethics for Registered Nurses. CNA develops and advocates nursing and public policy that promotes not only patient safety but also high standards of health care and excellence in nursing practice.

Provincial and territorial nursing associations and colleges regulate the practice of nurses. They continually develop and maintain standards of nursing within their jurisdictions through many programs, including licensure, disciplinary procedures and requirements for continuing competence, often with the involvement of other health care professionals and public representatives. CNA develops and maintains the Canadian Registered Nurse Examination.

This combination of setting and promoting standards for the profession at the provincial/territorial and national levels has worked well in guiding individual practice to ensure patient safety. What has changed in recent years is the recognition that while the systems aimed at promoting and ensuring individual competence and accountability

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\(^{19}\) (CNA, 2001).

\(^{20}\) (Affonso, Jeth, Derean, & Ferguson-Parl, in press).


\(^{22}\) See footnote 1.

\(^{23}\) See footnote 2.
are very necessary, they are not enough. Patient safety cannot be achieved without system accountability and system competence.

Patient safety concerns need to be evaluated and addressed as system-wide problems. The various movements for continuous quality improvement have tried to bring appropriate attention to system issues, but there continues to be a strong reliance on what is expected to be the flawless performance of individuals. Often this is the expectation without regard to circumstances. We are still working in a ‘culture of blame’ in which the investigation of adverse events is focused on assigning responsibility to individuals.

Within the national dialogue on patient safety, CNA participated in and was strongly supportive of the report of the National Steering Committee on Patient Safety, which recommended, among other important directions, the creation of a Canadian patient safety institute. The 2003 federal budget provided for $10 million annually to support the creation of the new institute, and CNA continues to participate in the development of the institute.

The work of CNA on promoting quality professional practice environments is one of our most important initiatives for patient safety. CNA is also a member of the Canadian Coalition on Medication Incident Reporting and Prevention and supports various efforts of other groups in relation to research on quality work-life indicators, dissemination of drug safety information, patient falls and other initiatives related to patient safety.

Central to CNA’s work on patient safety is the recently revised Code of Ethics for Registered Nurses. The Code provides an up-to-date framework of values and professional obligations to guide nurses’ actions in promoting and advocating for patient safety. It speaks to the many responsibilities for individual practice, such as obtaining informed consent, advocating for the patient’s right to self-determination and disclosing of error. In addition, it highlights the importance of the practice environment, and nurses’ duty to advocate for a quality practice environment and the human and material resources necessary to ensure safe and competent ethical care.

November 2003

References:


See footnote 13.


APPENDIX B:

Canadian Institutes of Health Research

Landmark Patient Safety Study Provides First National Estimate of Adverse Events in Canadian Hospitals

TORONTO (May 24, 2004) – The first national study of patient safety in Canadian hospitals estimates that 7.5 per cent of people hospitalized in Canada have experienced an adverse event as a result of their care.

“The Canadian Adverse Events Study: the incidence of adverse events in hospital patients in Canada”, to be published in the May 25 edition of the Canadian Medical Association Journal, found that the overall rate of adverse events in 2000 was 7.5 per 100 patient admissions, not including pediatric, obstetric or psychiatric admissions. This rate suggests that 185,000 of the almost 2.5 million medical and surgical admissions in Canada in 2000 were associated with an adverse event - defined as an unintended injury or complication resulting in death, disability or prolonged hospital stay caused by health care management rather than the patient's underlying condition.

Researchers from seven Canadian universities, led by the University of Toronto (U of T) and the University of Calgary (U of C), analysed the adverse event rate after reviewing 3,745 adult patient charts, randomly selected from 20 acute care hospitals across five provinces (B.C., Alberta, Ontario, Quebec and Nova Scotia). The study also found that:

- the majority of adverse events resulted in temporary disability or prolonged hospital stay
- five per cent of patients who experienced adverse events were judged to have a permanent disability
- adverse events were associated with death in 1.6 per cent of patients admitted to acute care hospitals
- surgical care accounted for the largest number of adverse events
- close to 37 per cent of adverse events in the study were potentially preventable. Based on this, the researchers estimate there were 70,000 preventable adverse events across the country in 2000.

“Our study indicates that care in Canadian hospitals is safe for the vast majority of patients,” says Prof. Ross Baker, PhD, principal investigator of the study and professor of health policy, management and evaluation at U of T. “However, certain patients are experiencing injuries and complications related to their care, some preventable. The good news is, this study gives hospitals a clearer picture of the scope and nature of this issue and will help them to determine why these problems are occurring and to develop strategies to address them.”

“It would be a mistake to focus on the performance of individual health care providers when interpreting these findings,” says Dr. Peter Norton, head of family medicine at U of C and co-principal investigator of the study. “We recommend that hospitals and health providers focus on
system-wide changes - such as ensuring that medications don't look or sound alike - to reduce the number and likelihood of adverse events.”

This research provides the first national estimate of adverse events across a range of teaching and community hospitals using methods comparable to recent studies in other countries. Those studies reported adverse events rates ranging from 2.9 per cent in the United States to 16.6 per cent in Australia. This variation is at least partly explained by differences in study methods.

The Canadian study also found that teaching hospitals had a higher rate of adverse events than other hospitals. The authors attribute this to several factors, including: patients with more complex illnesses may be treated in teaching hospitals; the complexity of care in teaching hospitals means patients may receive care from several care providers, thereby increasing the potential for adverse events relating to communication and coordination of care.

The study was jointly funded by the Canadian Institute for Health Information (CIHI) and the Canadian Institutes of Health Research (CIHR).

“As we all know, adverse events can have a devastating effect for everyone involved. But pointing fingers will not solve the challenges identified today,” says CIHI’s newly appointed board chair, Graham Scott. “The key here is to take this information, learn from it and use those lessons to ultimately make our health care safer.”

“This study has been designed as a first step to help Canada's health care system better understand what adverse events are occurring in our hospitals,” says CIHR president Dr. Alan Bernstein. “It will help decision makers plan interventions and improvements that can make hospitals more effective and safe. CIHR and its Institutes of Health Services and Policy Research, and Population and Public Health are dedicated to supporting innovative research and initiatives designed to improve health care services in the interest of improving the health and quality of life of all Canadians.”

Initiatives already underway in Canada to address issues of patient safety and adverse events include the formation of the Canadian Patient Safety Institute (CPSI), established by the federal government to provide hospitals with information about how to make care safer.

“Every region of the country and every health profession will have a unique perspective on this landmark study and on the issue of patient safety,” says CPSI chair Dr. John Wade. “However, the best long-term solutions will come from a truly national effort that brings together health providers, educators and the public in a spirit of collaboration and problem-solving. This is the approach the Canadian Patient Safety Institute will help make possible in Canada.”

The national research team includes Virginia Flintoft, RN, MSc, Adalsteinn Brown, DPhil, and Drs. Ed Etchells and Philip Hébert at U of T; Drs. William Ghali and Maeve O'Beirne and Luz Palacios-Derflingher, MSc, at U of C; Dr. Sumit Majumdar at the University of Alberta; Dr. Sam Sheps at the University of British Columbia (UBC) and Dr. Robert Reid of UBC and the Group Health Cooperative, Seattle, WA; Régis Blais, PhD, at the Université de Montréal; Dr. Jafna Cox at Dalhousie University; and Robyn Tamblyn, PhD, at McGill University.
For further information on this study, please visit: [www.cihr-irsc.gc.ca](http://www.cihr-irsc.gc.ca)

To view the full version of this study, please visit the Canadian Medical Association Journal website.

For media assistance please contact

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APPENDIX C:

PROMOTING CULTURALLY COMPETENT CARE

KEY CONCEPTS

Cultural competence is the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients. Cultural competence includes valuing diversity, knowing about cultural mores and traditions of the populations being served and being sensitive to these while caring for the individual.

CNA believes that to provide the best possible patient outcomes, nurses must provide culturally competent care.

CNA believes the responsibility of supporting culturally competent care is shared between individuals, professional associations, regulatory bodies, health services delivery and accreditation organizations, educational institutions and governments.

RESPONSIBILITIES

Responsibilities include, but are not limited to the following:

• **Individual nurses** are responsible for acquiring, maintaining and continually enhancing cultural competencies in relation to the clients they care for. They are responsible for incorporating culture into all phases of nursing process and in all domains of nursing practice.

• **Professional and Regulatory Nursing Organizations** are responsible to establish and promote standards encouraging culturally competent care. As well, they are responsible to encourage and support the integration of people from diverse backgrounds into the profession.

• **Accreditation Organizations** are responsible to develop and test performance indicators and to measure health care organizations’ ability to provide culturally competent care and positive responses to diversity.

• **Educational Institutions** are responsible to integrate issues of diversity and culture into curricula and to provide educational programs that enable nurses to acquire, maintain and enhance cultural competencies. They are responsible to remove barriers and promote access to education for members of diverse communities and to provide programs that aid nurses from diverse cultures to make the transition to work effectively in the Canadian health care system. They are also responsible to carry out research related to cultural competence in collaboration with other stakeholders.

• **Government** is responsible to promote a climate of diversity and acceptance, to fight racism and to ensure that health care systems promote culturally competent care. Government is also responsible to provide funding to enable the provision of culturally competent health services and the research that supports an evidence-based approach.

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1 A client may be an individual, a family, a group or a population.

2 Domains of nursing practice include clinical practice (direct care), education, research and administration.
• Health Service Delivery Organizations are responsible to create environments that promote a positive response to diversity. They are also responsible to organize physical and psychological structures, systems and supports for the delivery of culturally competent care. Systems and supports include:
  1. Developing, implementing and regularly evaluating organizational policies and practices to ensure cultural competence;
  2. Ensuring effective cross-cultural communication with diverse clients;
  3. Providing regular and frequent professional development opportunities and resources in order to build the cultural competence of staff;
  4. Developing, implementing and evaluating strategies to recruit, retain and integrate people from diverse backgrounds and culturally competent staff throughout the organization;
  5. Designing, implementing and evaluating services to meet the health care needs of the community;
  6. Ensuring active and meaningful participation and representation of community members in organizational processes, including governance, by identifying and implementing innovative strategies.
  7. Regularly evaluating results of efforts and monitor progress toward cultural competence; and
  8. Establishing mechanisms to develop meaningful research and evaluation methodologies, knowledge and data.5

BACKGROUND

Canadian nurses4 define culture broadly, referring to shared patterns of learned behaviours and values that are transmitted over time, and that distinguish the members of one group from another. In this broad sense, culture can include: ethnicity, language, religion and spiritual beliefs, gender, socio-economic class, age, sexual orientation, geographic origin, group history, education, upbringing and life experiences.6

It is important for nurses to provide culturally competent care to Canadians. The three main reasons are as follows.

• Nurses have a duty to provide ethical care to their patients. CNA's Code of Ethics for Registered Nurses provides clear guidance about how nurses carry out professional responsibilities with respect to culture.

• Nurses are providing care to a Canadian population that has a greater variety of cultures than ever before. A comparison of 1996 to 2001 census results shows the per cent of visible minorities rose from 11.2 to 13.4.7 The proportion of the population with a mother tongue other than English or French rose by 12.5 per cent with Chinese having grown to the third most common mother tongue.8 While Canada is still predominantly Roman Catholic and Protestant in religion, there has been growth in Islam, Hinduism, Sikhism and Buddhism.9 The proportion of traditional nuclear families consisting of mother, father and children continued to decline over the last 20 years, in favour of a variety of combinations.10

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4 For the purpose of this statement, the term nurse, refers to a registered nurse.
6 (Crouter & McNaughton, 2002).
7 (Canadian Mental Health Association, 2002).
8 (Statistics Canada, 2001).
9 (Statistics Canada, 2001).
10 (Statistics Canada, 2001).

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• In Canada, culture is considered to be one of the 12 key determinants of health. A determinant of health is a "complex set of factors or conditions that determine the level of health of all Canadians." Understanding and providing culturally competent care will make a difference to the health outcomes of many cultural groups including Canada’s aboriginal population. Aboriginals, primarily North American Indian, Métis and Inuit, have grown to comprise 4.4 per cent of the population in 200113 and have higher rates of infant mortality, chronic disease and suicide than other Canadians.13

March 2004

References

10 (Statistics Canada, 2001).
12 (Statistics Canada, 2001).
13 (Health Canada, 2003).

Also see

CNA Position Statements:
- Educational Support for Competent Nursing Practice (1998)
- Evidence-Based Decision Making and Nursing Practice (2002)
- Framework for Canada’s Health System (2000)
- Human Rights (1991)
- International Trade and Labour Mobility (2000)

Related ICN Position Statements:
- Ethical Nurse Recruitment (2001)
- Nurses and Human Rights (1998)
- Nurses and Primary Health Care (1978)
- Nursing and Development (2000)
APPENDIX D:

Introduction to the LeaRN™ CRNE Readiness Test

Welcome to the Canadian Nurses Association (CNA) LeaRN CRNE Readiness Test. This test will help you in assessing your readiness to take the Canadian Registered Nurse Examination (CRNE). The CRNE is the test you must pass in order to become licensed as a registered nurse (RN) in all provinces or territories in Canada except Québec.

For further information, visit CRNE. For further information on the Québec licensing exam visit Ordre des infirmières et infirmiers du Québec.

LeaRN CRNE Readiness Test is the first of a series of tools and resources trademarked under the title LeaRN that will be offered by CNA. LeaRN tools and resources are being provided to assist nurses to meet requirements to be licensed as RNs in Canada and integrate into the Canadian health care system.

What is the LeaRN™ CRNE Readiness Test?

The LeaRN CRNE Readiness Test is a mock, online, shortened format of the CRNE. The test includes 100 multiple-choice questions. All the questions on the test are from previous CRNEs. The questions on the test are matched with the CRNE in terms of level of difficulty and are presented in the same proportions as the CRNE with respect to:

- questions related to each of the six CRNE competency categories;
- questions addressing specific client age groups and client types; and
- case-based versus independent (stand-alone) questions.

The test provides you with an opportunity to take real exam questions presented in a similar manner to the CRNE. While the actual CRNE is a paper and pencil exam, this test is done completely online. Doing the test online allows an instant percentage score to be returned to you after you submit your test. You will also see the range of percentages required to pass the CRNE since June 2000. You will also receive your six sub-scores based on the CRNE competency categories, which should help you in focusing your continued study for the CRNE.

Of course, this is a mock test and is shorter than the actual CRNE. Your result on this test should not be the only thing you consider when deciding when to write the actual CRNE. Issues such as your personal circumstances, how much time you have spent preparing to take the CRNE and your own confidence level in writing the CRNE are some factors to take into account.

Purchasing the Test

When you are ready to begin the test, click the purchase test button above, located in the main menu. You will be first asked to check to ensure your system meets all the requirements for taking the test. Next, you will be asked for information about yourself that is necessary to process your credit card payment such as your name and address. We will also ask you to provide some additional information about your nursing education and experience. Completion of this information will help us to learn more about the users of this test.

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The next step is paying for the test. You pay online at a secure site using a credit card. The cost for the test is $42.79 including GST, in Canadian funds. After submitting your payment for the test, you will be sent a password by e-mail. You will need this password and your e-mail address to take the test.

After you have received your e-mail with your password, click on the link within the e-mail to go back to the test site.

**Taking the Test**

After you have purchased the test and are ready to begin, click the login button on the menu above. You will be asked to provide your e-mail address and the password given to you in the e-mail. Once you have entered this information and clicked the submit button, you will be provided with instructions about taking the test. After you have read the instructions click the “Start Test” button. You will receive the first of a sequence of 100 multiple-choice questions. Each question has four choices for an answer. The questions will either appear as independent (stand-alone) questions or will be part of a series of 4 or 5 questions based on a case.

When taking the test, you will benefit the most if you create a real testing condition. Otherwise, you will not be receiving a real indication of your performance on the test. You should take the test by yourself at a time when you do not anticipate interruptions. You should not use notes, books, calculators or other study aids during the test. However, it might be helpful to have a pen and paper handy for completing calculations and making notes. Jotting down a few notes regarding questions you find difficult may help guide future study. Please note, the note taking would need to occur during the test as the individual test questions cannot be reviewed again once you submit your test for scoring.

**Timing of the Test**

Two and one-half (2 ½) hours has been allotted for taking the test. This timing is set to be similar to the amount of time allowed per question on the real CRNE. It should allow you plenty of time to read the questions carefully and decide on your answers. The test comes equipped with a timer so you can monitor how you are doing in terms of time remaining to complete the test. You will be shown your time at the end of the test.

**How your Readiness Test results are reported**

Your result profile will include:

- Percentage obtained
- Percentages needed to pass the CRNE since June 2000
- Number of questions answered correctly in each of the competency categories
- Number of questions on the test in each competency category
- Percentage of questions answered correctly in each competency category

You can compare your result on the test to the standard required on the CRNE over the last few years. You can also use the information about how you performed in each of the competency categories to assist you in focusing your future study.
**Sample Test**

This sample test is a warm up tool to help you to become familiar with the style of the online Readiness Test, before purchasing the test. The sample test consists of 10 Canadian trivia questions covering Geography, Sports, Entertainment, Astronomy and History. You will receive a results report at the end of the sample test. Please note that this report is for the sample test only.

See Http://209.217.65.3/testbuild/index.html
APPENDIX E:

Figure 1: Canadian Nurses Association Regulatory Framework for the Integration of International Applicants

* Some exceptions may apply

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Appendix F:

Joint Position Statement

SCOPES OF PRACTICE

April 2003

Canada’s physicians, nurses, pharmacists and other health professionals recognize that a sustainable health workforce is a key challenge facing our health care system. In this regard, scopes of practice is an important issue that needs to be addressed.

The Canadian Medical Association (CMA), the Canadian Nurses Association (CNA) and the Canadian Pharmacists Association (CPhA) have approved the following principles and criteria for the determination of scopes of practice. The primary purposes of such determinations are to meet the health care needs of Canadians, and to serve the interests of patients and the public safely, efficiently and competently.

The CPhA, CNA and CMA believe that policy decisions taken in this area must put patients first. Secondly, they should be grounded in principles that reflect our commitment to professionalism, lifelong learning and patient safety. Thirdly, there be recognition of the need for legislative and regulatory changes to support evolving scopes of practice. Moreover, we believe that health professionals must be involved in decision-making processes in this area.

PRINCIPLES

Focus: Scopes of practice statements should promote safe, ethical, high-quality care that responds to the needs of patients and the public in a timely manner, is affordable and is provided by competent health care providers.

Flexibility: A flexible approach is required that enables providers to practise to the extent of their education, training, skills, knowledge, experience, competence and judgment while being responsive to the needs of patients and the public.

Collaboration and cooperation: In order to support interdisciplinary approaches to patient care and good health outcomes, physicians, nurses and pharmacists engage in collaborative and cooperative practice with other health care providers who are qualified and appropriately trained and who use, wherever possible, an evidence-based approach. Good communication is essential to collaboration and cooperation.

Coordination: A qualified health care provider should coordinate individual patient care.

Patient choice: Scopes of practice should take into account patients’ choice of health care provider.

CRITERIA

Accountability: Scopes of practice should reflect the degree of accountability, responsibility and authority that the health care provider assumes for the outcome of his or her practice.

Education: Scopes of practice should reflect the breadth, depth and relevance of the training and education of the health care provider. This includes consideration of the extent of the accredited or approved educational program(s), certification of the provider and maintenance of competency.
Competencies and practice standards: Scopes of practice should reflect the degree of knowledge, values, attitudes and skills (i.e., clinical expertise and judgment, critical thinking, analysis, problem solving, decision making, leadership) of the provider group.

Quality assurance and improvement: Scopes of practice should reflect measures of quality assurance and improvement that have been implemented for the protection of patients and the public.

Risk assessment: Scopes of practice should take into consideration risk to patients.

Evidence-based practices: Scopes of practice should reflect the degree to which the provider group practices are based on valid scientific evidence where available.

Setting and culture: Scopes of practice should be sensitive to the place, context and culture in which the practice occurs.

Legal liability and insurance: Scopes of practice should reflect case law and the legal liability assumed by the health care provider including mutual professional malpractice protection or liability insurance coverage.

Regulation: Scopes of practice should reflect the legislative and regulatory authority, where applicable, of the health care provider.

Principles and criteria to ensure safe, competent and ethical patient care should guide the development of scopes of practice for health care providers.

This document is based on a January 2002 policy developed by the Canadian Medical Association, which has been endorsed by the Canadian Nurses Association and the Canadian Pharmacists Association. We welcome the support of other health care providers for these principles and criteria regarding scopes of practice.

Reaffirmed by the Canadian Nurses Association’s Board of Directors, June 2003.
Appendix G:

Position Statement

STAFFING DECISIONS FOR THE DELIVERY OF SAFE NURSING CARE

CNA POSITION

CNA believes decision-making related to the delivery of safe nursing care, across the continuum of health care settings, must be based on the following key principles and criteria.

Principles for Decision-making

Decision-making is based on having the appropriate number of positions and the competencies required to ensure safe, competent and ethical care. Safety and client outcomes are primary concerns. While cost-efficiency is an essential element, the need to achieve good client outcomes, through an evidence-based approach, is central in making staffing decisions.  

Nurse administrators and managers (including supervisors, middle and senior managers) are responsible for ensuring the appropriate staff mix. In doing so, they recognize the learning needs of their staff and provide relevant educational opportunities for their staff. These nurse administrators and managers seek “input and participation in decision-making…from all those impacted by the decision.”  

Legislative, professional and organizational parameters are respected. Regulated care providers are accountable to the public through legislation. They adhere to their provincial/territorial standards of practice, codes of ethics and specialty practice standards. Decision-making tools and best practice guidelines direct them, when available. Organizational policies provide direction for all care providers.

The safety of clients must never “be compromised by substituting less qualified workers when the competencies of a registered nurse [RN] are required.” “The more complex the client situation and the more dynamic the environment, the greater the need for the RN to provide the full range of care requirements.” RNs determine how and when unregulated care providers can safely assist in the provision of tasks associated with nursing care. This includes being involved in decisions regarding the initial and ongoing use of unregulated care providers in an organization.

1 Competencies refer to the specific knowledge, skills, judgment and personal attributes required for regulated health professionals to practise safely and ethically in a designated role and setting.
2 Clients refer to individuals, families, groups, populations or entire communities.
3 Association of Registered Nurses of Newfoundland and Labrador, 2000, p. 5.
4 Staff mix refers to the combination and number of regulated and unregulated persons providing direct and indirect nursing care to clients in settings where registered nurses practice.
6 Registered care providers, for the purposes of this document, include registered nurses, licensed practical nurses and registered psychiatric nurses. Depending on where they are located in Canada, licensed practical nurses are also known as registered nursing assistants and registered practical nurses. Registered psychiatric nurses are registered to practise only in the following four provinces in Canada: Alberta, British Columbia, Manitoba and Saskatchewan.
7 (College of Nurses of Ontario, 2002, p. 4).

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The staffing decision-making process recognizes the unique and shared competencies of each care provider group. Each category of nursing care provider is a valued member of the health care team. The staffing process promotes optimal use of each provider’s competencies in the interest of providing safe, competent and ethical care.

Responsibility and accountability of care providers are clear. “RN[s] are familiar with the job description/scope of practice of any [care provider] to whom they are assigning or delegating.” Regulated care provider groups are held accountable to identify their competencies. Care providers must “identify when assignment of care exceeds their individual competency level, and... seek support and direction appropriately.”

RN[s] at all levels in the organization are involved in decision-making that affects nursing practice, client care and the work environment. RN[s] in direct care roles are invited to provide input through a discipline-specific structure, such as a nursing council. RN[s] “determine standards of client care in collaboration with other health care professionals.” The Code of Ethics for Registered Nurses states that RN[s] “must advocate... for sufficient human and material resources to provide safe and competent care.”

Staffing decisions are evidence-based. Organizations use a research-based approach to determine, implement and evaluate staffing mix, staffing patterns and models for delivery of care, based on achieving good client outcomes. This is done in consultation with RN[s] and other health care providers.

Organizations and other stakeholders, including RN[s], ensure that the elements necessary for a quality professional practice environment are in place. CNA’s position statement Quality Professional Practice Environments for Registered Nurses, outlines the elements and states that “developing and supporting quality professional practice environments is a responsibility shared by practitioners, employers, governments, regulatory bodies, professional associations, educational institutions, unions and the public.”

RN[s] are leaders in implementing collaborative practice and promoting effective communication among all members of the health care team. Collaborative working relationships among nursing care providers and within the multidisciplinary team of health professionals (e.g., nutritionists, pharmacists and physicians) facilitates all providers to work at their full scope of practice and within their level of competence. This is not only cost effective for employers but is in the best interests of clients.

Framework for Decision-making

Achieving optimal client outcomes is the central criterion for evaluation of staffing mix. Further criteria include preventing errors and achieving a quality professional practice environment that attracts and retains excellent staff. These criteria comprise three categories that provide a framework for decision-making related to staffing across the continuum of health care settings in Canada.

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10 (ARNNL, 2000, p. 6).
11 (CNA, 2001, p. 2).
13 (Alberta Association of Registered Nurses, 2002).
15 (CNO, 2002).

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Client

- Health care needs of the client are of primary concern when making decisions related to staff mix.
- Care assignments are influenced by the complexity of the health care needs of the client and by the predictability of outcomes in response to care provided. The more complex, acute and unpredictable, the more necessary it is to have care provided by RNs. "Reassignment of care may be necessary when a patient's health status changes and the assigned practitioner is no longer able to meet the client's needs." 14

Care Provider Competencies

- Care providers must have the competencies required to assess the client care situation, to understand the underlying contributing factors, to problem solve and intervene appropriately, to anticipate client needs, "to predict the outcome of an intervention, and to... respond with alternate interventions in the event of a lack of response or an untoward response to the intervention." 17
- Care providers whose competencies match the needs for care are the appropriate care providers. For example, when client conditions are stable and non-acute, the skills of a licensed practical nurse may be appropriate. When the client condition becomes more complex or acute, the skills of a RN are more appropriate. When the client is a family with complex issues, a community or a population, the competencies of a RN are required.
- Care providers are accountable to assess their own competencies, to recognize client health needs and to consult with someone more knowledgeable when a client situation demands expertise beyond their competency level or scope of practice. The right staff mix ensures there is someone available to provide the consultation.
- RNs have an in-depth and extensive knowledge base that is reflected in a broad scope of practice. They are the most comprehensive, productive, versatile, flexible and diversified of all nursing care providers 19 and can meet client needs at both basic and complex levels of care, whether in remote or populous settings.
- Competencies of care providers are affected by many factors. These include education, experience, professional development opportunities and familiarity with the setting.
- A clear understanding of the characteristics and competencies of the RN role is essential to ensure an appropriate staff mix in all health care settings.

The Practice Environment

- Practice environments affect client outcomes. 16 Staffing decisions made on the basis of client needs and care provider competencies need to be addressed within the context of the professional practice environment.
- In a quality practice environment, staff will have the supports – including a sufficient number of experienced RNs to provide mentoring, supervision and consultation – as well as sufficient staff to provide indirect care services, in order to allow for flexibility of staffing models.

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16 (ARNNL, 2000, p. 6).
17 (College of Registered Nurses of Manitoba, 2001, p. 2).
19 (CNA, 2003).

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• RNs who are asked to work in unfamiliar settings must identify the match between their own competencies and the health needs of the clients, as well as the environmental supports available to them, in order to determine if they are able to provide safe nursing care. This occurs, for example, when RNs (whether with advanced or minimal experience) are reassigned to meet a temporary staffing need.

• In a complex setting, where there is a high rate of client turnover, high client acuity and a high frequency of unpredictable events, there is a greater need for RNs.

• There is a need for all nursing providers to understand and communicate the policy related to their scope of practice within their work environment.

Background

Practice settings of RNs in Canada are staffed by a number of nursing care provider groups representing a wide range of educational preparation, competencies and scopes of practice.

The scope of practice, which is the “range of roles, functions, responsibilities, and activities which members of a discipline are educated and authorized to perform,” of RNs encompasses that of all other regulated and unregulated care providers. RNs are the most comprehensive, productive, versatile, flexible and diversified of these providers. Care from a RN is most linked to holistic and non-fragmented client care,” ensuring continuity of care. The competencies of RNs support holistic, responsive, client-centred care that meet practice standards in today’s dynamic health environment characterized by rapid change.

Regulated nursing care provider groups include RNs, licensed or registered practical nurses, registered psychiatric nurses and RNs with advanced nursing practice competencies. They are all accountable to their own regulatory bodies, within legislated scopes of practice, to adhere to standards of practice and codes of ethics.

Unregulated care providers have been introduced in various roles across the country. Accountability and job descriptions for unregulated care providers are determined at the organizational level and vary greatly from agency to agency and from one province or territory to another.

The mix of nursing staff on a unit has been linked to client outcomes. Research indicates that hospitals with more nurses per client or a higher RN skill mix are shown to have decreased mortality rates, lower rates of hospital readmission in the 30 days after discharge, shorter lengths of stay and fewer incidents of pressure ulcers, pneumonia, urinary tract infections and postoperative infections. In the area of home care, research demonstrated that care by baccalaureate prepared RNs “was associated with fewer visits” and “improved client outcomes.”

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21 (Shamian, 1998).
22 Advanced nursing practice is an umbrella term. It describes an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients (CNA, 2002).
24 (O’Brien-Follas, Doran, Munro, Cockrell, Stidai, Laurie-Shaw et al., 2001, p. 275).
25 (O’Brien-Follas, Doran, Munro, Cockrell, Stidai, Laurie-Shaw et al., 2002, p. 17).

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Research indicates that RNs’ comprehensive knowledge base prepares them to take leadership roles, make decisions with ease and apply research. These nurses play a leadership role within the collaborative model.

Making decisions concerning nursing staff mix is complex. RNs across Canada are finding themselves in challenging situations. Bound by professional and ethical responsibilities, they are expected to maintain client safety in spite of layoffs and the delegation of nursing duties to other health care workers, as well as substitution of RNs with other regulated nursing personnel.

Over the past decade, changes in the mix of nursing staff have led to overlapping scopes of practice with governments, employers and nursing providers needing to articulate responsibilities in specific work environments.

Provincial/territorial registered nursing regulatory bodies have developed decision-making resources for nurses with respect to staff mix. Related resources are also available regarding delegation and assignment of care, scope of practice and shared competencies.

The responsibility for the implementation of appropriate staff mix is shared among individual RNs, RN administrators and managers, employers, researchers, nursing associations and regulatory bodies, educational institutions and governments.

June 2003

References:


26 (Boblin-Cummings, Baumann and Deber, 1999; CNO, 2002; Brookes, 1998; Boyle, DiCenso, Baumann, Boblin-Cummings, Dyke and Mallette, 2000).


Also see:
