The Nursing Union Activist Focus Group Report

This report is part of an overall project entitled Building the Future: An integrated strategy for nursing human resources in Canada.

The Nursing Union Activist Focus Group Report
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Preface

This report is part of an overall project, **Building the Future: An integrated strategy for nursing human resources in Canada**. The goal of the project is to create an informed, long-term strategy to ensure that there is an adequate supply of skilled and knowledgeable nurses to meet the evolving health care needs of all Canadians. Through surveys, interviews, literature reviews, and other research, Building the Future will provide the first comprehensive report on the state of nursing human resources in Canada. The project comprises the following two phases.

**Phase I:** Research about the nursing labour market in Canada is being conducted in stages. Reports will be released as the research work is completed to share interim findings and recommendations with the nursing sector. A final report will be produced at the conclusion of this phase that will include all of the recommendations accepted by the Nursing Sector Study Corporation.

**Phase II:** A national strategy will be developed in consultation with government and non-government stakeholders that builds on the findings and recommendations presented at the completion of Phase I.

To oversee such a complex project, the Nursing Sector Study Corporation (NSSC) was created in 2001. The Management Committee of NSSC comprises representatives of the signatories to the contribution agreement with the Government of Canada and other government groups.

The multi-stakeholder Steering Committee for the project comprises approximately 30 representatives from the three regulated nursing occupations (licensed practical nurse, registered psychiatric nurse, and registered nurse), private and public employers, unions, educators, health researchers, and federal, provincial and territorial governments. The Steering Committee guides the study components and approves study deliverables including all reports and recommendations.

Members of the Management Committee and the Steering Committee represent the following organizations and sectors.

Aboriginal Nurses Association of Canada
Association of Canadian Community Colleges
Canadian Alliance of Community Health Centre Associations
Canadian Association for Community Care
Canadian Association of Schools of Nursing
Canadian Federation of Nurses Unions
Canadian Healthcare Association
Canadian Homecare Association
Canadian Institute for Health Information
Canadian Nurses Association
Canadian Practical Nurses Association
Canadian Union of Public Employees
Health Canada
Human Resources and Skills Development Canada

National Union of Public and General Employees
Nurse educators from various institutions
Ordre des infirmières et infirmiers auxiliaires du Québec
Ordre des infirmières et infirmiers du Québec
Professional Institute of the Public Service of Canada
Registered Psychiatric Nurses of Canada
Representatives of provincial and territorial governments
Service Employees International Union
Task Force Two: A human resource strategy for physicians in Canada
Victorian Order of Nurses for Canada

Together, we are committed to building a better future for all nurses in Canada and a better health system for all Canadians.
Executive Summary

This report describes the views of Canadian nurses who are union members on issues that affect their work environments. Practicing nurses from the three regulated nursing professions in Canada: registered nurses (RNs), licensed practical nurses (LPNs, referred to as registered practical nurses in Ontario), and registered psychiatric nurses (RPNs) participated in focus group discussions. This report complements the Canadian Nursing Labour Market Synthesis to be presented as part of the overall research for Building the Future.

The purpose of the focus group discussions was to examine nursing union activists' concerns about labour relations, work environment and conditions, retention and recruitment, employee assistance programs, and educational opportunities. Between June 2003 and March 2004, 33 focus groups were conducted across Canada. Each of the 10 provinces was represented in the total sample of 295 participants, and included RNs from northern Alberta. In terms of the three nurse groups, LPNs were over-represented. Also, full-time employment status was disproportionately high in this sample of focus group participants. The nurses' responses were organized according to six dimensions of stressors outlined in Kristensen's (1999) model for society, stress and health. According to this model, the optimal work environment for well-being includes: demands fitting the resources of the person; degree of basic predictability; degree of social support; degree of meaning; degree of influence; and balance between effort and reward. The six dimensions of this model provided the framework for the analysis and presentation of the findings.

Nurses from both hospital and non-hospital settings report workloads that are too heavy for the number of staff resulting in undue time constraints, decreased quality of care and lack of job satisfaction. Furthermore, the detrimental effects of poor working conditions on recruitment and retention are reportedly contributing to high rates of turnover that in turn, lead to decreased morale and further deterioration in the work environment. Participants indicated that resources are inadequate to address current health care demands. Closures of hospital beds had occurred without increasing community-based services, despite the requirement for higher complexity of care in the community due to shorter hospital stays. Nurses also state that equipment is not in working order, supplies are inadequate and computers malfunction regularly. In terms of care-giver skill mix, utilization of unregulated care-givers has raised concerns about the overall competency of the care team.

Sources of job unpredictability for nurses include risk of injury, workplace violence, and risk of burnout and illness. Community nurses expressed their sense of vulnerability, reporting dangerous situations causing them fear and risk of injury. Isolation and working alone is a particular challenge for nurses working in northern areas, making recruitment and retention problematic. Psychiatric nurses relayed their concerns about caring for aggressive patients and consequent workplace violence. Nurses feel that excessive work pressures in hospital and non-hospital settings are taking a toll on their physical and mental well-being.

In terms of workplace support, participants described nursing managers as lacking leadership skills, nursing experience and understanding of their workplace challenges. Furthermore, they reported that the lack of respect among nurses, particularly between RNs and LPNs, is decreasing morale and overall team functioning. They described educational support as being inadequate in that nurses are often...
unable to attend in-service sessions due to scheduling conflicts and lack of replacement staff, especially in northern areas. In-service education was claimed to be often inappropriate for the learning needs of nursing staff, and unresponsive to requests made by nurses. LPNs expressed that they do not have equal opportunity to attend the sessions, since RNs are often given priority for continuing clinical education. With respect to union support, nurses spoke of the adversarial nature of labour relations, the increasing numbers of grievances, the lengthy processing time, the budget constraints and the need to educate nurses about union matters. Positive statements about the role of nursing unions concerned providing support to patients and nurses, advocating for worker rights and safe work environments, and acting as a liaison between nurses and management. Others were less positive, referring to a lack of communication and action. Participants' responses about debriefing processes varied in relation to accessibility and adequacy. Some nurses spoke of the EAP (Employee Assistance Program) as being available but not always trusted.

In terms of nurses finding meaning in their work, LPNs across Canada commented about role confusion and lack of direction from their superiors. While most LPNs want to practice to their full scope, there are also those who are uncomfortable with increasing their level of responsibility. In terms of work meaning derived from the provision of holistic care, nurses repeatedly emphasized their belief that it is the patients that suffer the most when they, as the care-givers, are continually faced with excessive work pressures.

Lack of influence in nursing practice is an issue that was voiced, particularly by LPNs who perceive that RNs do not respect their contribution to patient care or afford them the independence they deserve. Nurses' having little control over their work schedules is also problematic. With the worsening nursing shortages and increasing difficulties in maintaining adequate staffing levels, nurses reported they are being pressured to work unscheduled shifts, many of which are at inconvenient times that impose on their personal time. Participants also commented on the lack of flexibility in scheduling vacation time.

Nurses identified several concerns pertaining to nurse salaries. An important issue for RNs is the pay inequity between community nurses and hospital nurses. Nurses from northern areas voiced concerns about the lack of pay differential and living allowances. LPNs reported that their increased scope of practice is not being accompanied by higher wages to reflect their additional responsibilities.

Some ideas for improving nurses' work environment were presented, some of which could be implemented locally at the unit level and others that would require cooperation. These recommendations include hiring more nurses, pay equity between the sectors, enabling nurses' input into decisions that impact their practice, improving educational and career opportunities, promoting improved working relationships between nurses, building better relations between employers and unions, and increasing managerial support for nurses.
1. Introduction

This report outlines the results of focus group discussions that were held with union nurses across Canada on issues that affect their work environments. The three regulated nursing professions, registered nurses, licensed/registered practical nurses, and registered psychiatric nurses, were represented. This report is intended to complement the Canadian Nursing Labour Market Synthesis to be presented as part of the overall research for Building the Future. The purpose of this component of the study was to capture the unique perspectives of union activists who act as a front for action on problems which affect unionized nurses and the quality of health care. They were given an opportunity to voice opinions about topics, including labour relations, work environment and conditions, retention and recruitment, employee assistance programs, and educational opportunities. To provide the context, the report begins with an account of the literature relating to health care restructuring, scope of practice issues, nursing unions and debriefing processes. This is followed by an overview of the methodology, conceptual framework, analysis processes, and presentation of the findings. The report concludes with recommendations for human resource policy to improve workplace environments for nurses. The following acronyms are used in this report.

- RNs registered nurses
- LPNs licensed/registered practical nurses
- RPNs registered psychiatric nurses
  (Note that although the acronym RPN refers to registered practical nurses in Ontario, Canada, it is not so used in this report. Also, RPNs are educated and regulated as a separate profession only in Manitoba, Saskatchewan, Alberta, and British Columbia).
- CNA Canadian Nurses Association
2. Literature Review

2.1. Search Strategies
A comprehensive literature survey was conducted using key words and phrases (see Appendix A). Published literature was searched using the databases MEDLINE, CINAHL, EMBASE, and PubMed. The use of published material included several reputable textbooks. The Internet provided access to grey literature such as reports, news releases, statistical data and databases, as well as documents from university-based academic research units, governmental publications, nursing unions and nursing regulatory bodies. In particular, websites of national and provincial nursing organization were accessed for current information (see Appendix A). RNs and LPNs are regulated in all provinces and territories whereas RPNs are unique to the four provinces of Western Canada.

2.2. Literature and Contextual Background

2.2.1. Health Care Restructuring
Since the early 1990s, health-care organizations in North America have undergone dramatic changes as a result of extensive downsizing, restructuring and merging (Burke & Greenglass, 2000). Hospital restructuring initiatives in Canada were categorized as processes of hospital redesign, strategic alliances and rationing of care (Shamian & Lightstone, 1997). In most provinces, health care restructuring involved a devolution of decision-making to the local level in order to contain costs, improve health outcomes, increase the flexibility and responsiveness of care delivery and better integrate and coordinate services (Lomas et al., 1997a). Unlike elsewhere in Canada, the Ontario government retained central control over funding and decision-making in the health care system (Ryan et al., 1998). In Ontario, hospital restructuring included a re-examination of the cost-effectiveness of the delivery of services that consequently placed tremendous pressures on patients, nurses and other health care professionals (O’Brien-Pallas & Baumann, 1999). Restructuring initiatives have involved downsizing of the workforce, with registered nurses increasingly being replaced by less well-educated practical nurses and nursing assistants (Robertson & Dowd, 1996; Burke, 2001b).

Studies have been conducted in Canada to examine the impact of restructuring, particularly redeployment and job change, on the working conditions and practices of nursing personnel. Nurses who were affected by job change were “more dissatisfied with their work environment, less confident in their practice, more concerned about the impact of restructuring on patient welfare and had less organizational commitment than nurses whose jobs were not affected by restructuring” (Baumann et al., 2001, p.19). Burke and Greenglass (2000) found that hospital restructuring and downsizing in Ontario resulted in greater emotional exhaustion and poorer health in the full-time nurses. Increased use of unregulated workers and significant increases in workload for nurses has resulted in longer hours and missed breaks, high stress levels, high job insecurity levels, poor morale, job dissatisfaction and deterioration of psychological well-being (Armstrong-Stassen et al., 1996; Burke, 2001b).

Health restructuring in the provinces involved a shift from acute care delivered in hospital settings to care in the community. The policy document, Human Resource Issues in Home Care in Canada: A Policy Perspective (Health Canada, 1999), which highlights the central role of home care, reports that...
agencies have been affected by an influx of acutely ill clients, growing use of health technology in the
home, new funding mechanisms which are putting downward pressure on reimbursement rates,
increased competition for public dollars by for-profit agencies, and new relationships with regional
health authorities. These changes are testing the capacity and skills of the home care workforce, as
home care employment issues include a large unregulated workforce, isolated work settings, and shared
responsibilities for care with family members.

From a British Columbia perspective, Ellis (2001) writes that as overtime and fatigue are common,
nurses may find themselves in the precarious position of having to self-assess their fitness to practice
and inform their managers if they believe they are too tired to provide competent care. Another workplace
issue threatening competency of care relates to nurse floating. In British Columbia, the Health and
Social Services Delivery Improvement Act (Bill 29) came into effect in January 2002. This Act extended
the concept of floating from within an agency to between agencies (Willson, 2002). However, if employers
choose to exercise their authority in reassigning nurses to alternate worksites, they are responsible for
supporting nurses to work within their level of competence.

Current national initiatives are indicative of efforts to improve the health care system. The
Commission on the Future of Health Care in Canada, headed by Roy Romanow, reviewed Canada's
health care system. Recommendations in the final report, Building on Values: The Future of Health Care
in Canada, were premised on three overarching themes: strong leadership and improved governance is
required to keep Medicare a national asset; the system needs to be made more responsive and efficient
as well as more accountable to Canadians; and strategic investments need to be made over the short-term
to address priority concerns, as well as over the long-term to place the system on a more sustainable
footing (Health Canada, November 28, 2002).

2.2.2. Scope of Practice in Nursing
2.2.2.a. Registered Nurses

All three categories of nursing are self-regulating professions in that the provincial/territorial
governments delegate to the nursing profession, by statute, the power to regulate itself. Regulatory bodies
for RNs have the legal requirement to set standards of practice for registered nurses to protect the public
in their province or territory (CNA, 2004). Registration and licensure ensure a minimum level of safe
practice at the time of initial registration and, as new knowledge is continually introduced to the field,
the individual must maintain and extend competence to meet the changing requirements required for
their practice setting. There has been a move in jurisdictions that have recently enacted new or amended
legislation for RNs to incorporate mandatory continuing education as part of the registration renewal
process for a license to practise (Ross-Kerr, 2003b).

Nearly three decades have passed since the first statement in Canada of the entry-to-practice
position for RNs by the Alberta Task Force on Nursing Education (1975). Entry to Practice 2000
(EP2000) refers to the goal endorsed by the CNA and the provincial nursing associations of attaining the
baccalaureate standard for RN initial registration to practice by the year 2000 (Wood, 2003). This goal
was not achieved by that year but a great deal of progress was made across the country. Implementation of the baccalaureate standard for RN entry to practice has taken place at the provincial/territorial level because this is where authority for health and education rests. The territories and Manitoba do not yet require a degree for entry to nursing practice and nursing diplomas are still available (Woods, 2003; www.gov.mb.ca).

2.2.2.b. Licensed Practical Nurses

During the 1980s and early 1990s when there was a perception of an abundance of health care dollars, nursing administration changed staffing ratios in acute care facilities in Canada to a higher mix of RNs (Canadian Practical Nurses Association, 2001). The role of the LPN was eroded as the permitted practice competencies were restricted and LPN positions eliminated. The widespread perception is that LPNs have not had any input as nursing administration made decisions about LPN utilization in nursing services (CPNA, 2003). Restricted practice and underutilization of LPNs across Canada has been a longstanding issue. The CPNA proposes that LPNs offer a solution to Canada's current nursing crisis if they are allowed to practice within their scope consistent with their educational preparation, experience, and practice setting (CPNA, 2001).

Steps to address the underutilization issue in LPN practice are varied. Greenlaw (2003) found in British Columbia an increase in LPN employment and utilization of their skills in assessment and medication administration, slightly more frequently in long-term care than in acute care. In Ontario, the College of Nurses of Ontario (CNO) Council made a motion (April 2004) to support the original December 2001 motion regarding the amendments to practical nurse registration regulation (RPNAO, 2004). The entry-to-practice requirement in 2005 will be a diploma from a College of Applied Arts and Technology. In Quebec, Bill 90 came into force in 2003 requiring LPNs to become educated on new clinical activities (taking blood samples, administering vaccines and inserting naso-gastric tubes) (Paradis, 2003).

Provincial initiatives are underway to provide clarification of practice expectations for all nursing categories. A Saskatchewan report, A Progress Report on Saskatchewan's Nursing Strategies (Saskatchewan Health, 2003), states that employers are developing new opportunities for LPNs to work to their full scope of practice to address the variation in their utilization across the province. The Nurses Association of New Brunswick and Association of New Brunswick Licensed Practical Nurses (2003) developed a framework to engage RNs, LPNs and employers in an ongoing dialogue about roles and working relationships, and differentiate scopes of practice between LPNs and RNs. RNABC guidelines (December 2003) state that the scope of LPN practice is fully contained within the scope of RN practice, and that increased client acuity requires closer collaboration between RNs and LPNs. RNs and LPNs provide nursing services within a continuum of care that acknowledges the separate and overlapping of provider roles. Although the RN is responsible for the overall direction of nursing care, she/he is not necessarily directly responsible for managing the performance of the LPN. As role expectations for LPNs' increase, nurses' unions are reminding employers and managers that practical nurse education varies depending on graduation year, therefore adequate workplace support for RNs and LPNs is critical when skills are upgraded and skill mix is altered.
2.2.2.c. Registered Psychiatric Nurses

Registered Psychiatric Nurses (RPNs) in Canada are only regulated in the provinces of Manitoba, Saskatchewan, Alberta and British Columbia where legislation provides all the responsibilities and privileges of a self-regulating profession. The government of Nunavut has entered into an agreement with the four psychiatric nursing jurisdictions so that RPNs can practice in Nunavut while maintaining registration in one of the four jurisdictions.

In western Canada, an average of 38% of RPNs work in hospital settings (both general and psychiatric); with an average of 23% working in community services (CIHI, 2003c). The other 39% work in a variety of settings including long-term care, psychogeriatric settings, educational institutions, correctional institutions and with self-help groups.

At least two of the four regulatory bodies have mandatory continuing competence programs, and a third will have it shortly under new legislation. The fourth province has a mandatory continuing education program. The education of RPNs varies from diploma to baccalaureate preparation for entry-level practitioners. The profession's goal is to have a degree as entry-level in all four jurisdictions. One difficulty with the achievement of that goal is the dearth of appropriate graduate programs for RPNs in Canada.

2.2.3. Nursing Unions in Canada

In Canada, professional nursing associations played key roles in the development of nursing unions. The Canadian Nurses Association (CNA) approved the principle of collective bargaining in the 1940s, affirming the provincial nursing associations as the bargaining agents (Ross-Kerr, 2003c). During the 1960s, nurses began demanding solutions to workplace inequality and unionizing to achieve social and economic justice. The employment relations committees of nursing associations gave advice on salary schedules and workplace conditions to employers, much of which was not accepted. In order to better serve the interests of their members, nurses' unions decided to separate from professional associations and create independent organizations (Larsen & Baumgart, 1988). By the mid-1970s, every province had the right to job action, but strike action has rarely been used, as nurses have traditionally been reluctant to exercise strike action (Larsen & Baumgart, 1988). Efforts to establish a national voice for unionized nurses were underway and, in 1981, the National Federation of Nurses' Unions (NFNU) was formed to represent Canadian unionized nurses, later changing its name to the Canadian Federation of Nurses' Unions (Ross-Kerr, 2003c).

Practical nurses followed a different unionization route than the RNs, being organized into the same bargaining units as other ancillary workers. For example, CUPE which was formed in 1963 is Canada's largest union and represents workers in health care, education, municipalities, libraries, universities, social services, public utilities, transportation, emergency services and airlines (http://www.cupe.ca/www/AboutOurUnion/). HEU is the BC Health Services Division of CUPE. Members of NUPGE, the second largest union in Canada, also work in a variety of public services (http://nupge.ca/aboutus.html).
The relationship between employers and employees has historically been defined by past practices, common law, and labour statutes (Hibberd, 1994). Over the years, employer control over employees has been replaced with laws protecting the rights of employees. All provinces have employment standards acts, labour relations acts, as well as laws in the areas of: occupational health and safety, human rights, pay equity, worker compensation, unemployment insurance, tax and pension provisions (Hibberd, 1994). Successful union-management relations depend on how each party views the other. If a “conflict viewpoint” prevails, then the collective agreement is perceived as a temporary “peace treaty” (Giles & Jain, 1989). On the other hand, when collective bargaining is viewed as “a joint decision-making process…grounded within a symbiotic relationship between employees and employers” (Fisher & Williams, 1989, p.185), the rules of engagement are framed in a consultative way, an approach usually followed by nursing professionals (Hibberd, 1994).

Professional associations and unions have many common goals, including promoting the welfare of members and improving their working conditions (Ross-Kerr, 2003d). The mandate of regulatory bodies (for example, the College of Nurses) is to protect the public interest through registration and licensing of nurses and discipline of members. While the mandate of unions is to protect interests of nurses through collective bargaining for wages, benefits, hours, and employment standards, professional associations are also interested in appropriate remuneration and employment conditions to maintain professional status and encourage prospective candidates to enter nursing. Professional associations, however, must avoid involvement in collective bargaining and in times of labour unrest, any action must be based on maintaining appropriate standards of nursing care and serving the public interest (Ross-Kerr, 2003d). While standards of practice that support the public right to safe care are important, unions are not legally bound to protect the public interest and view practice standards are pertaining to the working environment.

Ross-Kerr (2003d) states that although intolerance of the unique mandate of the negotiating body and the professional body may have “clouded perceptions of the appropriateness of the other’s actions in the past, understanding and acceptance of the role and functions of each type of organization are the norm rather than the exception in today's organizational context” (p. 308). Furthermore, current national and provincial initiatives to improve nursing work life conditions involve collaboration between nurses unions and other professional nursing bodies and key stakeholder groups. In the spring of 2002, the CNA convened a national workshop to develop quality of nursing indicators toward a better nursing work environment. Participants involved in the collaborative and consensus building process included representation from Health Canada's Office of Nursing Policy, Canadian Council on Health Services Accreditation (CCHSA), executive nurses, registered nurses' associations in six provinces, nurse researchers, nurses' unions, health care employers, CNA, the nursing informatics field, licensed practical nurses and practising registered nurses (Lowe, 2002). The following eight indicators were chosen: span of control; leadership; overtime hours; full-time/part-time/casual ratios; autonomy/scope of practice; professional development opportunities; absenteeism and grievances. These indicators are a sign that the regulated professional nursing community in Canada has collectively articulated a vision of the ideal professional practice environment.
2.2.4. Debriefing Processes in Nurses' Workplaces

In this study, participants were asked to give their views regarding debriefing processes and employee assistance programs in their workplaces. Because nurses at times experience acute stress, particularly in some clinical specialties, this type of support is important to coping and mental well-being. Critical Incident Stress Debriefing (CISD), a formal process offered to nurses within 24 to 72 hours of a critical event, may prevent and/or limit post-traumatic stress disorder by providing a safe forum to explore their needs, process their experiences and create constructive narratives (Irving & Long, 2001). In a study of emergency room nurses, Laposa et al. (2003) found a significant association between interpersonal conflict, as a source of workplace stress, and post-traumatic stress disorder symptoms. The results suggested that hospital administrators need to be more aware of the extent of workplace stress in their employees and to intervene to improve interpersonal climate in the work environment.

In some organizations, CISD services are an integral part of the Employee Assistance Program (EAP). Many organizations however, provide less formal interventions such as “reviews with staff” following an incident. The importance of helping nurses to maintain emotional and psychological equilibrium in stressful work environments has become paramount. Further research is needed to explore the use of different models of stress debriefing applied to special circumstances with the goal of alleviating symptoms and to prevent the development of post-traumatic stress disorder (Irving & Long, 2001).
3. Research Methodology

3.1. Research Design, Data Collection and Analysis

The research design for the study was qualitative exploratory. Following ethics approval from the Office of Research Services of the University of Toronto, an information letter (Appendix D) was sent to the union leaders and representatives to explain the importance of the study and describe how their participation could contribute. As the goal was to gain insight about the unique perspectives of union activists, a purposive sampling approach was used. Focus group coordinators from the different unions assisted in the organization of the sessions, including the obtainment of union member volunteers to take part in the discussions. Participants signed and returned the consent form (Appendix E), after which they were asked to provide demographic information by completing a brief form (Appendix F). A facilitator script (Appendix G) was utilized to initiate the focus group session, thereby promoting consistency between facilitators.

The focus group method was used in this study to explore participants' feelings and opinions about their current work environments. Between June 2003 and March 2004, 33 sessions were held with a total of 295 participants (Appendix H is a list of the focus groups), for an average of nine participants per group. The group sizes ranged from one to 18 with the sessions lasting no longer than 90 minutes. (The occasion in which there was one participant was a teleconference session with a nurse from northern Alberta.) For the convenience of the participants and the researchers, several of the focus group sessions were organized around union conferences. All of the sessions were audio-taped and subsequently transcribed.

The facilitators had prior experience in conducting focus group discussions. They encouraged interaction among participants, capitalizing on the focus group approach to obtain information that might not have emerged with the use of questionnaires or interviews (Basche, 1987; Kitzinger & Barbour, 1999; McDaniel & Bach, 1994; Sim, 1998; Webb & Kevern, 2001). Since many of the nurses already knew one another from their union work, a relaxed, friendly and open environment was present during the focus groups. Complimentary refreshments were offered to participants. Multiple focus groups were conducted to increase the validity and reliability of the data (Stewart & Shamdasani, 1990). When no new issues or content emerged from the discussions with participants, a point of 'saturation' occurred and further groups were not conducted (Basch, 1987; Krueger, 1994).

Two researchers independently read the transcripts and organized the data into thematic categories as a preliminary analysis, followed by consultation with each other for clarification and consensus of emerging issues and themes. Pertinent quotes were selected to represent the various themes according on the study's conceptual framework, while at the same time attempting to represent the nurse groups in each province. Because one could not attribute the province or health sector for all of the responses, and some provinces (including AB, MB, PE and NL) were not well represented in the sample, it was not possible for all areas and sectors to be presented equally in the findings.
In terms of comparison of separate groups, Sim (1998) claims that the objective should be to determine whether the same or different views or issues were aired, rather than the relative strength of opinion that emerged from them, since efforts to quantify views are generally problematic. Also, there are methodological barriers to generalizing from focus groups as participants are often gathered through a process of non-probability sampling (Carey, 1995); however, theoretical generalization may be feasible in that the findings of focus groups can be transferred to other settings which have similarities to the context in which the data were gathered (Sim, 1998). The analysis for this study was to determine the predominant issues voiced by the three nursing groups, and explore possible provincial and sector variations.

3.2. Limitations

The limitations of this study have to do with focus group methodology in general as well as the characteristics of the study itself. While a potential advantage of this data collection approach is greater spontaneity in expression of views than that of alternative methods, certain members may be more assertive or articulate than others and their views may dominate, while members of the group who are less self-confident may be inhibited from expressing alternative viewpoints (Henderson, 1995). The result may be that these alternative views are simply not voiced, and those who remain relatively silent are falsely assumed to agree with the prevailing view. In this study, the responses were predominantly negative in nature, and there may have been positive viewpoints that were not voiced. It is recommended that more than one focus group be conducted, for if one group is aberrant its effect may be countered, or at least diluted, by other groups (Stewart & Shamdasani, 1990). In this study, the multiple focus group discussions resulted in very few deviating comments.

While it is not necessarily the intent to have representative samples in focus groups, in this study the atypical (of the general Canadian nursing workforce) sample meant that viewpoints may have been over- or under-emphasized. For example, LPNs were over-represented, possibly contributing to the major emphasis being placed on the scope of practice issue. The full-time/part-time employment pattern was not similar to that of the general workforce and the provinces were not proportionately represented. Therefore, care was taken not to generalize inappropriately when making conclusions. Furthermore, given that the target sample comprised union activists who may have different opinions than that of the general nursing workforce, recommendations were formulated with this consideration in mind.

3.3. Research Questions

The researchers formulated questions and probes to be used by the union focus group facilitators to guide the discussion. They were vetted by the Nursing Sector Study Steering Committee and they are as follows.

1. What are your key concerns about working conditions? Are there different concerns about working conditions in non-hospital nursing environments (e.g., community health clinics)?
   
   Probe: safety, workload, abuse, support from management
2. What are your perceptions of the current challenges in the restructured health care system?
   *Probe: challenges with respect to workload, staff mix, or patient/client ratios, funding, work re-organization, use of Unregulated Care Providers; How has the system improved/changed since restructuring was implemented?*

3. What are your key concerns about labour relations?
   *Probe: contract issues, hiring process, scheduling process, benefits, pension, grievance process*

4. What role does the union play in your workplace?
   *Probe: harmony between union and management*

5. What are the recruitment and retention challenges in your work environment?
   *Probe: high turnover, times when there is a shortage of staff*

6. What challenges do you encounter to provide the standards of care that are consistent with good nursing practice?
   *Probe: Standards of Care related to: assessments, interventions, evaluation of outcomes, written care plans, documentation*

7. What in-service education (ongoing educational opportunities) are offered to you by your employer? What are some of the challenges to participate in in-service education? What in-service education is not offered but you feel is necessary?

8. What prevention and debriefing programs are available in the workplace? Which ones are helpful for nurses in your work environment?
   *Probe: related to violence and abuse in the workplace, sometimes known as employee assistance programs*
   *Probe: e.g., dealing with patient death; Is there a Risk Management Process? Do you have someone to talk to if you are feeling stressed or burned out?*

9. If there is one thing you could change in your work environment, what would it be? Why?

### 3.4. Conceptual Framework

Kristensen's (1999) model for society, stress and health was used as the conceptual framework for the study. The model outlines six inter-related dimensions which are necessary for an optimal work environment: 1) demands fitting the resources of the person; 2) degree of basic predictability; 3) degree of social support; 4) degree of meaning; 5) degree of influence; and 6) balance between effort and reward (further described in findings section). This conceptualization is highly applicable to nurses'
workplace environments and provides an appropriate framework to present this study's findings. Built on the demand/control or job strain model (Theorell & Karasek, 1996), and the effort-reward model (Siegrist, 1996), the model combines the six dimensions of stressors that have been identified through research, and relates them to both the individual and the social dimension. Prior adaptation of Kristensen's model produced a relevant framework for use in the policy document *Commitment and Care* (Baumann et al., 2001) that highlights key issues pertaining to nurses' work environments.
4. Focus Group Findings

4.1. Profile of Focus Group Participants

The responses from the demographic form were entered into SPSS 12.0 software. Descriptive
statistics were utilized to conduct frequency counts and cross-tabulations of the relevant variables. Of
the 295 participants, 87.5% (n=258) are female and 11.5% (n=34) male (three responses were missing).
Of the males, 15 are classified as LPNs, 16 as RPNs and three as RNs. In terms of marital status, 11.5%
(n=34) indicated they are single; 4.4% (n=13) separated; 72.9% (n=215) partnered; 9.8% (n=29)
divorced; and 0.7% (n=2) widowed (2 responses missing). Each of the 10 Canadian provinces was rep-
resented, as shown in Table 1.

Table 1: Province of residence by category of registration

<table>
<thead>
<tr>
<th>Province</th>
<th>RN</th>
<th>LPN</th>
<th>RPN</th>
<th>NP</th>
<th>Other</th>
<th>All groups</th>
<th>% all groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC</td>
<td>33</td>
<td>24</td>
<td>20</td>
<td>0</td>
<td>3</td>
<td>80</td>
<td>27.5</td>
</tr>
<tr>
<td>AB</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>10</td>
<td>3.4</td>
</tr>
<tr>
<td>SK</td>
<td>7</td>
<td>16</td>
<td>12</td>
<td>0</td>
<td>1</td>
<td>36</td>
<td>12.4</td>
</tr>
<tr>
<td>MB</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>2.1</td>
</tr>
<tr>
<td>ON</td>
<td>20</td>
<td>28</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>16.5</td>
</tr>
<tr>
<td>QC</td>
<td>1</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>20</td>
<td>6.8</td>
</tr>
<tr>
<td>NB</td>
<td>5</td>
<td>46</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>52</td>
<td>17.9</td>
</tr>
<tr>
<td>NS</td>
<td>17</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>26</td>
<td>8.9</td>
</tr>
<tr>
<td>PE</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>1.4</td>
</tr>
<tr>
<td>NL</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>3.1</td>
</tr>
<tr>
<td>Total</td>
<td>106</td>
<td>139</td>
<td>32</td>
<td>5</td>
<td>9</td>
<td>291</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Notes: “Other” = “dual RN/RPN,” “dual LPN/RN” and “other” categories from demographic form.
There were 4 missing responses.

The proportions of nurses per province and per category of registration are not representative of
the general Canadian nursing workforce. For example, the LPN group is over-represented.

In terms of age of the participants, Table 2 shows age frequencies in groups of five years, breaking
it down by category of registration. Most of the participants were over the age of 40 which is similar to
the age distribution of nurses in Canada.
Table 2: Age groupings by category of registration

<table>
<thead>
<tr>
<th>Age Group</th>
<th>LPN (%)</th>
<th>RPN (%)</th>
<th>RN (%)</th>
<th>Other (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt;30 (%)</td>
<td>6 (4.7)</td>
<td>2 (6.3)</td>
<td>3 (2.9)</td>
<td>0 (0.0)</td>
<td>11 (3.9)</td>
</tr>
<tr>
<td>Age 30-34 (%)</td>
<td>4 (3.1)</td>
<td>3 (9.4)</td>
<td>5 (4.8)</td>
<td>0 (0.0)</td>
<td>12 (4.3)</td>
</tr>
<tr>
<td>Age 35-39 (%)</td>
<td>14 (10.9)</td>
<td>6 (18.8)</td>
<td>10 (9.6)</td>
<td>1 (7.2)</td>
<td>31 (11.1)</td>
</tr>
<tr>
<td>Age 40-44 (%)</td>
<td>28 (21.7)</td>
<td>3 (9.4)</td>
<td>22 (11.2)</td>
<td>3 (21.4)</td>
<td>56 (20.1)</td>
</tr>
<tr>
<td>Age 45-49 (%)</td>
<td>34 (26.4)</td>
<td>7 (21.9)</td>
<td>19 (18.3)</td>
<td>4 (28.6)</td>
<td>64 (22.9)</td>
</tr>
<tr>
<td>Age 50-54 (%)</td>
<td>28 (21.7)</td>
<td>7 (21.9)</td>
<td>28 (26.9)</td>
<td>2 (14.3)</td>
<td>65 (23.3)</td>
</tr>
<tr>
<td>Age 55-59 (%)</td>
<td>13 (10.1)</td>
<td>2 (6.3)</td>
<td>15 (14.4)</td>
<td>4 (28.6)</td>
<td>34 (12.2)</td>
</tr>
<tr>
<td>Age 60+ (%)</td>
<td>2 (1.6)</td>
<td>2 (6.3)</td>
<td>2 (1.9)</td>
<td>0 (0.0)</td>
<td>6 (2.2)</td>
</tr>
<tr>
<td>Total</td>
<td>129 (100)</td>
<td>32 (100)</td>
<td>104 (100)</td>
<td>14 (100)</td>
<td>279 (100)</td>
</tr>
</tbody>
</table>

Note: “Other” = “NP,” “dual RN/RPN,” “dual LPN/RN” and “other” categories from demographic form. There were 13 missing responses.

Current employment status is shown in Table 3, separated into category of registration. Full-time employment status was over-represented in the sample of focus group participants, particularly in the psychiatric nurses.

Table 3: Current employment status by category of registration

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>LPN (%)</th>
<th>RPN (%)</th>
<th>RN (%)</th>
<th>Other (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent FT</td>
<td>95 (69.9)</td>
<td>28 (90.3)</td>
<td>72 (68.6)</td>
<td>11 (84.6)</td>
<td>206 (72.3)</td>
</tr>
<tr>
<td>Temporary FT</td>
<td>3 (2.2)</td>
<td>0 (0.0)</td>
<td>1 (1.0)</td>
<td>0 (0.0)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td>Permanent PT</td>
<td>29 (21.3)</td>
<td>3 (9.7)</td>
<td>31 (29.5)</td>
<td>1 (7.7)</td>
<td>64 (22.5)</td>
</tr>
<tr>
<td>Temporary PT</td>
<td>3 (2.2)</td>
<td>0 (0.0)</td>
<td>1 (1.0)</td>
<td>1 (7.7)</td>
<td>5 (1.8)</td>
</tr>
<tr>
<td>Casual</td>
<td>6 (4.4)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>6 (2.1)</td>
</tr>
<tr>
<td>Total</td>
<td>136 (100)</td>
<td>31 (100)</td>
<td>105 (100)</td>
<td>13 (100)</td>
<td>285 (100)</td>
</tr>
</tbody>
</table>

Note: “Other” = “NP,” “dual RN/RPN,” “dual LPN/RN” and “other” categories from demographic form. There were 10 missing responses.
Table 4 shows the participants’ employment setting by category of registration. The LPNs and RNs worked predominantly in hospitals and long-term care. Approximately half of the RPN sample participants work in forensic or correctional settings, which is a higher proportion than that of the general RPN workforce (CIHI, 2003c).

### Table 4: Current employment setting by category of registration

<table>
<thead>
<tr>
<th>Category</th>
<th>LPN</th>
<th>RPN</th>
<th>RN</th>
<th>NP</th>
<th>Other</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assoc/govt</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Community</td>
<td>5</td>
<td>2</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>20 (6.9)</td>
</tr>
<tr>
<td>District/RHA</td>
<td>19</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>30 (10.4)</td>
</tr>
<tr>
<td>Educational</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2 (0.7)</td>
</tr>
<tr>
<td>Forensic/correctional</td>
<td>1</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>20 (6.9)</td>
</tr>
<tr>
<td>Group home</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Home/visiting care</td>
<td>2</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>9 (3.1)</td>
</tr>
<tr>
<td>Community hosp</td>
<td>32</td>
<td>3</td>
<td>23</td>
<td>0</td>
<td>2</td>
<td>61 (21.2)</td>
</tr>
<tr>
<td>Teaching hosp</td>
<td>21</td>
<td>2</td>
<td>31</td>
<td>0</td>
<td>1</td>
<td>55 (19.1)</td>
</tr>
<tr>
<td>Mental health</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Int/long-term care</td>
<td>47</td>
<td>2</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>61 (21.2)</td>
</tr>
<tr>
<td>Nursing station</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td>Rehab/convalescent</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6 (2.1)</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>17 (5.9)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>138</td>
<td>30</td>
<td>106</td>
<td>5</td>
<td>9</td>
<td>288 (100)</td>
</tr>
</tbody>
</table>

Note: “Other” = “RN/RPN,” “dual LPN/RN” and the “other” categories from the demographic form. There were 7 missing responses.

As shown in Table 5, a large proportion of the registered nurses and practical nurses had undertaken continuing education to earn a post-basic nursing credential. For example, many colleges offer specialty programs in a variety of areas such as critical care, operating room, and palliative care to nurses who wish to advance their nursing education and increase their competency. Some of these programs require a registered nurse diploma and others are specifically for practical nurses such as those pertinent to increase scope of practice (for example, a certificate in administration of medications).
Table 5: Highest nursing education by category of registration

<table>
<thead>
<tr>
<th>Category</th>
<th>LPN</th>
<th>RPN</th>
<th>RN</th>
<th>NP</th>
<th>Other</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate</td>
<td>8</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>18 (6.2)</td>
</tr>
<tr>
<td>RN Diploma</td>
<td>0</td>
<td>1</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>21 (7.2)</td>
</tr>
<tr>
<td>Post LPN Certificate</td>
<td>75</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>77 (26.5)</td>
</tr>
<tr>
<td>RPN Diploma</td>
<td>0</td>
<td>26</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>26 (8.9)</td>
</tr>
<tr>
<td>RPN diploma RN and LPN</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2 (0.7)</td>
</tr>
<tr>
<td>Post LPN diploma</td>
<td>54</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>59 (20.3)</td>
</tr>
<tr>
<td>Post RN diploma</td>
<td>0</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>0</td>
<td>42 (14.4)</td>
</tr>
<tr>
<td>Advanced Psych</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3 (1.0)</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td>BN</td>
<td>0</td>
<td>1</td>
<td>30</td>
<td>1</td>
<td>1</td>
<td>33 (11.3)</td>
</tr>
<tr>
<td>BSc RPN</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>5 (1.7)</td>
</tr>
<tr>
<td>Total</td>
<td>139</td>
<td>32</td>
<td>106</td>
<td>5</td>
<td>9</td>
<td>291 (100)</td>
</tr>
</tbody>
</table>

Note: “Other” = “dual RN/RPN,” “dual LPN/RN” and the “other” categories from the demographic form. There were 4 missing responses.

Participants belonged to almost 20 different unions (see Appendix I for complete list), of which there were four main ones. CUPE had the highest frequency (n=99), primarily practical nurses in Ontario, Quebec and New Brunswick. The other three were: BCNU (n=33), an RN union in BC; HEU (n=27), mostly practical nurses in BC; and ONA (n=21), an RN union in Ontario.

As shown in Table 6, a substantial number of the participants have a key role in their respective unions, for example, president positions held by LPNs and RNs. Overall, only about 25% identified themselves as only a member.
Table 6: Position in Union by category of registration

<table>
<thead>
<tr>
<th>Position</th>
<th>LPN</th>
<th>RPN</th>
<th>RN</th>
<th>Other</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board/Chair</td>
<td>7</td>
<td>5</td>
<td>15</td>
<td>2</td>
<td>29 (10.0)</td>
</tr>
<tr>
<td>President</td>
<td>30</td>
<td>2</td>
<td>27</td>
<td>1</td>
<td>60 (20.7)</td>
</tr>
<tr>
<td>VP</td>
<td>10</td>
<td>0</td>
<td>12</td>
<td>2</td>
<td>24 (8.3)</td>
</tr>
<tr>
<td>Sec/Treas</td>
<td>22</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>30 (10.3)</td>
</tr>
<tr>
<td>Steward</td>
<td>10</td>
<td>9</td>
<td>16</td>
<td>2</td>
<td>37 (12.8)</td>
</tr>
<tr>
<td>Committee</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Member</td>
<td>54</td>
<td>13</td>
<td>3</td>
<td>4</td>
<td>74 (25.5)</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>3</td>
<td>25</td>
<td>2</td>
<td>35 (12.1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>139</td>
<td>32</td>
<td>106</td>
<td>13</td>
<td>290 (100)</td>
</tr>
</tbody>
</table>

Note: “Other” = “NP,” “dual RN/RPN,” “dual LPN/RN” and “other” categories from demographic form.
There were 5 missing responses.

In summary, the largest number of participants (n = 65) were 50 to 54 years of age. In terms of the three nurse groups, LPNs were over-represented in the sample. The proportions of nurses per province and per group were not representative of the Canadian nursing workforce. High numbers of nurses had earned continuing education diplomas and certificates beyond their basic nursing education. There was a higher than average number of RNs with BN degrees in this sample. Most of the RN and LPNs worked in hospitals or long term care facilities. Many participants held key executive positions in their respective unions. Full-time employment status was also disproportionately high in this sample of focus group participants.

4.2. Nursing Union Activists' Responses

The nursing workplace issues and concerns discussed by the respondents were categorized according to Kristensen’s six principles. In terms of the focus group findings for the study at hand, two major elements were added to the model to reflect the findings relating to the nature of union support and debriefing programs. Also, several of the issues were given in more detail to more accurately reflect the responses. In Figure 1 below, the left-hand side of the model outlines the six principles that represent the stressor dimensions, and the right-hand side of highlights the issues that were of concern to the respondents.
Direct quotes were selected from the transcripts to highlight the pertinent issues. Participants' responses were differentiated where possible according to nurse groups and geographic regions; where focus groups coincided with conferences being attended by participants, identifying the province was not possible. Each quote is italicized and is followed by parenthesis in which the province of the focus group is indicated (note: N.AB means northern Alberta), and the nurse's credential (RN, LPN, and RPN).

### 4.2.1. Demands fitting the resources of the person

**ISSUES:** Work pressures: workload, staffing, time constraints, patient acuity, equipment and other resources, skills of care team

Concerns were expressed by participants from all regions relating to the imbalance between workload demands and available resources. Staffing levels that are inadequate to meet the care demands of heavy patient workloads causes undue work pressure. The lack of time available for nurses to tend to patients' needs threatens the quality of care.

*Our workload has piled up and we only have the time to do the bare minimum, so we prioritize to do the meds and the basic care - we are unable to get to know the patient, to find out what their true needs are, to do a very thorough assessment because we are dealing with the here and now and not actually looking into what is best for the patient.* (CNFU conference Toronto)
Overall care has decreased, is given too quickly, running between feeding and care, it is very difficult. The care is given too quickly and the residents are at times insulted or feel rejected... You walk in, zip through the work and you're done. By the time the resident asks you a question, you've already moved on to the next resident. (NB LPN)

Lack of available nurses in the part-time and casual pools was a voiced concern as it causes difficulty in finding replacement staff.

The understaffing - there are no casual LPNs in our part of the country. We had two casuals who both got full-time positions that were just recently created in other facilities. Then we work short - the manager doesn't like overtime because we are over-budget. Casuals have been recruited but when you are far from the city, they don't really like coming out that far. (SK LPN)

...we don't have any real recruitment going on - our problem is when LPNs are hired, they are for the district and may work in three facilities - and when you need them in acute care to cover casual hours, they are already working in LT somewhere else - there is more hours for them - people off on sick leave, disability. So we have this casual pool that is depleted (SK LPN).

In addition to inadequate staffing and high patient volume, high patient acuity and complex care needs contribute to work pressures:

They are many serious cases. Many serious surgeries because in the past they used to stay four to five days to recover, now it's only two days. We are always in a “severe case mode” and they keep on coming, one more coming in, one more and one more coming in. It is extremely stressful (LPN conference Quebec).

An increased level of stress among the staff due to the increased acuity of the patients we are getting, the fact of turnover of the patients, we don't have length of stay now that are week long, just days long. Not doing the level of care, the quality of care is rushed because of the time factor. They are putting through more patients, no increase in staff that can lead to safety issues ... Sometimes we get them and they are not appropriate for psychiatric care and we send them back to a medical bed. (BC RPN)

Participants indicated that lack of staffing makes it difficult to provide mentoring to the new nurses because it adds further to workload of the older and more experienced nurses.

A lack of mentoring for the younger nurses that are coming in right now in the crunch of less nurses being available to give them the guidance. We're eating up our young. (CFNU conference Toronto)

To be honest, there are some older RNs around that don't want to help the younger ones. The older ones are really getting tired of mentoring - “everyday I come on, I have to do my work and her work”. (BC LPN)

Nurses expressed concerns about recruitment challenges and high nurse turnover that are seriously threatening health human resources in all nurse groups.
Acute care - We are putting lots of LPNs out there. RNs are different - change from the nursing schools within the hospitals to the four year program -But the numbers are not coming out to replace them. The graduates who are graduating here and from university after four years, are being offered big money to go elsewhere. (NS LPN)

Working in rural areas, the expectation is that you don't have a family life, a life besides your work and you are expected to be on call 24 hours a day, seven days a week, 52 weeks a year. In order to recruit and retain nurses in rural areas, we have to reassure them they don't have to sacrifice their families or personal lives. (CFNU conference Toronto)

Isolation can be a hardship - you need to be able to go out more often - even go to the nearest town for a break. We used to go every six to eight weeks, now sometimes I am in for four months - no one to relieve us. Have taken our paid trips away. Instead of a few weeks out, you are limited to three/four days in which you rush around doing so much, and come back tired. (N.AB RN)

The biggest one for us is the border - US - all of our graduates don't even consider a career in Canada at this point. They have a lot of enticement to go south of the border and you can't fault their reasons. They have full-time jobs waiting for them, they have the chance for continuing their education in a paid way with time provided as well by the employer. They get their choice of field, their choice of hours. (ON RN)

Resources such as adequate supplies and working space are needed for delivery of patient care. Equipment that is in poor working condition only adds stress to the nurses' work day. Health system restructuring has affected resources in terms of patient beds and accessibility to health care and this has an impact on the nature of demands placed on health care workers. Nurses spoke about health dollars, referring to poor funding and budgets that do not put patients first.

We have a limited amount of space...Makes it difficult for me to do my job because I have things scattered all over the place and can never find resources that I need. ...we are still using an outdated DOS-based program which crashes frequently, loses data and ...patients are extremely irate (ON RN)

We have no beds to move our patients who could be admitted for longer term care. We have nurses doing assessments of patients in the waiting room who have chest pains, who are unable to bring their patients in... not enough equipment - no blood pressure cuffs, thermometers... (NS RN)

For the home sector, part of the problem with the restructuring is the way placement occurs... and the programs that we have in place now don't adequately serve anybody - very piecemeal and nobody is happy, including the families and the expectations of the families is much greater...Increasing stress on the nurses, in particular. (ON RN)

It has minimized the importance of mental health - the budgets collapse - only so much money for certain problems...and mental health is always undervalued and that does impact the program I'm in - while the public wants more nurses, they don't distinguish what brings the quality - now there are more budgets being provided for more nurses in the program that I am in and more nurses to train in mental health, more registered psychiatric nurses and we don't have a program for them. (SK RPN)
Concerns were voiced about poor access to health care resources.

What my concern is people who live in the rural areas such as the Kootenays, where the expectation was they did have health care and they retired there and now the health care is being removed. People go on vacation there and there is an expectation that they can get an ambulance - this has been removed without the input from the community. (CFNU conference Toronto)

Resources - we are part of the region, but we’re not - like our OTs - it goes through an extra-mural program - you have to have a referral. We lost our rehab people - dietician. We are not in the region but when there are cuts - we get the cuts. We rely on the community for that service. We do access resources but she is not there long enough to teach you - may take a year to see the wheelchair and it might not fit. (NB LPN)

The expertise and knowledge of co-workers are a resource that influences how smoothly a work day proceeds and the quality of care provided. Nurses voiced concerns about a lack of competency in their co-workers, including the new grads.

And what these health care aides were concerned is what they are allowed to do - they can put ointment, do a dressing yet some of them are in a program for maybe five weeks, if that. They have no idea why they are putting ointment on, they have no idea why they are doing some things. (QC LPN)

...in probably all acute.... I find that the workload on the LPN is so much greater now, because we are always working with somebody who is a brand new grad, who is not able to cope with their load, and so we are having to take on more than what we can normally handle, and there are not enough older RNs around to help the younger ones. (BC LPN)

Psychiatric mental health - Because of the changes in the entry to practice levels, we are producing nurses who are unable to meet the clinical expectations of a new graduate in the workforce and consequently impacts on the rest of the nurses working within the health care system. The university trained nurses are not as clinically prepared (NS RN)

The ones without the basic skills, right out of school, going to work in a neonatal ICU. I wouldn't work there with 25 years of ICU experience, but the scary part is they don't know enough to be frightened. They go directly from getting their BScN to working on their masters - so now they can teach people what they don't know. (ON RN)

4.2.2. Degree of basic predictability

ISSUES: Job security, workplace safety, violence in the workplace, risk of burnout & illness

Sources of unpredictability include job security, risk of injury and workplace violence (Baumann et al., Commitment and Care, 2001). Research findings have linked job insecurity with job dissatisfaction and decreased organizational commitment (Armstrong-Stassen, 1994; Cameron et al., 1994; Blythe et al., 2001). Furthermore, workplace unpredictability exists as hospital nurses are required to “float” to unfamiliar units where they are unsure of the expectations. Job uncertainty and general distrust are a
consequence of ongoing organizational change.

The hospital where I work has been continually closing beds, moving beds, re-amalgamating units... a lot of stress on the staff. There is a lack of trust from the staff about the supports that are there in their new roles ...A lot of uncertainty in the workforce about where the changes will continue to go and what will that mean. (NS LPN)

While some degree of unpredictability is expected as community nurses visit clients' homes, nurses expressed that they often face potentially dangerous situations.

Nursing in the community presents a lot of challenges...everything from a smoking environment to dogs, cats, pets, broken stairs, icy sidewalks...You work in the dark, you work alone. On evening and nights you are entering homes in the dark ...There have been assaults on home care nurses because people on the street think you have needles and drugs. (CNFU conference Toronto)

When you are going out doing home visits, they are not providing you with i.e. enough cell phones for your own safety; the ability to go out as couples is difficult because of the increase in caseloads - you can't go out with one of your colleagues because they are busy. Space is not designed for safety. People have access to walk in off the street into our offices at some clinics. (BC RPN)

Lack of security and isolation in northern and rural areas are ongoing concerns of nurses working in such areas, and make recruitment and retention particularly challenging.

I worry about physical injury to myself. We act as the ambulance here...The housing are mainly bi-levels that have very steep steps... we have one safety officer with us after hours. We do have a lot of alcohol abuse in the community. And again the physical safety issue. We have some support in the fact we do now have safety officers - in the past we were alone. I feel they are headed in the right direction. (N.AB RN)

Homecare - When the LPNs working homecare in the rural community...The big concern that we did have was nobody knew where we were. We were often out of cell phone range... you have no idea how to get back to the highway, or how to describe where you are if you did happen to be able to phone, if something happened. (SK LPN)

I think the issues would be the same in the North as they are in rural Saskatchewan... why would anyone go there when they hear the horror stories. If you get snowed in you work a double shift, if somebody phones in sick you just stay on for 24 hours. There is just no back-up. (CFNU conference Toronto)

Some responses suggest that improved security and means of communication could make nurses feel less vulnerable.

We only have security from 11 pm - 7 am. They provide security for the nursing station and two other buildings, so if we need them in the nursing station, we would have to call them. We take a radio home and call them by radio to advise them to meet us at the station. (N.AB RN)
Communication is sorely lacking - between units and managers - information being relayed to line staff. There are three groups, management, correctional and the nursing between which communications break down leading to potentially unsafe situations. (BC RPN)

Potential violence in the workplace increases the unpredictability of nurses' work and is an issue in some work environments. Psychiatric nurses, in particular, relayed this concern.

We have the same amount of patients as before or more. I work in mental health where there is a lot of aggression in physical behavior. A lot of times the alarm system is not set up accordingly, especially if you are doing one to one nursing. Sometimes you can’t even get to the alarm and sometimes you are in a secluded room, by yourself with this patient. (ON LPN)

We are lucky when it comes to safety concerns in our environment because we have officers. I know that other nurses that work in different environments, they are the security. And in psychiatry, whether in a correctional facility or not, it is always a concern. (BC RPN Regional Correction Treatment Centre)

Safety, workload and abuse - that’s a common theme for my day-to-day activities. I have, for a partner, a specially trained police officer to work with me. I am specially trained to deal with some of their equipment and dealing with violent people in the community. I have the luxury of getting other police backup for doing my calls but we still get into a lot of tough situations and my partner and I are dealing with this. (BC RPN)

Long-term care is another high-risk area for nurse injury and abuse, although no related comments were found that specified LTC as the area of responsibility. Overall, the work pressures nurses are experiencing in both hospital and non-hospital environments are evidently taking their toll on their physical and mental well-being:

We give everything we have to our job, but at one point, it's our family and our health that suffers. We get home and we are exhausted, unable to do anything, worn out. You don't even have the energy to talk to your kids, you just want to collapse. (LPN conference QC)

...if you are doing the work of three people - it doesn’t matter how you reorganize - not everything is going to get done - the things that don’t get done is the things that are still essential - I still have to do them - I don't think I work with a lot people who recognize that almost all of us are burned-out. (LPN conference Que)

**4.2.3. Degree of social support**

**ISSUES:** Support by managers and colleagues; education and development; role of union; debriefing and employee assistance processes

In *Commitment and Care* (Baumann et al., 2001), social support in the workplace refers to emotional support from managers, supervisors and colleagues, and cognitive support from mentors and from organizational policies that help with professional development. Nursing unions and debriefing programs also have a support role in nurses' work environments.
Comments relating to nursing management were about a lack of leadership, respect and support, nursing expertise and understanding of the daily challenges encountered by nurses.

“We have a major problem on the large psych unit I work in (Alberta). The unit manager is not a nurse. She is an occupational therapist who knew nothing about managing or nursing, so the staff on that unit cannot ask her anything about clinical practice.” (CFNU conference Toronto)

“A lot of our managers now have not really had patient care experience, as a staff nurse. Because of the way things were evolving, they get into a co-ordinator or management position right away, just because of the way they were restructuring, so they don’t really know what we are talking about sometimes.” (BC LPN)

“Desired change… To have strong informed nursing leadership - so management would be strong nursing leaders. A nurse that is not afraid to stand up to an administrator ... At this point, we have management that do not stand up for nursing and the work we do. She has no idea of what we are dealing with.” (NS RN)

In terms of support from colleagues, participants reported that nurses are not working together effectively as a team, particularly in terms of the tension and poor relationships that exist between RNs and LPNs. This lack of respect and collegiality among care-givers has decreased morale and added to the work pressures already experienced by nurses.

“The three shifts don’t get along (day shift, evening shift and night shift). The day shift staff say they don’t have time, the evening staff says the same and the night staff as well. There is no continuity of care. We are attacking each other and we have no support from the head RN for that.” (LPN conference QC)

“I am in a hospital sector, and one of the concerns of working conditions - morale - I don’t think we can sink any further at our place. Everything is throwing down and pushing down and we got told that the nurses are to blame for the bad report card - we are the fault and we should report each other. So you can imagine where our morale is.” (ON RN)

Poor working relationships appear to be most evident between RNs and LPNs in the hospital setting. There were no comments that alluded to lack of collegiality between RNs and RPNs, even in settings such as correctional and community agencies where these two nursing groups would work together as equals.

Educational support is an important aspect of the work environment. Nurses indicated that barriers to in-service attendance include scheduling conflicts and lack of replacement staff.

“In BC... we have a central education department, who have wonderful in-service for the homecare nurses. However, in the new budget there no monies for backfilling. So people are being paid to get these courses going and bringing people in but we can't go because no replacements.” (CFNU conference Toronto)
In facility, they offer the in-services on dayshift. And they don't repeat them evenings or nights. And they expect that people who works those shifts will come in and stay following a shift and participate in that! (CFNU conference Toronto)

In-service agendas were sometimes perceived as inappropriate for the learning needs of nursing staff, and not always responsive to requests made by nurses.

Travel with the weather conditions is sometimes a challenge to get to the courses - getting a plane in or out... I would like advanced cardiac life support course - I have asked for this - they feel those skills aren't required here at this time. (N.AB RN)

In our hospital, they do offer in-service, it is hospital-driven though. Most of the budget is used for upgrades and most of that is on a computer, so you don't have any choice on what the education is, other than if you work in a specialty unit, you get some education because you need different qualifications and must keep those qualifications up. (ON RN)

To be frank, our employer does offer what they call professional development days once a year, where they bring in people with humour, gardening, stuff that is not even appropriate. The money could be much better spent at a more relevant conference. (SK RPN)

Some LPNs expressed the opinion that in-service sessions are directed at the RNs, and that LPNs do not have as much opportunity to attend.

And if you are an LPN, you really don't have a chance because they all think the LPNs should cover the floor because they think it is more important the RNs get the education. Definitely LPNs are ripped off that way. (BC LPN)

Acute care - our education is on demand from some nurse educator from the district - she will research stuff and bring forward info that we want. Most of the education is directed to the RNs and the LPNs are left on the floor causes a little friction. If the LPNs attend in-services there are no replacements... (NS LPN)

According to the law, Act 90, the government gave funds to certain areas for further education... They receive money for us but decide to give this to the RNs instead... They never have what we request, no money they say but when an RN requests something, they get it. (QC LPN)

There were positive comments pertaining to clinical in-service, which indicates that efforts are being made to provide educational support.

I am more fortunate in NS. education is fairly good at my facilities. We have telehealth, travelling in-service which is done by our education department on day shift as well as evenings. They go around to the different units and they are mini in-services that are 15 to 30 minutes. The staff is paid, as well. If it is pertinent to your unit then they do pay for you on your day off to attend, even a whole day. (CFNU conference Toronto)

In-service is offered by employer - condition of employment - basic trauma life support - pediatric advanced life support. Time and registration covered. They have also added on a trauma nursing core course this year. Provided on an ongoing basis for updates. (N.AB RN)
Public Health - we have an excellent in-service - we have an in-house computer and we can access it anytime... So nobody within our health unit has any concerns about education. We also have the opportunity to request and go anywhere we want to any course that we want. (ON RN)

Participants described the adversarial nature of labour relations, increasing numbers of grievances, lengthy processing times, budget constraints and the need to educate nurses about union matters.

...it's (labour relations) become very adversarial and again, it's the higher ups are being driven by a corporate agenda; and it's a corporate ideology and a corporate agenda. It has nothing to do with health care and especially, and I'm going to speak for BC here, all the heads of the boards and everything were recruited from business. (CFNU conference Toronto)

...We have increased grievances due to workplace issues such as management doing bargaining unit work, other members doing bargaining unit work such as RNs doing LPNs jobs, where they could call in LPNs that are available - they choose not to. The employer is complaining about the union because of the increased grievances - not our fault. If they would follow the collective agreement... (SK LPN)

It takes so long to get anything done, changed. To set up meetings with your employer if you have grievances, to put something on the agenda for a hack meeting, it is very difficult to actually meet with you, because if they try to schedule it when they are working, it is too busy for us. It is a constantly juggling of time away from your work. Also, to get arbitration, it is a long time. (ON RN)

My issues are directly related to budget constraints that we work under, and as the government tightens it, the employer finds creative ways of looking at our contracts and interpreting them in such a way that it has a negative effect for the nurses and we wind up with a lot of grievances that we don’t get any settlement on and so the game we are in, round robin of arbitrations, trying to arrive at settlements. (ON RN)

My major concern is nurses coming from school know nothing about unionism and have a hard time following their own contract and understanding it. (ON RN)

The positive comments about the role of nursing unions were about providing support to patients and nurses, being involved in professional issues, advocating for worker rights and safe work environments, and acting as a liaison between nurses and management.

Would you not say that the union can be seen not only in the workplace, but for patients, supporting patients as well, making sure that they do get the right care. (CFNU conference Toronto)

The nurses say it is the right tool to fix the problem. It is a hammer to hit the nail on the head, rather than using a screwdriver. Accountability. The union is the only thing that keeps up morale in the workplace. (CFNU conference Toronto)

They make sure there is a safe environment to work in. Most homes are starting to implement and strengthen their health and safety committees with stronger union involvement. It used to be the employers dominated or dictated the health and safety committee. The unions are having a stronger say and we are compensated monetarily for our time with the health & safety committee.
Every home or long-term facility are looking at health and safety because of union involvement. (NB LPN)

My rep is acting now as a liaison between us and management - our group has a problem with management. Without her, we wouldn't know what we are allowed to do, our roles. We would just take a nurse manager's word for it - when, in fact, most of the time she is wrong. We go to our rep first re: conflicts. (NB LPN)

The union polices, to make sure the collective agreement is upheld. You have to be on your toes the whole time to make sure the nurses themselves aren't making deals that go against the collective agreement because the older nurses generally aren't as concerned because they don't have that much longer to work and the younger ones don't have an understanding as to what it is like to work without a union. (ON RN)

Other comments about nurses' unions were less positive, referring to a lack of communication and action and, in the interest of LPNs, a failure to value the full scope of professional practice.

We have very little contact with our union, actually nil. We keep updated through the website. I have been here four years and never once been phoned by anyone. (N.AB RN)

Deductions from union on my paycheck - role they play. A lot of periodic mail. We are so far away. Don't know who we are voting for. A lot of titles - but unaware of actually what they do. A few years back, I did talk to a union rep, took me several days to get a hold of him. No real interaction. (N.AB RN)

We do have an issue here with this union and provincially with this union because they treat every member the same, whether you are dietary, housekeeping, we are all equal but they don't consider professionals to be at a different level, so that is why this union fails nursing and it does put us all back. (SK LPN)

We just got our wages all reduced and they are hiring more staff. We have contacted the union. Union does nothing. We mailed them and told them what was happening. We got a newsletter that said “the budget has now balanced”... LPNs were reduced, everybody was reduced except for RNs and management. The union forced us to take that cutback. (BC LPN)

Debriefing processes and employment assistant programs (EAP) represent another type of workplace support. Many of the comments referred to a lack of or limited accessibility to this type of support despite the recognized need for it. Another issue was that nurses are not always informed of or aware of this service and therefore do not access it. Some nurses spoke of the EAP (Employee Assistance Program) that is available but not always trusted.

I am in acute care, we have a floor that IV drug users get violent often - from patients and patient visitors - we constantly have security on floor, but we don't get debriefing. We have had nurses abused, nurses physically assaulted, we don't get debriefing. (BC LPN)

As health care workers, we do a terrible job of taking care of each other. Debriefing is unheard of. We face life and death situations day in and day out. We are expected to perform at a very
high professional level and then we face one emergency after another and expected to keep on going and going. No one asks, how are you feeling, how are you doing. (CFNU conference Toronto)

In BC - this is actually one thing we are just getting on board in our region - debriefing very limited - some have it some don’t...It is not automatic, you have to request it. Many times, in critical incidence, they don’t realize the need debriefing. It is not identified by management or anybody. (CFNU conference Toronto)

It might seem odd for nurses in nursing home to need debriefing on death, when it happens so regularly. But we build up in-depth relationships with our clients and with the families. Generally speaking there is no support system - from peers only (ON RN).

Our program is strictly the EAP program that is an out of contract, out of the employer. The biggest problem is people are fearful of using it because they feel that it is probably connected. The occupational health and safety nurse that we have, they encourage people to go to her, but again she is a contract position and when she changes over, it is sort of like these locked files that human resources has access to, so where's the confidentiality? (ON RN)

Other nurses felt that debriefing programs in their workplace are adequate for their needs. Although it is more difficult to provide this type of support in isolated areas, accommodations are being made for nurses who require assistance.

Prevention and debriefing programs - we can call critical stress incidents management out of Winnipeg by phone - they are very good. Have used this numerous times. Very positive. The EAP program is available and I have utilized that. But as far as debriefing in the community - there isn't - they would fly us out, if we asked for it. (N.AB RN)

We debrief informally with one another - my immediate manager is aware enough to ask if you want to talk. Sometimes we're distrustful of the formal debriefing program - if you say something it can come back at you. On our team we have an understanding, if you want to talk, you can interrupt somebody. We will make ourselves available. (BC RPN)

4.2.4. Degree of meaning

ISSUES: Professional identity, scope of practice, provision of holistic care

Nurses will find meaning in their work if they are able to adhere to the philosophy and standards of care held by their respective profession. Nurses generally believe that a holistic approach to nursing care is highly meaningful to their own practice when they are able to attend to all aspects of patients’ health and well-being (Baumann et al., Commitment and Care, 2001). Healthcare restructuring and changing scopes of practice have impacted nurse's practice environment, nature of care-delivery, professional identity and, ultimately, the degree of meaning attributed to work. The focus group participants commented that, within the current nursing environment, their role is being devalued and not being given priority in actual practice.
I think protecting what is nursing is really important right now… In our intensive care unit in the last three or four years, they have implemented unit aids, specifically and it has been beneficial in the sense that we have additional hands, but some of the work that they are doing or that they are assuming… In some areas, they are given that freedom to perform those functions and I don’t think that is right. We need to make very clear what is nursing…. (CFNU conference Toronto)

Even the doctors don’t know our role, our qualifications, what’s an LPN? We are high class PSWs! We can’t even answer questions asked by family members, the RN has to do that. The RN told me to fetch her if a family member had a question. (QC LPN)

The nurses' professional role is defined by the specified practice scope guidelines. Currently, LPNs are voicing concerns about the lack of consistency in the tasks they are allowed to do in a given shift or nursing unit. LPNs expressed role confusion and lack of direction from their superiors.

When there are RNs available we become PSWs, but when there are no RNs, well, now were good enough to do the job, now we are competent. We are always “good” when someone is missing. They don't have enough confidence in us, the employers and the nurses alike. We are fully capable of doing the tasks…. (QC LPN)

...there are certain assumptions made with the RN that here she knows - when the LPN wants on, full scope, partial scope, no scope, nobody knows and so they are coming from all different perceptions of the people that are looking at you...Policies or guidelines in units that are different. If I go to emerg, I can do certain things, catheters, vitals... but I can't touch medication, but if I go somewhere else, then I do the medication. (BC LPN)

Your role - one moment you are being used one way, the next minute another way....and you are treated completely different when you are in the roles, eg., you are almost treated like a peer when you are doing the medications and whatnot by your fellow RNs and your care staff. When you work as a care aid, you are treated as if you don't know what you are doing but you don't have that knowledge but you are an LPN - your just a care aid…I feel badly about that. We have the knowledge, experience, ability - one day we are and one day not - no consistency. (BC LPN)

Where I work, the RN decides what the LPN will do. I work in a long-term care facility. I can do everything, including medications as an LPN. But when I worked on the other floor, all of a sudden I'm stupid and apparently I'm just like a PSW. (QC LPN)

In general, LPNs expressed a desire to practice to their full scope.

Rehab - Certainly full scope is an issue. If you are trained and coming out of a nursing program and ready to use all skills and wind up on gynecology - you can't catheterize, or you can't pass medications, etc. That is a retention problem for me. I am thinking of getting off rehab, but I will not go to a place where they aren't going to use me, if I can't use my skills. (SK LPN)

We are now just starting to work in the scope of our practice. If I worked on the alternate level of care unit, I could be drawing blood, but because they have no RNs there. So, we'll use the LPNs when we don't have an RN. But if we can perform these duties at one point, we should be able to perform these duties at the other. I love being an LPN, but I would like to be respected in full scope. (QC LPN)
Some LPNs expressed feelings of discomfort with the increased level of responsibility and range of tasks they are expected become competent in.

I'm old - at the facility I work at - and I'm struggling to remember stuff I learned - and everything - but - you have to remember those skills again - quickly sometimes - when I started my work - I worked in long-term care, so it's the Nurse that does the drug passing - you know - and now we have had IVs, oxygen and all those things that we have to remember and relearn and this thing - and we are working - doing almost identical work to the RN - but - for us - it's just added to our workload for one thing (QC LPN)

As far as med-surg is concerned, it feels like everyday we go to work, we have more responsibilities that the RNs used to do that we are now being asked to do - e.g., assessing the patient, the RN doesn't have time to do physical assessment anymore - and this is in our scope of practice - some of us - if you have the proper education to do it, some don't. A lot of my co-workers are uncomfortable being asked to do this, having these extra duties. (NS LPN)

Although LPNs are to be held accountable for all tasks they perform within their scope of practice, some RNs perceive they are ultimately responsible for LPN actions. Ongoing tension exists between the two nurse groups as RNs perceive LPNs to be taking over their “territory.”

LPNs are now being placed where they never have been placed before - they are in emergency rooms. So, they are in the emergency room area and now they are being delegated tasks but the RN is ultimately responsible that was the task carried out properly. Like ECG, blood withdrawals, IV medication administration, hanging blood in emerg, and the RN is there just to do the task, it is the RN who is responsible in the supervisory role - they (are) the liable one. (CFNU conference Toronto)

They have created this issue themselves by creating us doing it that way, because it is our fault that we are left with the mess, we have to deal with it. But what's happening is, it is creating a line between the RNs and LPNs. And that needs to be erased. (BC LPN)

I was in acute care as the most senior, I worked on a ventilated ward access for two and a half years and sometimes I was the only vent trained - no RN was vent trained. The RNs don’t know how to work with the LPNs or it is like they feel threatened that we are taking their jobs instead of us being seen making the whole patient the priority of everybody rather than this is your task, this is my task…(BC LPN)

Role confusion and conflicts were no limited to RNs and LPNs. In some settings, psychiatric nurses experience tension and lack of clarity in terms of role expectations between themselves and other workers, such as correctional officers.

I think there is a strained relationship between disciplines - nursing and correctional officers. Issues - who does what - defined role duties not enforced. (SK RPN)

Polarization of the two groups, security versus nursing. [Security] look at a situation in a certain light, from a safety correctional point of view and it is most times directly opposite to what nurses do, by providing therapeutic intervention. (BC RPN)
I find that our roles are different - we are more concerned with rehabilitation and programs and correctional officers are into security and safety. Also, they are very uncomfortable when you talk about rehabilitation. I find they are quite fearful that we are - we have a different understanding of these patients. (BC RPN Regional Correctional Treatment Centre)

Nurses repeatedly emphasize their belief that it is the patient care that suffers the most when they, as the care-givers, are continually faced with undue work pressures. Participants stated that excessive workloads and lack of resources are threatening provision of holistic, meaningful care.

What's missing is the emotional support that you and give to your patient - no time to hear what they are saying and respond. Too busy doing normal basic physical care - feeding, changing, charting. ...it is not adequate to give the briefest response to their questions. They need emotional and physical touch, a hug now and then. (NB LPN)

One of the things I miss in nursing in our profession is just sitting and talking to the client and family. That is what they remember the most. They don't remember how well you performed a procedure or how efficient you were in making their bed. They remember if you had time to talk. And this sometimes ends up being the housekeeping staff. (CNFU conference Toronto)

They also stressed how emphasis on economics comes into conflict with patient care.

I feel that our residents have lived their lives, are now in a nursing home, in their last environment before dying, and they deserve to have more hours, more care. Respect. That's not how it is, its go go go, it is a business, it is for money... (NB LPN)

With respect to the standards of care, the thing that I find most abhorrent these days - the whole focus is on volume. We have to treat more patients quicker without really having resolved the problem that they came in with....so, revolving door syndrome. (ON RN)

Health-care restructuring has left many nurses with a less meaningful work environment, one that does not value the patient, as summarized here.

... who wants to work in an environment that is privatized and now running on corporate structure. 'The bottom line is the problem... the bottom line is the question. Not the patient, we don't care about the patient anymore, we care about the bottom line...’ (CFNU conference Toronto)

4.2.5. Degree of influence

ISSUES: Control over practice; control over scheduling; nursing leadership

Three factors that can help nurses to increase their influence in the workplace have been identified as control over practice, control over scheduling, and nursing leadership (Commitment and Care, 2001). Nurses working in US Magnet hospitals have indicated that effective control over nursing practice requires an empowered organizational structure. Work environment structures have been shown by researchers to have an impact on employees' work effectiveness (Laschinger & Havens, 1996). Before nurses can establish control over their practice, the freedom to act independently within the full scope
of their education and practice, they must establish professional identities and role clarity.

As indicated earlier, LPNs expressed that they do not have control over their practice.

*The changes in nursing policy that states exactly where we fit in, no one seems to be following that policy and that was about November, 2002. The region's policy and passed by the regional board of directors. It states that we are partners in care and that we have the right to say where our competency begins or ends. Yet we are being told by RN co-workers where our competency begins and ends, without us being able to say I can do that, I want to do it. They say you can't because you are an LPN.* (BC LPN)

*I work in rehab center - when I have a heavy workload - the RN will ask me “Did you do this and was this done” and I will chart that for you - I don't have a chance to do my own charting because she has already run back down the hall and charted what I do - as if they did it. They are taking credit for our work.* (NB LPN)

As the nursing shortage grows, it has become more difficult to replace nurses, particularly in certain specialties and areas that are facing serious recruitment and retention problems. Staff have been pressured to work unscheduled shifts, often at inconvenient times, imposing on personal and/or family life. Nurses perceived a loss of control when there was decreased input into work schedules. One of the main complaints by participants involved the difficulties they had in getting preferred vacation and requested days off.

*....senior LPNs are granted vacation time because we have the skills, they can't replace us with casuals because the casuals don't have the skills - they just can't come in and take care of these 23 hr observations. ...so we do get it (vacation) but not when we want it.* (NS LPN)

*I work as a primary health care nurse practitioner in a rural area in (the Atlantic region) and my biggest concern is that we cannot get time off. We have no replacements. We are working tons of overtime, we cannot get statutory holidays, Christmas, Easter - we have to cover each other's sick time. We can only take our annual leave when it is convenient for our employer, so I would say my chief concern is lack of coverage.* (CNFU conference Toronto)

*Working in rural areas, the expectation is that you don't have a family life, a life besides your work and you are expected to be on call 24 hours a day, seven days a week, 52 weeks a year. In order to recruit and retain nurses in rural areas, we have to reassure them they don't have to sacrifice their families or personal lives.* (CNFU conference Toronto)

Participants expressed that they do not have the opportunity to participate in decisions that affect their practice environment.

*Let the nurses have more input. They are at the basis of health care and management likes to believe that we think that we are having input to a lot of these decisions and restructuring and we don't have squat.* (CFNU conference Toronto)
A lot of the retention issues - e.g., nobody wants to do the schedules - we have nurses who have volunteered to do it on their own time for no compensation and management will not give it to (them) because they want to keep that control. We have nurses who have great ideas about how to change things, but they can’t get the support from management. (NS RN)

4.2.6. Balance between effort and reward

ISSUES: Remuneration; recognition and rewards

Societal rewards are distributed by money, esteem and status control; perceived imbalance between work efforts and received rewards result in adverse emotional and physical responses (Siegrist, 1996). One of the main concerns of RNs in terms of their wages relates to the pay inequity between community nurses and hospital nurses.

Our biggest problem is the fact that nurses in the community are not paid the equivalent of what hospitals are… the gap widened even greater when we went to the for-profit agencies and privatizing home care more and more in Ontario. Now you’re looking at a $10 an hour (difference) between a community nurse and a hospital nurse. (CFNU conference Toronto)

Nurse wages are also a concern in northern nurses due to the lack of pay differential and other allowances.

They lump us in with other nurses and there is no comparison, e.g., isolation pay, weekend premiums, shift differential, all that we don't receive now - and at time, we should be paid danger pay, like penitentiary nurses. Now we are finally on par with the federal nurses. The role that we perform here not acknowledged in the pay scale - we are paid less than southern nurses. (N. AB RN)

The resource pool has many more benefits that someone full-time so, therefore, I have a lot of nurses that come in for a month at a time, some six weeks and they are flown home, off several weeks, where the indeterminate (permanent staff) receive two trips out a year. Another example is they don't pay rent, where I pay $450 a month rent. It is unequal. They are not going to recruit full-time nurses, just perpetuate the resource pool. (N.AB RN)

An effort-reward imbalance for LPNs has to do with the lack of compensation for their increased scope of practice and additional duties and responsibilities.

... we are having to take on more responsibilities, and we are not getting the extra wages. We are basically being used as an RN and we are not making the money. So, my point is, you can be an LPN... or a care aid who makes $1 less an hour and they are not responsible for anything and we are working side by side with these people, making a $1 an hour more and I am working side by side with an RN, doing the same thing she or he is doing and they are getting $9 an hour more than me. (BC LPN)

The LPNs are tired of not being paid enough, where our level of care - we had medication courses, assessment courses, phlebotomy we do, but we are paid $1 more than the ones that are sweeping the floor under our feet. (NB LPN)
Participants echoed the pervasive view that nurses are neither valued in general nor given recognition over time for their increasing experience and advancing clinical expertise is reflected in the pay scales which have relatively few increments (Commitment and Care, 2001).

...a nurse of 26 years experience making the same as one with six years, or someone with 10 years, making no additional premiums and when positions are being posted the Baccalaureate are preferred but what they are saying is they will only interview Baccalaureate. (NS RN)

If you are going to work in a hospital setting - you don't have a chance for advancement based on your skills, your years in training, education. People who want to increase their education, there is no financial compensation. (NS RN)

In terms of esteem and status control, participants voiced concerns that the lack of recognition and promotional opportunities is contributing to problems relating to recruitment and retention.

...One of the challenges I see is keeping people here for a longer period of time, like recruitment and retention. People are actually coming, getting the experience they need and going elsewhere getting positions in the States or going where there is higher wages or whatever... so it is hard to actually retain them and people are looking elsewhere... because it is so hard and they don't see that promotion. (NS RN at CFNU conference)

... being RPNs and not being recognized across the country, even though we work in a federal environment. I could transfer to (an institution in Ontario) and I would be considered a registered practical nurse rather than a psychiatric nurse- where here my specialty is quite appreciated and utilized - Psych nurses need to be more recognized across the country. (RPN BC)

In summary, these quotes from the focus group discussions have provided a realistic account of what nurses are experiencing in their workplaces. These findings will now be summarized to recapitulate the pertinent issues.

4.3. **Summary of Findings**

The union focus group responses were organized according to six dimensions of stressors outlined in Kristensen's (1999) model for society, stress and health. According to this model, the optimal work environment for well-being includes: demands fitting the resources of the person; degree of basic predictability; degree of social support; degree of meaning; degree of influence; and balance between effort and reward. These overarching principles were discussed in terms of identified issues that characterize nurses' concerns about their work environments.

Across the country, nurses from both hospital and non-hospital settings report work pressures resulting from workloads that are too heavy for the number of available staff. Time constraints make shortcuts to care necessary, resulting in decreased quality of care and lack of job satisfaction. Replacing staff from a casual resource pool can be difficult in a regionalized health environment as nurses are required to work in more than one facility in a district. Lack of staffing makes it very difficult to provide mentoring to the new nurses because it only adds further to workload of the older and more experienced
nurses, who will soon be retiring. Poor working conditions impact negatively on recruitment and retention, causing high rates of turnover that, in turn, lead to lower morale and further deterioration in the work environment. New nurse graduates often relocate to positions they perceive to be more enticing. Recruitment and retention issues are particularly challenging in northern and rural areas where isolation and working alone are a reality, and incentives for full-time nurses to stay often compare poorly to the benefits offered in recruitment initiatives.

Many resource issues were voiced by nurses from all settings. Nurses claim that closure of hospital beds occurred without an increase in community-based services. Patients are discharged earlier and therefore require more complex care in the community. In hospital and home-care settings, nurses perceive that budgets do not reflect the needs of patients in terms of appropriate patient placement and access to health care. Equipment is not in working order, supplies are inadequate and computers malfunction regularly.

In terms of staffing, issues around skill level vary among the nurse groups. Continued utilization of unregulated care-givers raises concern about the overall competency of the care team. Psychiatric nurses working in correction treatment centers are in a unique situation in that security workers are concerned only about security, resulting in a tension between health needs and security needs. Registered nurses are worried about the lack of clinical preparation and competency of newly graduated nurses from colleges and universities, particularly when they go directly into critical care or community care without first gaining experience. Furthermore, when mentoring is inadequate, as is often the case, patient care is threatened.

Sources of job unpredictability for nurses include risk of injury, workplace violence, and risk of burnout and illness. Although nursing shortages may result in job security in terms of available work hours, workplace unpredictability exists as hospital nurses are “floated” to different units where they are unfamiliar with the environment and unsure of their expectations. Of particular concern is the unpredictability in community nursing when nurses feel they are encountering potentially dangerous situations and fear they are risking injury. This issue was expressed by RNs, LPNs and RPNs in home-care positions. Isolation and lack of security are problematic for nurses in northern and rural areas, and nurses indicate that improved security and better means of communication would make them feel less vulnerable. Potential violence in the workplace increases the unpredictability of nurses’ work and is a concern, particularly in mental health settings. Work pressures felt by nurses in both hospital and non-hospital environments are taking their toll on their physical and mental well-being.

The third key principle relates to workplace support. Each nurse group spoke about nursing managers who are ineffective leaders, do not respect the nurses, are unsupportive, and have little nursing experience with poor understanding of the daily challenges encountered by nurses. In terms of support by colleagues, statements were about nurses not working together effectively as a team and the poor relationships that exist between RNs and LPNs. This lack of respect among care-givers decreases morale and causes additional work pressure. Educational support is also lacking as nurses are often unable attend in-service sessions due to scheduling conflicts and lack of staff to replace them. With respect to northern areas, finding replacement staff presents a particular difficulty and there is not always equal
In-service education is sometimes perceived as inappropriate for the learning needs of nursing staff, and not always responsive to requests made by nurses. Some LPNs feel that in-service sessions are directed at the RNs, and that LPNs do not have equal opportunity to attend. In all fairness, it is important to acknowledge the positive comments pertaining to clinical in-service, which indicates that efforts are being made to provide educational support in some settings, and that nurses are benefiting from these initiatives. With respect to career development through formal nursing education or promotion, nurses spoke of barriers relating to lack of scheduling flexibility, managerial support and opportunity for advancement.

Nurse unions are there to support nurses with respect to the collective agreement. Nurses spoke of the adversarial nature of labour relations, the increasing numbers of grievances, the length of time processes take, the budget constraints and the need to educate nurses about union matters. The positive comments about the role of nursing unions were about providing support to patients and nurses, advocating for worker rights and safe work environments, and acting as a liaison between nurses and management. Other comments about nurses' unions were less positive, referring to a lack of communication and action and, in some instances, a failure to value the full scope of LPN practice.

Responses were varied in terms of the nature of debriefing processes in nurses' workplaces. Many of the comments referred to a lack of or limited accessibility to this kind of support despite the recognized need for it. Another issue was that nurses are not always informed of or aware of this service and therefore do not access it. Other nurses felt that debriefing programs in their workplace are adequate for their needs. Although it is more difficult to provide this type of support in isolated areas, accommodations are being made for nurses who require assistance. Some spoke of the EAP (Employee Assistance Program) as available but not always trusted.

The fourth principle in Kristensen's model refers to the level of meaning that one finds in the workplace. Nurses will find meaning in their work if they are able to adhere to the philosophy and standards of care held by the nursing profession. Currently, a predominant issue with LPNs in the implementation of increased practice scope is the inconsistency in the range of interventions practical nurses are allowed to do in a given shift or nursing unit. For example, they are allowed to administer medications more commonly in long-term care settings than in acute care. LPNs from all locations relayed comments pertaining to role confusion and lack of direction from their superiors. Generally, LPNs want to practice to full scope, except for those who are uncomfortable with increasing the level of responsibility. Although LPNs are to be held accountable for all tasks they perform within their scope of practice, some RNs believe they are still responsible for LPN actions. Also, tension exists between the two nurse groups as LPNs are perceived to be taking over RN “territory.”

In terms of work meaning derived from the provision of care, nurses repeatedly emphasize their belief that it is the patient care that suffers the most when they, as the care-givers, are continually faced with undue work pressures. Nurses indicated how excessive workloads, lack of resources, and at times, technological interferences are threatening quality of care as their ability to provide holistic care becomes almost impossible. Health-care restructuring has left many nurses with a less meaningful work
Kristensen's fifth principle of work refers to degree of influence. LPNs feel that they do not have control over their practice and that the RN neither respects their contribution to patient care nor allows them the independence they deserve. As the nursing shortage worsens, it becomes more difficult to replace absent staff nurses and maintain sufficient staffing numbers, particularly in clinical specialties and geographic areas that are facing serious recruitment and retention problems. Current staff members are then pressured to work unscheduled shifts, many of which are at inconvenient times, thereby imposing on the nurse's personal and/or family life and resulting in a loss of control over work schedules. One of the main complaints related to the lack of flexibility in getting vacation when preferred and the difficulty in getting time off at all.

The sixth principle is balance between effort and reward. One of the main concerns of RNs in terms of their wages relates to the pay inequity between community nurses and hospital nurses. Nurse wages are also an issue in northern areas due to the lack of pay differential and other allowances. An effort-reward imbalance issue of great importance to the LPNs has to do with the increased scope of practice and associated additional duties that are not accompanied by higher wages to reflect the increased responsibilities. The reward-imbalance model is also about esteem and status control which would be enhanced by promotional opportunities. In this regard, Canadian nurses have concerns to the extent that recruitment and retention are problematic and they don't feel valued for the work that they do.
5. Recommendations

Recommendations were formulated to address nursing work life issues that were raised by the focus group participants. Effective long-term solutions require collaborative efforts between governments, professional associations and councils, nurses’ unions, employers, nurse managers, nursing staff members, educators and researchers. The following outline initiatives for nurse managers and employers that would promote healthy nursing workplaces according to the dimensions of an optimal work environment.

5.1. Promote a fit between demands and resources:

• work with unions in hiring decisions to enable reasonable workloads, address staff mix issues and full-time/part-time ratios;

• enhance recruitment and retention by offering full-time job to new graduates and ensuring adequate orientation and mentoring;

• consider patient complexity and nurses' skill levels in allocating workload;

• examine whether costs related to use of agency nurses and overtime could be redirected toward establishment of permanent positions; and

• ensure supplies and equipment are adequate, in good working condition, and appropriate for the particular settings.

5.2. Promote a high level of basic predictability:

• enhance workplace safety through reasonable workloads and adequate supplies;

• ensure that nurses do not miss breaks and have access to nutritional snacks during nights;

• involve nurses in development of strategies toward safer work environments that consider their particular circumstances, such as those associated with community and psychiatric settings;

• implement actions to address abusive or violent behavior, such as buzzers for nurses in dangerous settings and processes for efficient reporting of incidents; and

• when nurses work alone in rural and northern environments additional support mechanisms need to be in place to prevent them from being left in the field without access to their support network.

5.3. Promote support in the workplace:

• develop strategies to build communication and improve working relationships among nurses, and between nurses and other health care professionals in the care team;

• assess adequacy of employee assistance and debriefing programs and improve existing arrangements where indicated; and

• offer educational support through ongoing relevant learning opportunities, providing the necessary flexibility and replacement staff to enable nurses to attend the sessions.
5.4. Promote meaningful nursing practice:
   • ensure that nurse managers understand the specific roles of both regulated and unregulated care providers, including the additional responsibilities associated with increased LPN scope of practice; and
   • recognize and respect nurses' individual care philosophies, especially in the provision of holistic patient care.

5.5. Promote nurses' influence in their work:
   • clarify to the care team what LPN full practice scope entails;
   • provide nurses with the necessary information and opportunity to participate in governance, encouraging their input into decisions that impact their practice; and
   • collaborating with unions to interpret the collective agreement and develop flexible schedules that meets the needs of nurses and employers.

5.6. Promote balance between effort and reward:
   • motivate and reward nurses who assist with preceptoring and mentoring;
   • recognizing seniority through pay increments and introduce clinical laddering to recognize skill and experience;
   • lobby for pay equity between the sectors; and
   • recognize the increased skill level of practical nurses as they take on additional responsibilities.
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Canadian Institute for Health Information. (2003a). *Workforce Trends of Registered Nurses in Canada, 2002*. CIHI.


Canadian Institute for Health Information. (2003c). *Workforce Trends of Registered Psychiatric Nurses in Canada, 2002*. CIHI.


Appendix A. Main Search Methods

**Key Words and Phrases**

*Note:* Where appropriate, key words and phrases were used to search for data for each of the three regulated nursing professions: Registered Nurses, Licensed/Registered Practical Nurses, and Registered Psychiatric Nurses. As differing titles were found in the general search, they were then also used as search words. This list below is not a comprehensive list.

**Databases**

Electronic Databases
- University of Toronto Library Catalogue
- Nursing Research Unit (U of T Site) EndNote

**Published Literature**

- CINAHL
- MEDLINE
- EMBASE
- PubMed

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### Nursing Organizations

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</table>
NL  Association of Registered Nurses of Newfoundland and Labrador http://www.arnn.nf.ca/links/criteria_for_arnn_licensure.htm
Licensed Nursing Assistants of Newfoundland and Labrador http://www.nlhba.nf.ca

NT  Northwest Territories Registered Nurses Association (includes NU) http://www.nwtrna.com
NU  Licensed Practical Nurses of the Northwest Territories http://www.hlthss.gov.nt.ca/
Nunavut, Health and Social Services, Government of NWT No website available

YT  Yukon Registered Nurses Association Email only yrna@yukon.net
Licensed Practical Nurses of the Yukon Territory No website available

*Quebec nursing associations’ websites are not accessible in English.

**Union Websites**

Canadian Labour Congress (CLC) http://www.clc-ctc.ca

CFNU and Affiliates
Canadian Federation of Nurses Unions (affiliate of CLC) http://www.nursesunions.ca
British Columbia Nurses Union (BCNU) http://www.bcnu.org
United Nurses of Alberta (UNA) http://www.una.ab.ca
Saskatchewan Union of Nurses (SUN) http://www.sun-nurses.sk.ca
Manitoba Nurses Union (MNU) http://www.nursesunion.mb.ca
Ontario Nurses Association (ONA) http://www.ona.org
Nova Scotia Nurses Union (NSNU) http://www.nsnu.ns.ca
Prince Edward Island Nurses Union (PEINU) http://www.peinu.com
Newfoundland & Labrador Nurses Union (NLNU) http://www.nlnu.nf.ca
New Brunswick Nurses Union (NBNU) http://www.nbnu-siinb.nb.ca

Other CLC Affiliates
Hospital Employees Union http://www.heu.org
United Steelworkers of America http://www.uswa.org
Canadian Union of Public Employees http://www.cupe.ca
National Union of Public and General Employees http://www.nupge.ca
Service Employees International Union - Canada http://www.seiu.ca
Alberta Federation of Labour http://www.afl.org
Union of Psychiatric Nurses of British Columbia http://www.upnbc.org
Professional Institute of the Public Service of Canada http://www.pipsca.ca
# Appendix B. Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCNU</td>
<td>British Columbia Nurses Union</td>
</tr>
<tr>
<td>CAAT</td>
<td>College of Applied Arts and Technology</td>
</tr>
<tr>
<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
</tr>
<tr>
<td>CISD</td>
<td>Critical Incident Stress Debriefing</td>
</tr>
<tr>
<td>CLPNA</td>
<td>College of Licensed Practical Nurses of Alberta</td>
</tr>
<tr>
<td>CNA</td>
<td>Canadian Nurses Association</td>
</tr>
<tr>
<td>CNO</td>
<td>College of Nurses of Ontario</td>
</tr>
<tr>
<td>CPNA</td>
<td>Canadian Practical Nurses Association</td>
</tr>
<tr>
<td>CPNRE</td>
<td>Canadian Practical Nurse Registration Examination</td>
</tr>
<tr>
<td>CUPE</td>
<td>Canadian Union of Public Employees</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Program</td>
</tr>
<tr>
<td>HEABC</td>
<td>Health Employees Association of British Columbia</td>
</tr>
<tr>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
</tr>
<tr>
<td>NANB</td>
<td>Nurses Association of New Brunswick</td>
</tr>
<tr>
<td>NFNU</td>
<td>National Federation of Nurses’ Unions</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>NRU</td>
<td>Nursing Effectiveness, Utilization and Outcomes Research Unit</td>
</tr>
<tr>
<td>NSGEU/NUPGE</td>
<td>Nova Scotia Government Employees’ Union/NUPGE</td>
</tr>
<tr>
<td>NSSC</td>
<td>Nursing Sector Study Corporation</td>
</tr>
<tr>
<td>PIPSC</td>
<td>Professional Institute of the Public Service of Canada</td>
</tr>
<tr>
<td>RHA</td>
<td>Regional Health Authority</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RNABC</td>
<td>Registered Nurses Association of British Columbia</td>
</tr>
<tr>
<td>RNAO</td>
<td>Registered Nurses Association of Ontario</td>
</tr>
<tr>
<td>RPC</td>
<td>Regional Psychiatric Centre</td>
</tr>
<tr>
<td>RPN</td>
<td>Registered Psychiatric Nurse</td>
</tr>
<tr>
<td>RPNAA</td>
<td>Registered Psychiatric Nurses Association of Alberta</td>
</tr>
<tr>
<td>RPNAO</td>
<td>Registered Practical Nurses Association of Ontario</td>
</tr>
<tr>
<td>RPNAS</td>
<td>Registered Psychiatric Nurses Association of Saskatchewan</td>
</tr>
<tr>
<td>SEIU</td>
<td>Service Employees International Union</td>
</tr>
<tr>
<td>SRNA</td>
<td>Saskatchewan Registered Nurses Association</td>
</tr>
<tr>
<td>UPNBC</td>
<td>Union of Psychiatric Nurses BC</td>
</tr>
</tbody>
</table>
Appendix C. Glossary of Key Terms

Note: This glossary is meant to indicate only how the following terms are used in this report. It is not meant to provide comprehensive definitions.

**community services.** Any health services rendered in the general community and not associated with admission to a hospital or special clinic (National Union Research, 1997).

**jurisdiction.** A province or territory.

**labour mobility.** Situations where workers qualified for work in a particular occupation in one province/territory have access to similar employment opportunities in another Canadian province/territory, which allow the qualified worker to work wherever opportunities exist (Human Resources Development Canada [HRDC], 2002b, p. 1).

**licensed practical nurse (LPN).** LPNs are “regulated health care professionals who work in partnership with other members of the health care team to provide nursing services to individuals, families and groups of all ages. LPNs combine nursing knowledge, skill and judgement when treating health conditions, promoting health, preventing illness and assisting clients to achieve an optimal state of health. They assess, plan, implement and evaluate care for clients throughout the lifecycle as disease progresses and through palliative stages” (Building the Future, 2003b).

**nurse.** For the purposes of the report, a nurse is a graduate of an accredited nursing program who has passed the requisite licensing examinations and is registered with an appropriate regulatory body. A member of any of the three regulated nursing professional groups in Canada: registered nurses (RNs); licensed practical nurses (LPNs), with the title of registered practical nurses in Ontario; and registered psychiatric nurses (RPNs).

**nurse practitioner (NP).** An NP is an advanced practice nurse whose practice is focused on providing services to manage the health needs of individuals, families, groups and communities. The NP role is grounded in the nursing profession’s values, knowledge, theories and practice and is a role that complements, rather than replaces, other health care providers. NPs have the potential to contribute significantly to new models of health care based on the principles of primary health care (PHC) (CNA, June 2003).

**privatization.** Privatization means the act of turning something over to private for-profit companies. This is a loaded word in the health care context, because public and private interests are at play in both the financing and delivery of health services. “Privatizing” the financing of health services implies shifting the burden of funding the system from government (through tax revenues) towards individuals (e.g., user fees and private insurance). “Privatizing” the delivery of health services implies greater reliance on individuals and organizations outside government in the production and provision of health services.
registered nurse (RN). “Through their legislated scope, RNs are authorized to practice autonomously regardless of the complexity of the client’s/client’s condition(s) or the predictability of the outcomes of care. RNs are diversified health care workers, able to provide care to individuals, families, groups, communities and populations of all ages and levels of health. RNs provide client care across the continuum of health promotion, disease prevention, treatment, support and rehabilitation and palliative care” (*Building the Future*, 2003a).

registered psychiatric nurse (RPN). RPNs “participate as members of interdisciplinary health care teams in providing holistic care to client groups in the context of mental and developmental health services. Psychiatric Nursing promotes the restoration of client health and wellness through health promotion initiatives that are evidence based. RPNs practice at all levels of prevention, including primary, secondary, and tertiary health care services across the life span” (*Building the Future*, 2003c).

unregulated care provider (UCP). UCPs are paid care providers who are neither registered nor licensed by a regulatory body and who have no legally defined scope of practice. UCPs do not have mandatory education or practice standards. UCPs include, but are not limited to, resident care aides, home support workers and special education assistants. Their work settings include client homes, group homes, residential care facilities and schools (RNABC, October 2000).
Appendix D. Information Letter to Union Leader

MAKE YOUR VOICE HEARD TODAY

Nursing Union Activists
Invitation to Participate in Focus Groups

The Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU) is conducting focus groups with union activists for "Building the future: an integrated strategy for nursing human resources in Canada". This milestone project is the first national human resources analysis of the Canadian nursing labour market that is both endorsed and led by all the nursing stakeholder groups in Canada. The overall goal of this multi-year study is to produce an integrated human resource strategy for the three regulated nursing occupational groups (Licensed/Registered Practical Nurse, Registered Nurse and Registered Psychiatric Nurse) in Canada. You can help us by making your voice heard today.

As you already know, Canada is faced with a growing nursing shortage that will affect the ability of health care agencies to deliver services to patients. This study will explore the opinions and perspectives of union activists on topics such as: labour relations, work environment/conditions, retention and recruitment, employee assistance programs, and ongoing educational opportunities.

The information collected from these consultations is essential, as the study will provide important information for decision-makers regarding the Canadian nursing labour market. It is hoped that this will assist in resolving the human resource issues facing nurses, including the shortage of nurses. This will benefit both nurses and their patients.

What will be expected of me as a participant?

As a participant in this study, you will be asked to voluntarily take part in a focus group for about 90 minutes in which you will be asked to discuss your opinions, perceptions, and experience working as a nurse in Canada. You will also be asked to complete a short demographic form that will take about 5 minutes to complete.

How will I benefit from participating in this project?

While you will not benefit directly from this study, the results collected from these consultations will shed light on the nursing union perspective on labour relations, work environment/conditions, retention and recruitment, employee assistance programs, and ongoing educational opportunities, as well as helping decision-makers with developing strategies. The implementation of these strategies will result in policies that will improve nurses’ work environments. There are no known risks associated with participating in this study. Your participation will help to address human resource issues and will help us develop an action plan to manage nursing human resource planning decisions. On behalf of the research team, and the national Steering Committee, we wish to extend our sincere thanks and appreciation for taking time to participate in this important study.

Sincerely,

Linda O’Brien-Pallas, RN, PhD
CHSRF/CIHR National Chair, Nursing Human Resources
Professor, Faculty of Nursing, University of Toronto
Director and Co-Principal Investigator, Nursing Effectiveness, Utilization and Outcomes Research Unit, University of Toronto
Appendix E. Consent to Participate Form

Nursing Union Activists
Consent to Participate in Focus Groups

I understand that the Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU) at the University of Toronto is a multidisciplinary network of researchers who are studying the changing needs of the health care system and the challenges to provide evidence to inform decisions.

I understand that they are conducting a research study on the current and future state of the nursing labour market in Canada. They are requesting my cooperation, as a nursing union activist, to be a voluntary participant in this study. This study will provide the basis for the first ever national, long-term nursing human resources development strategy. Nursing union representatives from across Canada are being invited to participate. The purpose of the focus groups is to understand the perspective of nursing unions about a number of key issues which may influence how nursing work is completed.

I understand the information given to me about this study, "Building the future: an integrated strategy for nursing human resources in Canada", and my questions about the study have been answered to my satisfaction. I am willing to participate voluntarily in a focus group to discuss the key issues in nursing and am aware that the focus group will be audio taped and transcribed. I understand that all data obtained as part of this study will be kept confidential and that I will not be identified in reports or publications.

I understand that my participation in this study is strictly voluntary and I am under no obligation to provide consent. I am aware that I am free to withdraw from the study at any time, for any reason, without penalty and that neither the agreement to participate or withdraw from the study will affect my position as a nursing union delegate.

Confidentiality
I understand that data will be coded with anonymous identifiers; my data will only have a code number in the data analysis file. I understand that the information shared during the session is confidential, and is not to be repeated to those outside of the group. However, there is a limit to my ability to ensure confidentiality for information shared during this session. My name and workplace will not be revealed in any publications or reports. The data will only be reported in summary fashion. Audio tapes and transcripts from focus group sessions will be kept for seven years in the Nursing Research Unit’s locked data storage unit, after which time the material will be destroyed.

In signing and dating the statement below, I understand that I am agreeing to be a voluntary participant in this focus group.

I give permission for my data to be used for this research study, "Building the future: an integrated strategy for nursing human resources in Canada", only.

I agree to participate in this study.

/ / /  
Participant's Name Signature Date (dd/mm/yy)
(Print Name)

This signature sheet is to be given to the facilitator at the front of the room. The consent sheet will be stored in a secure unit.
## Appendix F. Demographic Form

### Union Representative Focus Group

**Demographic Form**

Thank you for taking the time to participate in this focus group. We would appreciate you taking a moment to answer these few questions. Your answers will help us describe the characteristics of those attending these groups. Your answers will be kept confidential and you will not be identified in any reports or publications.

**Please do not put your name on this form**

1. In which province/territory do you live? *(Circle one number only)*

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nunavut</td>
<td>1</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>2</td>
</tr>
<tr>
<td>Yukon</td>
<td>3</td>
</tr>
<tr>
<td>British Columbia</td>
<td>4</td>
</tr>
<tr>
<td>Alberta</td>
<td>5</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>6</td>
</tr>
<tr>
<td>Manitoba</td>
<td>7</td>
</tr>
<tr>
<td>Ontario</td>
<td>8</td>
</tr>
<tr>
<td>Quebec</td>
<td>9</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>10</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>11</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>12</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>13</td>
</tr>
</tbody>
</table>

2. What was your *highest completed nursing educational qualification*? *(Please choose one answer only)*

<table>
<thead>
<tr>
<th>Educational Qualification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate</td>
<td>1</td>
</tr>
<tr>
<td>Registered Nurse Diploma</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Assistant (Quebec)</td>
<td>3</td>
</tr>
<tr>
<td>Post Licensed/Registered Practical Nurse Certificate</td>
<td>4</td>
</tr>
<tr>
<td>Registered Psychiatric Nurse Diploma - General</td>
<td>5</td>
</tr>
<tr>
<td>Registered Psychiatric Nurse Diploma for RNs and LPNs</td>
<td>6</td>
</tr>
<tr>
<td>Post Licensed/Registered Practical Nurse Diploma</td>
<td>7</td>
</tr>
<tr>
<td>Post Registered Nurse Diploma</td>
<td>8</td>
</tr>
<tr>
<td>Advanced Diploma in Psychiatric Nursing</td>
<td>9</td>
</tr>
<tr>
<td>Nurse Practitioner [RN(EP) or RN Extended Practice]</td>
<td>10</td>
</tr>
<tr>
<td>Baccalaureate in Nursing</td>
<td>11</td>
</tr>
<tr>
<td>Baccalaureate of Science in Mental Health</td>
<td>12</td>
</tr>
<tr>
<td>Baccalaureate of Science in Psychiatric Nursing</td>
<td>13</td>
</tr>
<tr>
<td>Masters in Nursing</td>
<td>14</td>
</tr>
<tr>
<td>PhD in Nursing</td>
<td>15</td>
</tr>
<tr>
<td>Other (Specify):</td>
<td>16</td>
</tr>
</tbody>
</table>

3. In what category(s) and province(s) is your *current nursing registration*? *(Please complete all that apply)*

<table>
<thead>
<tr>
<th>Current Nursing Registration</th>
<th>Province(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed/Registered/Certified Practical Nurse (or Nursing Assistant)</td>
<td>1</td>
</tr>
<tr>
<td>Registered Psychiatric Nurse</td>
<td>2</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Nurse Practitioner [RN(EP) or RN Extended Practice]</td>
<td>4</td>
</tr>
<tr>
<td>Dual RN/RPsychN</td>
<td>5</td>
</tr>
<tr>
<td>Dual LPN(RPracN)/RN</td>
<td>6</td>
</tr>
<tr>
<td>Dual LPN/RPsychN</td>
<td>7</td>
</tr>
<tr>
<td>Other (Specify):</td>
<td>8</td>
</tr>
</tbody>
</table>

4. Are you currently employed as a...?

<table>
<thead>
<tr>
<th>Employment Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>1</td>
</tr>
<tr>
<td>LPN (RPracN)</td>
<td>2</td>
</tr>
<tr>
<td>RPsychN</td>
<td>3</td>
</tr>
</tbody>
</table>

5. How long have you worked in nursing? ________ years
6. What is your current employment status? (Circle one answer only - based on the position where you work most of the time)

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Full time</td>
<td>1</td>
</tr>
<tr>
<td>Temporary Full time</td>
<td>2</td>
</tr>
<tr>
<td>Term contract position Full time</td>
<td>3</td>
</tr>
<tr>
<td>Casual</td>
<td>7</td>
</tr>
<tr>
<td>Permanent Part time</td>
<td>4</td>
</tr>
<tr>
<td>Temporary Part time</td>
<td>5</td>
</tr>
<tr>
<td>Term contract position Part time</td>
<td>6</td>
</tr>
</tbody>
</table>

7. In which type of setting are you currently employed? (Please circle ONE answer only. If you have more than one position now, please answer based on the position where you work most of the time.)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association/Government</td>
<td>1</td>
</tr>
<tr>
<td>Business/Occupational Health</td>
<td>2</td>
</tr>
<tr>
<td>Centre for Developmentally Challenged</td>
<td>3</td>
</tr>
<tr>
<td>Community Health/Health Centre</td>
<td>4</td>
</tr>
<tr>
<td>District/Regional Health Authority</td>
<td>5</td>
</tr>
<tr>
<td>Educational Institution</td>
<td>6</td>
</tr>
<tr>
<td>Forensic Services/Correctional Institution</td>
<td>7</td>
</tr>
<tr>
<td>Group Home</td>
<td>8</td>
</tr>
<tr>
<td>Home Care/Visiting Care Agency</td>
<td>9</td>
</tr>
<tr>
<td>Community Hospital (General/Maternal/Pediatric/Psychiatric)</td>
<td>10</td>
</tr>
<tr>
<td>Teaching Hospital (General/Maternal/Pediatric/Psychiatric)</td>
<td>11</td>
</tr>
<tr>
<td>Mental Health Centre</td>
<td>12</td>
</tr>
<tr>
<td>Intermediate/Long-Term Care</td>
<td>13</td>
</tr>
<tr>
<td>Nursing Station (Outpost/Nurse Clinic)</td>
<td>14</td>
</tr>
<tr>
<td>Physician's Office/Family Practice Unit</td>
<td>15</td>
</tr>
<tr>
<td>Private Nursing Agency/Private Duty</td>
<td>16</td>
</tr>
<tr>
<td>Rehabilitation/Convalescent Hospital</td>
<td>17</td>
</tr>
<tr>
<td>Self-Employed – Independent Practice</td>
<td>18</td>
</tr>
<tr>
<td>Telehealth</td>
<td>19</td>
</tr>
<tr>
<td>Other (Please specify):</td>
<td>20</td>
</tr>
</tbody>
</table>

8. What is the name of the union you represent? __________________________________________

8a. What position do you hold in your union? __________________________________________

8b. How long have you held this position? _________ years

8c. How long have you been a member of this union? _________ years

9. Sex: Female .........1
   Male .............2

10. Year of birth: 19_______

11. Marital Status: Single, .................................................................1
    Separated .................................................................2
    Married/Common-Law/Partnered/Same Sex Relationship ................................ 3
    Divorced .................................................................4
    Widowed ............................................................5

Thank for you completing this form. Your answers will be kept confidential and you will not be identified in any reports or publications.
Appendix G. Script for Focus Group Facilitators

Script for Focus Group Facilitators

Good afternoon, my name is ______________. To ensure complete confidentiality, the organizers have retained the services of neutral facilitators who will lead the discussions today.

[Helping me with the tasks is ______________ who will record the discussions and highlight the key points.]

So let’s begin by telling you about the research being conducted by the Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU), who in partnership with major Canadian stakeholders is responsible for a study entitled “Building the future: an integrated strategy for nursing human resources in Canada”. The study researchers are holding focus groups with union activists, members of nursing unions from across Canada.

You may be asking “how will I benefit from participating in this project?”
As you already know, Canada is faced with a growing nursing shortage that will affect the ability of health-care agencies to deliver services to patients unless they can find ways to recruit and retain more nurses. As part of the larger study, this focus group will explore the opinions and perspectives of union members on topics such as: labour relations, work environment and conditions, retention and recruitment, employee assistance programs, and ongoing educational opportunities. The information collected today is essential in resolving the human resource issues facing nurses including the shortage of nurses. This will benefit both you and your patients.

What to expect as a participant?
You were asked to voluntarily take part in this focus group lasting about 90 minutes. We are asking you to discuss your opinions, perceptions, and experience working as a nurse in Canada. We are also asking you complete a short demographic survey that will take about 5 minutes to complete. Your answers will help us describe the characteristics of those attending these groups.

We would like to take a little time to tell you what to expect in these sessions. A focus group is a way to obtain a better understanding of various groups’ perception about a specific topic. You will engage in a discussion around the themes that the Nurse’s Union Representatives on the study Steering Committee have identified. The discussion will be free flowing and there are no right or wrong answers. A key requirement for successful discussion is the freedom of participants to express their beliefs/values/opinions. The facilitators strongly acknowledge this and wish to assure you that they will rigorously guard the confidentiality of your discussions.

To develop a useful report, a detailed analysis of your discussions will be completed. Because of the complexities of the issues and our desire to include all of your comments, we plan to audio tape the discussions. No identifying voices or traceable features of your comments will go beyond the Study Team.

We are going to distribute a Consent Form for taping and participating if:
You understand the information about this study,
Your questions have been answered,
You are willing to participate voluntarily,
You understand that all data obtained will be kept confidential, and that
You will not be identified in reports or publications.
Distribute the CONSENT FORM for Taping and Participation. Answer any questions, have each participant sign and collect signed forms. Have all participants sign it now!

We would appreciate you taking a moment to answer the few demographic questions now. Distribute the Demographic Form.

Please do not put your name on this form. Your answers will be kept confidential and you will not be identified in any reports or publications.

Answer questions, give them a few minutes to complete, and ask for the completed forms back.

We know that you have offered up your free time to help in this important study. On behalf of the research team, and the national Steering Committee, we wish to extend our sincere thanks and appreciation for taking time to participate in this focus group.

Distribute guidelines to each participant. Begin by asking question #1.

At the end:
Thank everyone again for their time and candor.
## Appendix H. List of Focus Groups

<table>
<thead>
<tr>
<th>Date</th>
<th>City</th>
<th>Prov</th>
<th>Convention/host</th>
<th># partic</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/3/2003</td>
<td>Toronto</td>
<td>ON</td>
<td>CFNU</td>
<td>7</td>
</tr>
<tr>
<td>6/3/2003</td>
<td>Toronto</td>
<td>ON</td>
<td>CFNU</td>
<td>9</td>
</tr>
<tr>
<td>6/3/2003</td>
<td>Toronto</td>
<td>ON</td>
<td>CFNU</td>
<td>9</td>
</tr>
<tr>
<td>6/3/2003</td>
<td>Toronto</td>
<td>ON</td>
<td>CFNU</td>
<td>10</td>
</tr>
<tr>
<td>6/4/2003</td>
<td>Toronto</td>
<td>ON</td>
<td>CFNU</td>
<td>12</td>
</tr>
<tr>
<td>6/4/2003</td>
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Total = 295
### Appendix I. Union Names and Participant Frequency

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