Good Nursing, Good Health
The Return on Our Investment

Progress Report
JPNC Implementation Monitoring Subcommittee

November 2003
January 2004

JPNC Co-Chairs:

Shirlee Sharkey  
President and CEO, St. Elizabeth Health Care

George Zegarac  
Assistant Deputy Minister, Ministry of Health and Long-Term Care

Dear Shirlee and George:

On behalf of the Implementation Monitoring Subcommittee (IMS) of the Joint Provincial Nursing Committee (JPNC), we are pleased to present you with the second report evaluating the outcomes and effectiveness of the implementation of the eight Nursing Task Force (NTF) recommendations accepted by the Ontario government in March 1999.

This report is the result of the significant dedication, time and energy of nursing colleagues and Ministry of Health and Long-Term Care staff participating on the IMS. More importantly, the report is evidence of our accountability to the people of Ontario. We would especially like to thank Jean Bacon for drafting the final report and Anna Cain for serving as a key staff resource to the IMS team.

The report is good news for Ontario. It indicates that strategic investments in nursing in response to the Nursing Task Force report are strengthening and stabilizing the nursing profession in this province. Nursing in Ontario has made important advances in the last three years. There are more nurses working in Ontario, more of them are working full-time, and more nurses are engaged in continuing education, which results in better preparedness for practice. Nursing, for the fifth consecutive year, enjoys the highest public trust compared to any other profession. And, there is increased recognition that this knowledge profession is central to the well-being of Ontarians. Our province’s nursing best practice guidelines are shaping the practice of nursing in healthcare organizations all across the province, and they are greatly praised nationally and internationally.

The nursing strategy is in the early stages. While substantive gains have been made, these improvements are not equally experienced across all sectors of the health system, resulting in a growing shortage of nurses in home health and long-term care sectors. There is still much work to be done. An increasingly complex healthcare environment and global nursing human resources challenges will continue to necessitate sustained action.

We are confident that the Nursing Task Force strategy accepted and acted upon by the Ontario government is forming a solid foundation to ensure Ontarians have access to high quality nursing services when and where they are needed. Our message to the new minister: together we can succeed!

With kindest regards,

Doris Grinspun, RN, MSN, PhD (Cand.)  
Executive Director  
Registered Nurses Association of Ontario  
Co-Chair, IMS

Peter Finkle  
A/Director, Finance and Information Management Branch  
Ministry of Health and Long-Term Care  
Co-Chair, IMS
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>2</td>
</tr>
<tr>
<td>- The Challenge</td>
<td>2</td>
</tr>
<tr>
<td>- The Response</td>
<td>2</td>
</tr>
<tr>
<td>- Monitoring the Progress</td>
<td>3</td>
</tr>
<tr>
<td>I. Nursing Initiatives to 2003</td>
<td>4</td>
</tr>
<tr>
<td>- Practice Readiness</td>
<td>4</td>
</tr>
<tr>
<td>- Undergraduate Education</td>
<td>4</td>
</tr>
<tr>
<td>- Graduate Education</td>
<td>4</td>
</tr>
<tr>
<td>- Continuing Education</td>
<td>5</td>
</tr>
<tr>
<td>- Clinical Best Practice Guidelines</td>
<td>7</td>
</tr>
<tr>
<td>- Scope of Practice</td>
<td>8</td>
</tr>
<tr>
<td>- Changes that Support Nursing Practice</td>
<td>8</td>
</tr>
<tr>
<td>- The Role of the Primary Healthcare Nurse Practitioner</td>
<td>8</td>
</tr>
<tr>
<td>- Retention and Recruitment</td>
<td>9</td>
</tr>
<tr>
<td>- Retention</td>
<td>9</td>
</tr>
<tr>
<td>- Recruitment</td>
<td>11</td>
</tr>
<tr>
<td>- Leadership</td>
<td>14</td>
</tr>
<tr>
<td>- Regulatory Changes</td>
<td>14</td>
</tr>
<tr>
<td>- Leadership Skill Development</td>
<td>14</td>
</tr>
<tr>
<td>- Data and Information</td>
<td>17</td>
</tr>
<tr>
<td>- Access to Data</td>
<td>17</td>
</tr>
<tr>
<td>- Data Collection and Information Management</td>
<td>17</td>
</tr>
<tr>
<td>- HR Planning Measures</td>
<td>17</td>
</tr>
<tr>
<td>II. Impact on Nurses and Nursing</td>
<td>18</td>
</tr>
<tr>
<td>- What are the Trends in Nurse Supply?</td>
<td>18</td>
</tr>
<tr>
<td>- Is the Aging of the Workforce Still an Issue?</td>
<td>20</td>
</tr>
<tr>
<td>- Are More Nurses Working Full-Time?</td>
<td>21</td>
</tr>
<tr>
<td>- Where are Nurses Working?</td>
<td>23</td>
</tr>
<tr>
<td>III. Impact by Sector</td>
<td>24</td>
</tr>
<tr>
<td>- Hospital Sector</td>
<td>24</td>
</tr>
<tr>
<td>- Progress</td>
<td>24</td>
</tr>
<tr>
<td>- Challenges</td>
<td>24</td>
</tr>
<tr>
<td>- Long-Term Care Sector</td>
<td>28</td>
</tr>
<tr>
<td>- Progress</td>
<td>28</td>
</tr>
<tr>
<td>- Challenges</td>
<td>29</td>
</tr>
<tr>
<td>- Community Care</td>
<td>34</td>
</tr>
<tr>
<td>- Progress</td>
<td>34</td>
</tr>
<tr>
<td>- Challenges</td>
<td>34</td>
</tr>
<tr>
<td>- Primary Care</td>
<td>37</td>
</tr>
<tr>
<td>- Progress</td>
<td>37</td>
</tr>
<tr>
<td>- Challenges</td>
<td>37</td>
</tr>
<tr>
<td>- Public Health</td>
<td>36</td>
</tr>
<tr>
<td>- Progress</td>
<td>36</td>
</tr>
<tr>
<td>- Challenges</td>
<td>37</td>
</tr>
<tr>
<td>- Nursing Education</td>
<td>38</td>
</tr>
<tr>
<td>- Progress</td>
<td>38</td>
</tr>
<tr>
<td>- Challenges</td>
<td>38</td>
</tr>
<tr>
<td>IV Recommendations</td>
<td>41</td>
</tr>
<tr>
<td>- References</td>
<td>45</td>
</tr>
</tbody>
</table>
List of Figures

Figure 1: Nurses Employed in Nursing in Ontario, 1992-2002 18
Figure 2: Nurse to Population Ratios for Nurses Working in Ontario, 1992-2002 19
Figure 3: Number of Graduates from RN Programs, 1990/91 to 2001/02 19
Figure 4: Number of Students Entering and Graduating from RPN Programs, 1990/91-2001/02 20
Figure 5: Age Distribution of RNs and RPNs Registered with CNO in 2002 20
Figure 6: RN Employment Status, 1992-2002 21
Figure 7: RPN Employment Status, 1992-2002 21
Figure 8: Where RNs Work, 1992-2002 23
Figure 9: Where RPNs Work, 1992-2002 23
Figure 10: Average Resource Intensity Weight (RIW) for All Inpatients, By Age, 1994-2000 25
Figure 11: Homes for the Aged Resident Classification 30
Figure 12: Nursing Home Resident Classification 30
Figure 13: Clients Waiting for Long-Term Care Beds in Ontario in 2001 by Current Location 32
Figure 14: Trends in Number of Home Care Visits, 1991-2001 34
Figure 15: Enrolment in RN Programs, 1990-91 to 2002-03 39

List of Tables

Table 1: Nurses Studying at the Masters Level, 2000-02 5
Table 2: Nursing Leadership Institute Participants by Sector 15
Table 3: Nurses Employed in Nursing in Ontario 18
Table 4: Total Workload/Worked Hours by Hospital Type 00/01 25
Table 5: Percentage of Full-time Staff by Category by Facility 26
Table 6: Use of Agency Nurses 2000/01 27
Table 7: Trends in Case Mix Measure in Long-Term Care Facilities 31
Table 8: Projected Roll Out of New Long-Term Care Beds 32
Table 9: Number of Nurses Required to Staff New Long-Term Care Beds 32
Preface

Nurses comprise 60.3% of all regulated health professionals (Regulatory Colleges of Ontario) and about 35% of the health workforce (Commission on the Future of Health Care in Canada, 2002). They are the primary providers of home care services, long-term care, public health services, health promotion, hospital-based care and the provincial telehealth program. Nurses also play a key role in the delivery of primary care within areas such as Community Health Centres (CHCs) and aboriginal communities. Nurses work in most settings where healthcare is delivered, and are the heart of the healthcare system. As the Canadian Nursing Advisory Committee (CNAC) noted, “as nursing goes, so goes the rest of the system” (Canadian Nursing Advisory Committee, 2002).

The Challenge

Between 1991 and 2000, at a time when the supply of most other healthcare professionals in Canada was growing, the number of nurses per 100,000 people decreased: 8% for registered nurses and 21% for registered practical nurses (Commission on the Future of Health Care in Canada, 2002).

According to the Commission on the Future of Health Care in Canada, the drop in the number of nurses was due in large part to changes and reforms in the healthcare system which had a “direct impact on the workload of nurses and the competencies they are expected to have.”

Many changes in the healthcare system were driven by the recession in the early 1990s, which resulted in cost-constraints. Some were driven by advances in medical treatment and technology, and the development of new drugs and therapies, which changed how care is delivered. Others were driven by a vision of serving people in their own communities and homes.

As a result of all these changes, the 1990s produced the largest displacement of nurses in Canadian history. Layoffs and a massive move to part-time and casual work led to the loss of thousands of nurses and a marked decrease in continuity of nursing care (Grinspun, 2002). For the nurses who remained, the work environment became increasingly “unhealthy”. Morale declined substantially and a significant number chose to leave the profession (Commission on the Future of Health Care in Canada, 2002).

The Response

In 1998, Ontario’s Nursing Task Force examined the impact of healthcare reform on the delivery of nursing services and the nursing profession. Its 1999 report, Good Nursing, Good Health: An Investment for the 21st Century, recommended several strategies designed to help Ontario retain and attract nurses, improve working conditions for nurses, and ensure nurses have the skills they need to provide care in an increasingly complex environment. A second report, Ensuring the Care will be There (RNAO & RPNAO 2000), set out a comprehensive recruitment and retention strategy. Ontario used these two documents as the basis for its nursing strategy, and set about implementing their recommendations.

In the last year, several national reports - including the Final Report of the Canadian Nursing Advisory Committee, the report of the Senate Standing Committee on Social Affairs, Science and Technology, Building on Value (the final report of the Commission on the Future of Health Care in Canada), and the 2003 First Ministers Accord on Health Care - have also made recommendations designed to relieve the pressure on nurses, improve their working conditions, and make more effective use of their knowledge. Their recommendations echo and reinforce Ontario’s Nursing Strategy.
Monitoring the Progress

Since 1999, Ontario has been working to implement its nursing strategy. Has it been successful? Has it achieved its goals?

In 2001, the Joint Provincial Nursing Committee (J PNC) Implementation Monitoring Subcommittee (IMS) issued the first progress report on the strategy. That report noted that “strategic investments in nursing ... are serving to strengthen and stabilize the nursing profession in this province. Nursing in Ontario has made important advances in the last two years.” At the same time, the report identified a number of priorities for action.

This second report prepared by the IMS of J PNC:

- summarizes Ontario’s recent progress in implementing the province's nursing strategy and recommendations from the first progress report
- assesses the impact that the task force and other initiatives have had on nurses in Ontario by sector
- identifies next steps the profession and the healthcare system should take to ensure the citizens of Ontario have access to and receive high quality nursing care in all healthcare settings.
I. Nursing Initiatives to 2003

Over the past three years, Ontario has implemented a number of initiatives designed to strengthen support for nurses, increase the supply of nurses in the province, and improve the quality and consistency of nursing education and healthcare services. These initiatives focus on the critical success factors for a strong nursing workforce:

• practice readiness or the education / knowledge to meet Ontario’s health needs
• scope of practice or the ability to use nursing knowledge to provide quality care and enhance career opportunities
• retention (the ability to keep nurses in the system) and recruitment (the ability to attract new people to the profession)
• leadership
• data and information.

1. Practice Readiness

Nursing is a knowledge based profession. Since March 1999, the nursing profession and the government have taken a number of steps to strengthen education and improve nurses’ readiness to practice.

Undergraduate Education

Effective January 2005, all new registered nurses are required to have baccalaureate education for entry to practice, in order to comply with new national competencies. By 2002, all RN education programs in Ontario were at the baccalaureate level. Working together, the university and college nursing programs have developed collaborative programs that ensure baccalaureate education is accessible to students across the province.

The College of Nurses of Ontario (CNO) proposes that, effective January 2005, all new RPNs be required to have graduated from a community college practical nursing or equivalent program for entry to practice. The Colleges of Applied Arts and Technology education program for registered practical nurses has been modified to comply with new competencies. The new diploma program was offered by four colleges in 2001 and by the remaining 18 colleges in 2002. Two high schools still offer a practical nursing program at this time but, given the new competencies, it is not known whether they will continue to do so. All programs will have to meet an initial and ongoing approval process sanctioned by the CNO.

Graduate Education

The Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Training, Colleges and Universities (MTCU) have allocated $12.6 million over seven years (2001-02 to 2007-08) to expand graduate nursing programs and accommodate the increased demand for masters level studies in nursing expected from the transition to baccalaureate nursing. The funding will cover the incremental costs to the universities of expanding MScN or equivalent enrolment by 320 places as well as the tuition costs for college nursing faculty enrolled in these programs. Between 2001-02 and 2002-03, total enrolment in masters programs (full-time and part-time) increased by 4% from 503 to 524. Between 1999 and 2002, the number of nurses studying at the Masters level grew from 496 to 549, an increase of almost 11%.

Other Education Initiatives in 2002

• RNAO’s Centre for Professional Nursing Excellence sponsored the first International Nursing Education Conference: “Embracing the Future: Educating Tomorrow’s Nurses”. Over 350 nurse educators from across the country and abroad discussed key global issues in nursing education. The next education conference is scheduled for October 2004.
Table 1: Nurses Studying at the Masters Level, 2000-02

<table>
<thead>
<tr>
<th>Masters Headcount Enrolment as of November 1</th>
<th>Full-Time</th>
<th>Part-Time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>142</td>
<td>354</td>
<td>496</td>
</tr>
<tr>
<td>2001</td>
<td>152</td>
<td>382</td>
<td>534</td>
</tr>
<tr>
<td>2002</td>
<td>179</td>
<td>370</td>
<td>549</td>
</tr>
</tbody>
</table>

Primary healthcare nurse practitioner education is now available on-line (distance education), giving more nurses in Ontario access to the program. According to preliminary numbers in the fall of 2003, since its inception a total of 882 nurses have enrolled in the primary healthcare nurse practitioner program, and 515 have graduated.

Continuing Education

Nursing Education Initiative

Through the Nursing Education Initiative (NEI), each RN and RPN in the province is eligible for a $1,500 annual educational grant to support professional development, including attending courses, conferences, and workshops. As of February 2003, nearly 22,000 nurses had taken advantage of the program, and the value of the grants was almost $17 million. Applications to the NEI have increased steadily since its inception. (Between February and May 2003, the program had funded approximately 14,000 more courses.) The program continues to receive applications from nurses who have not used the program before, as well as from nurses who apply each year for education opportunities. In 2002-03, for the first time since the NEI’s implementation, the fund was over-subscribed. If this trend continues, the NEI will have to develop strategies to ensure the fund is distributed equitably.

The Nursing Education Initiative also provides funds to support educational programs for nurses working for organizations in northern / rural areas that have more difficulty accessing continuing education. Organizations must submit proposals that detail the education required, who will participate, and when and where it will occur.

Who is Using the Nursing Education Initiative?

Since its inception, about 17,000 RNs and 5,745 RPNs have received NEI grants (as of Feb, 2003).

<table>
<thead>
<tr>
<th>Sector</th>
<th>#of RN courses paid for</th>
<th>#of RPN courses paid for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>14,023</td>
<td>6,368</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>1,387</td>
<td>3,508</td>
</tr>
<tr>
<td>Community</td>
<td>2,079</td>
<td>1,377</td>
</tr>
<tr>
<td>Public Health</td>
<td>473</td>
<td>93</td>
</tr>
<tr>
<td>Other</td>
<td>1,880</td>
<td>945</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,842</strong></td>
<td><strong>12,291</strong></td>
</tr>
</tbody>
</table>

Source: NEI Evaluation

Response from nurses to the program is extremely positive. Nurses report that the NEI is a significant factor in their ability to pursue continuing education. Examples of comments from nurses about the initiative include: “This funding has been a real incentive for me to continue with my education” and “I really don’t know how I could have afforded to work on my degree [without the funding]”. They also report other positive impacts, including better quality of patient care, higher morale and greater job satisfaction, an increase in knowledge and skills, and an increase in professional specialty skills.
Advanced Clinical / Practice Fellowship

The Advanced Clinical / Practice Fellowship (ACPF) project, managed by the Registered Nurses Association of Ontario (RNAO), with $500,000 funding annually from MOHLTC, is designed to improve client care and nurse retention. Through this mentoring program, participants spend 450 hours with nursing experts to develop skills in a clinical specialty or nursing leadership. As of June 2003, a total of 164 fellowships had been awarded and 123 completed (the remainder were still in progress). Over the next 12 months, the number of fellowships should exceed 200.

Who is Receiving Advanced Clinical / Practice Fellowships?

To date, the fellowships have been awarded as follows:

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th># of fellowships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospitals</td>
<td>97</td>
</tr>
<tr>
<td>Visiting Nurse / Home Care/CCAC</td>
<td>20</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>14</td>
</tr>
<tr>
<td>Complex Continuing Care / Long-Term Care</td>
<td>15</td>
</tr>
<tr>
<td>Ambulatory Care / Community Health Centres</td>
<td>8</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>3</td>
</tr>
<tr>
<td>Public Health</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>164</strong></td>
</tr>
</tbody>
</table>

In a recent evaluation of the project, external consultants interviewed nurses who had participated and determined that the program does have a positive impact on nursing education and practice. Comments from nurses included:

“[The ACPF] has restored my personal faith in nursing as a profession and a science.”

“The ACPF has made the experience of ‘learning’ attainable for many nurses who may not, for a variety of other commitments, have had such an experience.”

“Information packages and pain management protocols ... will be used in that unit and entire organization... across all programs, on three hospital sites ... we have buy-in from our Patient Services Leadership Council internally, as well as the Palliative Care Network in the community.”

“We were able to establish effective community teams with local CCACs six months to a year earlier because of the ACPF. Now I am able to do what I am supposed to do because the Fellows in their sponsoring organizations are more skilled / educated and are making the appropriate referrals to my unit.”

While nurses appreciate this and other education initiatives, a number have noted that shortages of nurses in certain sectors prevent them from being able to obtain time off to pursue education.

Other Continuing Education Initiatives in 2002

• Nurse leaders from across the country attended a Nursing Education Think Tank sponsored by the MOHLTC Nursing Secretariat, the Office of Nursing Policy at Health Canada and the RNAO’s Centre for Professional Nursing Excellence. They discussed four key issues: supply of nurses, innovative nursing education curriculum, practice education, and faculty supply.

• Over 300 participants attended the First Biannual International Elder Care: Are We Ready for the Future? conference, hosted by the RNAO Centre for Professional Nursing. They discussed innovative practices in the care of older persons as well as policy imperatives to enable healthy aging.
**Ministry Education Initiatives**

MOHLTC has also recognized the importance of nursing education, particularly in implementing new strategies and programs. In the last few years, the ministry has developed and funded nursing education courses to support priority programs, such as diabetes, stroke and Alzheimer Disease. Nurses, particularly those working in long-term care settings, report that the education is extremely useful.

**Clinical Best Practice Guidelines**

Over the past two years, the Best Practice Guidelines (BPG) project, led by RNAO and funded by MOHLTC, continued to develop, pilot test, evaluate and disseminate guidelines for nurses and healthcare organizations across Ontario. To date, expert panels have developed 17 clinical guidelines and a “toolkit” for organizations, and guidelines are being pilot tested in 47 sites across the province. All completed and published guidelines can be downloaded free from the RNAO website, and the RNAO reports 2000 to 6000 downloads per month per guideline. Each published guideline will be reviewed every three years by an expert panel. Between the formal reviews, project staff conducts quarterly literature reviews and semi-annual internet searches for new information.

In 2002, the RNAO developed a marketing plan and database to raise awareness and promote use of the guidelines. A newsletter is issued three times a year, and about a dozen articles on the project have been published in provincial, national and international journals. The RNAO is also working with academic curriculum committees to encourage the integration of the guidelines in college and university nursing programs.

Since June 2002, the project has recruited about 280 BPG Champions (nurses in settings across the province) to a Best Practice Champions Network, which assists healthcare organizations implement the guidelines. The champions, who are supported by their organizations to participate in the network for a minimum of two years, participate in an initial two-day orientation workshop as well as subsequent networking activities.

<table>
<thead>
<tr>
<th>Where do Best Practice Champions Work?</th>
<th>#of champions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospitals</td>
<td>110</td>
</tr>
<tr>
<td>Complex Continuing Care / Long-Term Care</td>
<td>50</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>40</td>
</tr>
<tr>
<td>Ambulatory Care / Community Health Centres</td>
<td>20</td>
</tr>
<tr>
<td>Public Health</td>
<td>24</td>
</tr>
<tr>
<td>Visiting Nurses</td>
<td>16</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>278</td>
</tr>
</tbody>
</table>

To develop the capacity within the profession to evaluate the clinical, financial and system outcomes of the BPGs, the project will offer its first doctoral fellowship in 2003. The fellowship will provide $25,000 a year renewable for three years to a researcher who will focus on measuring the impact of knowledge transfer and uptake on clinical and system outcomes.

In 2003, the project held a week-long summer institute, which gave participants the opportunity to participate in dynamic interactive learning experiences that used theory, techniques and tools to plan clinical innovations. The nurses who attended the institute also learned successful approaches to leading clinical innovation in the workplace.

The project, which is the only one of its kind in Canada, has joined forces with the international nursing community through a newly formed consortium “NICEBERG” (Nursing International Collaboration in Evidence-Based Implementation and Research with Guidelines) aimed at moving evidence to practice, and promoting knowledge transfer / knowledge uptake and evaluation, particularly as it relates to impact on healthcare outcomes. Several joint projects are currently underway.
2. Scope of Practice

To help nurses respond to more complex care demands, MOHLTC and the profession have continued to refine the role of nursing within the healthcare system. Recent efforts have focused on allowing nurses to practice to their full scope, and on supporting the role of the nurse practitioner in the healthcare system.

Changes that Support Nursing Practice

In April 2002, Ontario announced a comprehensive Advanced Practice Nursing Strategy, which included policy, regulatory and legislative changes that will enable all nurses to take on greater responsibility for patient care within their scope of practice. Revised practice standards clarify roles and outline practice expectations for RPNs, RNs and RN(EC)s (e.g., Medication Standards, Practice Expectations: A Guide to the Utilization of RNs and RPNs, and the revised RN(EC) standards). During 2002 and 2003, the CNO provided province-wide education programs for employers and nurses on the practice expectations for RNs and RPNs. The CNO’s Regional Education Network is educating members about the revisions to the medication standards.

RN(EC). In March 2003, the government approved amendments to five provincial regulations to remove barriers to the RN(EC) current scope of practice. These regulatory changes will make it easier for the public to access primary healthcare services provided by RN(EC)s or Primary Health Care Nurse Practitioners (PHCNPs)1 in public hospitals and long-term care facilities. For example:

- RN(EC)s working in public hospitals can now prescribe and order treatments for out-patients, including those provided in the emergency department. The amendments also insure the out-patient services provided by the RN(EC).
- Amendments to three long-term care regulations acknowledge the role of RN(EC)s in long-term care facilities, and outline specific services they may provide within their legislated scope of practice. The amendments also give residents the option of choosing an RN(EC) along with an attending physician to provide their health / medical care services.

RN/RPN. The new practice standards clarify the RN and RPN role in administering medications. Regulatory amendments have also removed barriers to registered practical nurse (RPN) scope of practice in long-term care.

The Role of the Primary Healthcare Nurse Practitioner

A number of recommendations from the first nursing task force progress report focused on supporting and making more effective use of primary healthcare nurse practitioners (PHCNPs). Over the past two years, Ontario has taken several steps to promote and support the PHCNP role.

Promoting the PHCNP Role

In June 2002, the ministry initiated the Nurse Practitioner Integration Study, which is designed to:

- identify the factors that help and hinder the integration of PHCNPs in practice teams, care settings and the healthcare system
- describe the impact that PHCNPs have had on access, quality and outcome, innovation and satisfaction
- make recommendations about the data required to continue to evaluate PHCNP practice.

The study was submitted to the Ministry of Health and Long-Term Care in June 2003.

In 2002, the Nursing Secretariat also organized a consultation process with physicians and primary healthcare nurse practitioners to review the legislative, regulatory and policy barriers to PHCNP practice. The first phase of the review was completed in March 2003 and resulted in regulatory changes described above, which allow public hospitals and long-term care facilities to make more effective use of RN(EC)s. Phase 2 of the review will address other barriers to PHCNP practice.

---

1At the current time in Ontario, the only legislated Nurse Practitioner role is the Primary Healthcare Nurse Practitioner, also known as the Registered Nurse Extended Class or RN(EC). In this paper, PHCNP and RN(EC) are used interchangeably.
The RNAO and OMA led a joint survey for PHCNPs and family physicians designed to identify both supports and barriers to collaborative practice. Results will be available shortly.

Providing Employment Opportunities
In its 2001 progress report on the Nursing Task Force Strategy, the Implementation Monitoring Subcommittee highlighted the significant number of PHCNPs (200 at that time) who were employed in positions that did not allow them to practice to their full scope. Employment of PHCNPs in a non-RN(EC) role compromises their ability to maintain their competencies and denies the healthcare system access to their skills. During the past year, two steps have been taken to provide appropriate employment opportunities for PHCNPs:

• In May 2002, the government announced $3 million annually for three years to fund demonstration projects that will place 20 PHCNPs in 12 communities that have little or no access to family physicians. Recruitment for these positions began in January 2003, and, as of September 2003, 19 of the 20 positions had been filled.
• In September 2002, the government made a commitment to double the number of PHCNP positions in the province by adding a total of 369 new positions by 2005. Funding for 117 of these positions was announced in 2003. Recruitment began in June 2003 and, by September 2003, over 50% of the positions had been filled.
• In spring 2003, after successful completion of the pilot projects, the 17 long-term care positions were converted to permanent full-time.

According to CNO 2002 data, a total of 519 nurses were registered as RN(EC)s. Of those, 449 were working as PHCNPs in Ontario and 29 were employed as PHCNPs outside Ontario. (Of the remainder: 8 were not employed and looking for work, 2 were employed in fields other than nursing, 12 were not employed and not seeking work, 3 were employed in another nursing position, 12 provided no information, and 4 were working outside Ontario, but not as PHCNPs.)

3. Retention and Recruitment

Retention
Most initiatives designed to improve retention of nurses focus on improving the working environment, minimizing casualization, reducing the over-reliance on part-time and agency work, creating more full-time jobs for nurses, and ensuring strong nursing leadership at all levels of an organization.

Workload / Capacity
As the extensive use of overtime and high rates of absenteeism indicate, workload is a serious issue for nurses in all settings. Although workload has implications for the health system’s capacity to provide routine care and respond to health emergencies, the data available are not adequate to measure and analyze workload, or support health human resource planning.

At the current time, most hospitals collect workload measurement data, as mandated through the MIS guidelines. However, the data are not externally comparable (although they are utilized that way), and there are periodic validity and reliability problems internally. The CNAC report highlighted the need for all sites to have a valid and reliable workload measurement system in place in order to routinely gather consistent data on workload. (Note: Workload measurements are not available in the community or long-term care sectors.)

Using the data that are available, the Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU) is conducting research on workload and appropriate staff:patient ratios. Its analysis of workload and productivity in acute care hospitals is included later in this report.

2 NOTE; There are more nurses registered as RN(EC)s in Ontario than have completed the primary healthcare nurse practitioner education program. This is because some nurses had already taken advanced education before the PHCNP program was introduced. They were able to meet the requirements for registration by taking some transition courses and did not complete the full education program.
Opportunities for Full-time Employment
A significant proportion of nurses continue to work part-time and casual. Between 1998 and 2001, in response to the Nursing Task Force recommendation, MOHLTC provided over $800 million in new funding for nursing positions through the Nursing Enhancement Fund (NEF). Health care organizations were asked to use these resources to provide permanent full-time and part-time positions for nurses. The goal was to create 12,000 new positions. According to the 2001 IMS report: “Based on a ratio of 1.5 positions per FTE, the formula used by the Nursing Task Force, it is estimated that the NEF and related funding initiatives have potentially resulted in the equivalent of up to 12,833 additional nursing positions. This figure is composed of full-time, part-time, and casual employment, as well as overtime, agency time and sick time hours.” (IMS: 10). However, it should be noted that, with respect to the hospital sector, the funding was provided at a time when hospitals had just cut budgets and staff. The result was often to bring hospitals up to pre-cutback staffing levels, so there was a minimal if any increase in the overall number of nurses employed.

It should also be noted that the funding did not have the same impact on the long-term care and community sectors as it did in the hospital sector. For example, while the funding did result in an increase in the number of case managers in the community care sector, it did not result in an increase in the number of visiting nurses who provide the direct nursing care.

This funding from the NEF has been now incorporated into organizations’ annual base funding, so it is no longer possible to monitor or track it, or ensure that it is being used to hire nurses.

An increase in funding for nursing and personal care (NPC) staff in long-term care facilities, effective in August 2002, has resulted in a modest increase in full-time employment for RNs and RPNs. Between July 2002 and March 2003, the number of full or part-time NPC staff in Ontario’s long-term care facilities grew from about 42,738 to 45,088, an increase of 2,350 individuals (or 1,782 FTEs). Of those 1,782 FTEs, 92.67 were RNs, 268.23 were RPNs, and 1,273.90 were personal support workers (PSWs). Long-term care facilities also used the funding increase to avoid a total of 544.9 layoffs, thereby reducing some of the employment insecurity that is implicit in the way this sector is funded (Sigma-3 Policy Research Inc., 2003).

Supportive Work Environments
The quality of the working environment has a significant impact on the ability to retain nurses. Over the past two years, the nursing profession and the MOHLTC have taken a number of steps designed to improve working environments for nurses. For example:

• The CNO has developed an evidence-based program designed to help nurses and employers create quality practice settings. Participating sites learn how to use a quality improvement methodology to set priorities, plan strategies and evaluate actions used to improve practice settings. According to anecdotal evidence, the program is effective. The CNO and participating sites have jointly presented several papers and abstracts that describe the program’s impact.

• The CNO surveyed over 17,000 nurses from more than 108 organizations about their perceptions of their practice settings, and has developed a database. The CNO is in the process of reassessing sites that committed to re-survey.

• The OHA is actively encouraging its members to take a more flexible approach to scheduling, and has held workshops on creative scheduling, such as using weekend workers.

• MOHLTC is funding the Faculty of Nursing, University of Toronto to conduct the Quality Work Environment for Nursing Study. Eight acute care hospitals are participating in demonstration projects to implement strategies to improve practice settings for nurses.

• The RNAO, with funding from MOHLTC and Health Canada, is developing a series of Best Practice Guidelines (BPGs) designed to promote healthy work environments. The advisory committee for this two-year initiative includes all major nursing organizations in Ontario as well as representatives from other provinces, Health Canada, the International Council of Nurses (ICN), and the World Health Organization (WHO). The BPG guidelines will be pilot tested and disseminated widely. The project reports to JPNC.

• Each year, the RNAO and RPNAO host an international conference on Healthy Work Environments in Action. The 2002 and 2003 conferences focused on key strategies for strong and inspiring leadership, human capital development, sustainable and empowering structures, journeys for professional excellence and relationship building. Over 400 healthcare professionals attend the conference each year.
Orientation to the Workplace
Orientation programs are designed to help prepare nurses for their particular work setting. Nurses who are well oriented to their settings are more likely to be satisfied with their work and to stay in the jobs.

With almost $700,000 in MOHLTC funding, the RNAO has developed an orientation program for nurses working in long-term care (available now), and is in the process of developing an orientation program for nurses in home healthcare (scheduled for release early in 2004).

The orientation programs for long-term care and home healthcare promote the particular area of nursing practice, and can be used for both orientation and in-service education. Topics include the professional role of the nurse in these practice settings; a description of the organizations and how they function; and education on relevant best clinical practices.

The RNAO has also provided an orientation program for PHCNPs and physicians working in long-term care facilities, and will provide a similar program for the 117 PHCNPs recruited to work in underserviced communities.

Recruitment
Ontario’s recent recruitment initiatives have focused on creating opportunities for existing nurses, attracting back nurses who left the system and encouraging recruitment into the profession. Recruitment strategies include creating new job / career development opportunities for nurses, understanding the factors that might persuade nurses who have left the profession to return, and activities that promote careers in nursing.

Creating New Work Opportunities
In September 2002, the government made a commitment to double the number of PHCNP positions in the province by 2005. Funding for PHCNPs has created opportunities for RN(EC)s to work in community health centres, long-term care facilities, primary care networks, aboriginal health access centres, public health units, and rural and underserviced communities. While the profession welcomes efforts to provide employment that allows PHCNPs to use their competencies, it remains concerned about the trend to place PHCNPs only in areas designated as underserviced (as a result of chronic physician shortages in these areas). PHCNPs could enhance the public’s access to health services in all settings and regions of the province. For example, people living in Toronto experience a great deal of difficulty finding a family doctor but, because this part of the province is not designated as underserviced, PHCNPs in Toronto are unemployed.

The profession has also recently highlighted the need to create appropriate clinical opportunities for the growing number of masters prepared nurses.

Understanding Why Nurses Leave
In 2003, RNAO’s Earning Their Return surveyed 3,272 Ontario RNs registered with the CNO but working outside Ontario. The goal was to find out why they left the province and what would bring them back. Response to the survey was very positive: a 36.6% response rate (with no reminders) and many accompanying letters. According to the survey results, the main reasons nurses left Ontario during the 1990s were related to job opportunities (70%), including downsizing and lack of full-time employment in Ontario. A substantial proportion (78%) would consider returning to Ontario to work. The two main factors that would entice them back are full-time jobs (65.5%) and relocation expenses (66.3%).

Another reason nurses leave is the perception that the academic health science centres are not hiring new graduates into full-time positions. (Discussion during a teleconference between COUPN and OCOTH CNE.) New university graduates must be supported in their decision to apply to an Ontario hospital.
To gain a better understanding of why nurses leave the profession, RNAO, in collaboration with RPNAO, surveyed nurses who are currently not working in nursing and nurses who did not renew their registration with CNO. The main reasons that nurses leave the profession are: health (23.9%), family responsibilities (22.1%), the pursuit of other interests (21.7%), lack of support or respect in the work environment (17.4%), shift work (16.9%), and workload (14.2%). Initial survey results are very encouraging in terms of the potential to bring existing nurses back into the workforce. They indicate that a percentage of nurses who stated that they were not seeking nursing employment or who did not renew their CNO registration in 2001 or 2002 did, in fact, want to be employed in nursing. If the group surveyed is representative of nurses outside the workforce, then there are about 3,008 nurses in Ontario who are not actively seeking jobs, but who would like work in nursing. When that number is combined with the number of nurses outside the workforce who are actively seeking a nursing job (2,124 RNs and 1,209 RPNs), then Ontario has over 6,300 nurses (6,341) who want employment in nursing.

The survey also indicates that an additional 5,050 nurses who are not seeking or wanting nursing employment now would consider a job in nursing if circumstances changed. The factors that would encourage these nurses to return to the workforce are: the right to accept or reject shift work (62.6%), self scheduling (34.9%), flexible scheduling (31.2%), job sharing (27.1%), the availability of employment in their choice of clinical area (58.3%) or geographical area (44.5%), sustainable workloads (51.8%), greater support or respect in the workplace (51.0%), opportunities for professional development (40%), work environments that support full utilization of competencies (38.3%), secure and stable employment (36.7%), more collaborative relationships with physicians (31.4%), accommodation to physical limitations (30.4%), and improved compensation (23.7%).

This means that, if the healthcare system could sufficiently improve circumstances for nurses and make employment available to all who wanted it, it could potentially increase the nursing workforce by over 11,000, just from the pool of nurses who are not currently working in nursing. The NRU (Toronto site) is expanding this research and will survey nurses from six provinces from all age cohorts, including those who no longer maintain registration, to identify the interventions most likely to retain nurses or bring them back.

Although the healthcare system is aware that it has a nursing shortage, it does not know the actual extent or location of the shortages. To obtain more accurate information on the nature and scope of nursing vacancies, the NRU (McMaster site) conducted a vacancy study focused on hospital (acute and teaching) and long-term care settings. Findings indicate that there is little consistency in the way health organizations collect data, which made it difficult to categorize or compare information, or to develop an accurate picture of nursing vacancies in these sites. The study recommended that Ontario develop a simple, standard approach to collecting data on vacancies that would be used consistently across organizations to assist in health human resources planning.

**Attracting Nurses**

The RNAO and RPNAO, with funding from MOHLTC, continue to offer career days/job fairs for nurses in Ontario. The events combine a traditional job fair with concurrent education sessions related to career enhancement, attaining life balance, and maximizing mature career and life opportunities. They are offered free of charge to RNs, RPNs and nursing students. In all, over 6,000 nurses and nursing students have attended the fairs since their inception in 1999. Four career days/job fairs were held in 2003.

**Promoting Nursing as a Career**

In a collaborative effort, RNAO and RPNAO have developed the Team Up With Nursing career awareness program. It consists of two kits: one for secondary school teachers to be used as part of the Grade 10 career awareness course; and the other for nursing professionals to use in local presentations and career days. Each kit includes a video which depicts various career choices for RNs and RPNs, as well as teaching notes, presentation templates and brochures. The teacher's resource kit was distributed to over 700 Ontario English public and catholic secondary schools, along with a list of nursing professionals willing to speak to high school students. According to evaluations, teachers found the material effective and it seems to motivate students to take a closer look at nursing as a career option. The presenter's kit was distributed to over 250 dedicated professionals, including College and University Faculty, RNAO members, RPNAO members and volunteers, and education was provided at an RNAO Assembly meeting and at the RPNAO offices. Educational institutions have used the kit extensively during their regular recruiting process and find them very helpful. The initiative appears to have been effective. While applications to all post-secondary education programs from secondary school students (for fall 2003) using the Ontario Universities Application Centre increased 46% as a result of the double cohort, first choice applications to nursing programs increased 93%. In addition, confirmed acceptances increased 31.8% for all programs, but 43.9% for nursing.
Other Recruitment Initiatives

In February 2001, RNAO hosted a job fair in Houston, Texas, targeted at Ontario registered RNs. Thirty-two Ontario employers, representatives from Human Resources Development Canada (HRDC), MOHLTC, OHA and ONA and about 200 nurses attended the fair. About 109 nurses completed a registration form detailing their current job status and plans with respect to returning to Ontario. Of these, 95% were employed, most on a full time basis. In considering whether to return to Ontario, 74% stated that they wanted a full time job (9% were looking for part-time work and 20% did not specify). Only 24% reported being interested in returning in 2001. The remainder was uncertain or did not specify a return date. A solid minority will definitely return to Ontario, but the majority will only return based on personal circumstances and / or the work situation in Ontario, specifically the availability of full-time employment. According to two follow-up surveys of employers who attended the job fair, approximately 8 to 10 RNs returned as a direct result of the initiative. Given the resources required and the very modest results, RNAO did not pursue a second international job fair.

Other RNAO/RPNAO initiatives to promote careers in nursing include:

- NursingNow website (www.nursingnow.org), which went live in September 2001, giving people electronic access to current information on nursing as a career. The site had well over 10,000 visitors just in the last year alone.
- presentations at the Ontario Universities Fair in 2000, 2001, 2002 and 2003 to promote nursing as a preferred career. In 2000 and 2001, over 40,000 students / parents attended the fair and over 3,000 visited the RNAO booth. In 2002, 75,000 attended the fair and 11,000 visited the RNAO display booth. In 2003, 86,383 individuals attended the fair and about 10,000 individuals visited the RNAO display booth.
- attending the Ontario School Counsellors’ Association annual meeting and convention in 2000, 2001, 2002 and 2003. This forum provides an excellent opportunity to develop relationships with guidance counselors and teachers across the province, and provide up to date information on nursing education and career opportunities in nursing.
- attending the College Information Fair 2001, 2002 and 2003, the Youth Empowerment Fair in 2001 at Skydome, and community sponsored career fairs, and other events and forums. These events target all levels of students (including mature students) and the general public.
- launching provincial public awareness campaigns during nursing week in 2001, 2002 and 2003 to educate the public about nurses’ role in the healthcare system and highlight their contribution to the health of Ontarians. The 2001 themes – Nurses raise us, Nurses transform us, and Nurses touch us – sent a message to potential nurses that nursing is a profession worth choosing and reassured working nurses that their role is valued and respected. The 2002 and 2003 themes – Nurses, Putting Patients First and Nurses, Real Heart. Real Smart – promoted nursing and informed the public that nurses offer Ontarians compassion and knowledge. Both campaigns involved transit advertising, newspaper ads across the entire province, and radio public service announcements. The feedback from nurses and the public has been outstanding.

Other Initiatives to Promote Nursing

Marketing materials that describe the nursing profession and career opportunities, distributed at elementary and secondary schools, colleges and universities, include:

- “Nursing & You”, an issue of the College of Nurses newsletter devoted to nursing as a career, developed in collaboration with RNAO and RPNAO.
- Buttons and temporary tattoos, with the caption “Nursing: A Career for Life” in both English and French.
- Three brochures: “Take a look at Nursing”, “Do you have what it takes to be a nurse?” and “A Career in Nursing” as well as a poster.
4. Leadership

According to the Nursing Task Force Report, leadership is key in maintaining and building an effective nursing workforce. Several recent initiatives are designed to support and encourage nurse leaders.

Regulatory Changes

In March 2003, the Public Hospitals Act – Regulation 965 was amended, making it mandatory for all public hospitals to have a chief nursing executive (CNE). The CNE, the most senior employee for nursing services, is responsible to the administrator / chief executive officer (CEO). Those hospitals with by-laws that provide for a nursing advisory committee (NAC) are also required to appoint the CNE as chair of the NAC.

In addition, the MOHLTC has asked all other healthcare settings to have a senior nurse at the senior management table of their organization.

Leadership Skill Development

Dorothy M. Wylie Nursing Leadership Institute

In the spring of 2001, MOHLTC provided funding for the NRU to establish the Dorothy M. Wylie Nursing Leadership Institute (NLI). The NLI is designed to build capacity in nursing leadership and support evidence-based decision-making. It works to help nurses develop and apply a set of core leadership competencies appropriate to the settings where they practice. It also identifies and nurtures potential nurse leaders. The curriculum recognizes that today's nurses must be competent in nursing practice as well as the business of healthcare, understand their own strengths and weaknesses, and be skilled in leading others. Since 2001, the NLI has provided four leadership courses to 286 participants. The majority of participants to date have been from the hospital sector (see Table 2).

This Ontario initiative has helped link nurse leaders from six provinces and one territory. The Institute has also been effective in finding other funding sources to support nursing leadership training, and is able to offer bursaries for organizations that would otherwise be unable to afford to send employees. To date, these bursaries have been awarded to the long-term care and community care sectors.

An evaluation of the first course indicated that the NLI is effective in strengthening the five key leadership practices: challenging processes, inspiring shared visions, enabling others to act, modeling the way, and encouraging the heart. Positive changes in leadership behaviours were reported more by peer observers than by the participants themselves. They were also noted more by established leaders than aspiring leaders. This may indicate that changes in how we view ourselves take more time, and that established leaders have more opportunities to engage in leadership behaviours.

Participants themselves rate the residential course very highly. Their comments include:

“This was one of the best learning experiences I have ever had. It was very well designed, content [was] excellent, and [it was] a great opportunity to learn from nursing leaders from all over Canada.”

“This has been an awe-inspiring experience. The leadership practices really touched the basis of nursing and why we chose this profession.”

“Nurses teaching and sharing ideas with other nurses which leads to practical and concrete ideas that are useful in the workplace. I have found myself using what I have learned in my everyday work and personal life.”
Table 2: Nursing Leadership Institute Participants by Sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>August 2001</th>
<th>August 2002</th>
<th>October 2002</th>
<th>May 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>61</td>
<td>43</td>
<td>32</td>
<td>48</td>
</tr>
<tr>
<td>Community and Public Health</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Long-Term Care, Rehabilitation and Respite</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Regional Health Authorities</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>First Nations and Inuit Health Branch, Health Canada</td>
<td>0</td>
<td>16</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Others (CNO, WSIB, post-secondary education, government)</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>73</strong></td>
<td><strong>75</strong></td>
<td><strong>56</strong></td>
<td><strong>82</strong></td>
</tr>
</tbody>
</table>

Other Nursing Leadership Programs

Several other recent initiatives are also helping Ontario nurses develop leadership skills. For example, the RNAO Centre for Professional Nursing Excellence provides workshops such as “Discovering the Leader Within You,” for staff nurses, “Working Effectively in Health Care Organizations” for nurse managers, and “Keeping Your Team for Life” for interdisciplinary teams. The Centre is also working with several organizations to enhance clinical, administrative, and team effectiveness.

In 2002, the RPNAO, in partnership with George Brown College, developed the first Registered Practical Nurse Leadership Certificate program in Canada. To date, just under 60 RPNs have successfully completed the program, and they are now implementing leadership projects in their workplaces that contribute to organizational change. The leadership program is now being purchased by other provinces and has growing employer support and recognition.
The Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario (ANDSOOHA) is actively working to advance public health nursing leadership. It has developed a position paper, *Leadership in Public Health: A Nursing Perspective*, that highlights the importance of nursing leadership in creating effective healthcare organizations and recommends several steps designed to strengthen nursing leadership in public health, including:

- supporting discipline leadership at senior levels in public health units for all professional groups governed by the Regulated Health Professions Act
- creating awareness among public health nurses about the importance of strong professional leadership throughout the organization
- implementing the proposed Canadian Community Health Nursing Standards within all public health units across Canada
- incorporating nursing leadership development into the nursing curriculum.

### Other Leadership Initiatives

The profession is also striving to play a leadership role in broader health policy development and to influence policymakers:

- As part of the dissemination strategy for Clinical Nursing Best Practice Guidelines, the RNAO organized a full day Policy Think Tank with senior government bureaucrats and other key stakeholders.
- The ministry has used the profession’s best practices to inform its osteoporosis strategy and its diabetes strategy.
- The joint MOHLTC/RNAO Elder Care Think Tank (2002) highlighted policy issues in sustaining seniors as vibrant members of our communities.
- The 2003 RNAO/MOHLTC Think Tank focused on quality of care, housing and caregivers knowledge and skills, and set the stage for the development of a provincial framework for Older People’s Care.
- The profession has identified a number of research gaps in implementing best practices. Several research initiatives are now underway.
5. Data and Information

Effective health human resource planning depends on accurate information. To manage its nursing resources effectively, Ontario needs consistent, high quality information on the supply, production and use of nursing resources and the demand for nursing services. In its 2001 report, the IMS highlighted a number of data gaps and made recommendations about the type of information that should be developed to support health human resources policy and planning.

Access to Data

In the past, getting timely access to MOHLTC databases was an issue for the researchers involved in assessing Ontario’s supply and use of nurses. The NRU (Toronto site) reports that there have been improvements in the process of accessing data. However, more can still be done to ensure the right type of data is collected and shared.

Data Collection and Information Management

Several initiatives are now underway to improve the amount, quality and consistency of data on nurses and nursing practice. New automated data collection systems will be implemented in the community care sector this year, and in the long-term care system within the next two years. This will help provide the same level and type of data on nursing practice in those settings that is available now from the hospitals. However, there are still gaps. For example, there is an absence of valid reliable (externally comparable) workload measurement data in all settings. In a recent report, the Canadian Institute for Health Information (CIHI), highlighted the need for consistent, relevant, flexible and user-friendly data on nursing services. It also recommended a series of specific steps that should be taken to improve the quality of nursing data across the country and enhance the Canadian Nurses Database.

HR Planning Measures

The NRU (Toronto site) is currently developing more accurate measures (than nurse to population ratios) to assess the adequacy of the nurse supply and the distribution of nurses across the healthcare system. These new measures will take into account a number of factors, including patient acuity and complexity, workload and staffing mix.

Three current research initiatives have the potential to contribute to nursing knowledge and data:

• The Nursing and Health Outcomes Project, led by Dr. Diane Doran, is conducting feasibility studies in 16 Ontario healthcare facilities (4 acute care, 8 long-term care, 3 CCACs, and one complex continuing care facility) to evaluate the feasibility, quality, utility and cost of collecting outcomes data.
• The Nurse Staffing and Quality Nursing Work Environment Study, led by Dr. McGillis Hall, is identifying nursing indicators to assess the work environment (e.g., staff mix ratios, educational background, experience, overtime hours, use of agency staff, absenteeism hours, grievances) and will conduct feasibility studies in selected acute care, complex care, long-term care and home care settings in Ontario.
• Gail Tomblin Murphy, Linda O’Brien-Pallas, Stephen Birch, George Kephart are just completing a study entitled Health Human Resource Planning: An Estimation of the Relationships Among Nursing Service Utilization, an Estimation of Population Health and Overall Health Status Outcomes in the Province of Ontario. The report, which will be released in the next few months, highlights how population health needs and nursing service utilization influence population and system outcomes.
II. Impact on Nurses and Nursing

Over the past four years, Ontario has seen a significant amount of activity to support nursing in the province. But what impact have these initiatives had on nurses or nursing? For many initiatives, such as the new education requirements or workplace projects, it is too early to assess their impact. However, it is useful to look at current trends in the profession and in the healthcare system.

What are the Trends in Nurse Supply?

One of the main goals of the Nursing Task Force Strategy was to increase the supply of nurses in Ontario (i.e., the number of nurses available to work). The following table summarizes CNO data on the number of nurses employed in nursing in Ontario from 1997 to 2002.

Table 3: Nurses Employed in Nursing in Ontario

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>80,369</td>
<td>79,267</td>
<td>78,174</td>
<td>82,788</td>
<td>81,026</td>
<td>83,123</td>
</tr>
<tr>
<td>RPN</td>
<td>25,703</td>
<td>25,597</td>
<td>25,189</td>
<td>26,177</td>
<td>25,122</td>
<td>25,573</td>
</tr>
</tbody>
</table>

Source: College of Nurses of Ontario, 2003

Based on data from the College of Nurses of Ontario (CNO), the number of nurses working in Ontario (RNs and RPNs) did increase in 2000 to the highest levels in eight to 10 years (O’Brien-Pallas et al., 2003). This increase may reflect the impact of the Nursing Task Force initiatives, particularly the Nursing Enhancement Fund. In 2001, the number dropped by 2,817, and then rose again in 2002. Because the CNO data do not include nurses who did not specify their practice sector and a significant number of nurses (4,596) did not provide this information for 2002, the numbers underestimate the actual number of nurses employed in nursing in that year.

Figure 1: Nurses Employed in Nursing in Ontario, 1992-2002

Table does not include number of nurses who indicated they were employed in nursing but did not specify their practice sector. The number of members who did not report in 2002 was significantly higher than the previous year (RN: 3,176 in 2002, 337 in 2001; RPN: 1,420 in 2002, 159 in 2001). Members were asked to report practice sector every year rather than having option to default to the previous year’s information.
While the number of nurses working in Ontario has increased over the past three years, that increase has not kept pace with the increase in Ontario’s population. As Figure 2 illustrates, the ratio of working nurses to the population declined steadily between 1992 and 1999, rose slightly in 2000, and dropped again in 2001 to 1999 levels. As of 2002, Ontario had the lowest nurse to population ratio of all provinces in Canada (CIHI, 2003; O’Brien-Pallas et al, 2003).

Figure 2: Nurse to Population Ratios for Nurses Working in Ontario, 1992-2002

After several years of decline in the mid-1990s, Ontario has begun to see a steady increase in the number of nurses graduating from RN programs in the province.

Figure 3: Number of Graduates from RN Programs, 1990/91 – 2001/02

4 Nurse to population ratio measurement is a good foundation for comparison but it is not the sole determinant of how many registered nurses are required in a community. Factors such as population health needs, accessibility to medical services, the distribution and mix of health professionals and different models of health delivery all impact on a community’s nursing needs.
There has also been a slight increase in the number of new RPNs graduating from education programs in the province.

**Figure 4: Number of Students Entering and Graduating from RPN Programs 1990/91 – 2001/02**

Is the Aging of the Workforce Still an Issue?

Yes. In 2001 and 2002, the average age of nurses registered with the CNO was 44 and the median age was 49. The average age of RNs and RPNs is about the same at 44. Between 66% and 68% of RNs and RPNs were over 40, up from 58% in 1993. Less than 2% of RNs and 3% of RPNs were between the ages of 18 and 24. In 2002, for every RN under age 40, there were two 40 years of age and older (O’Brien-Pallas et al, 2003).

The implications of an aging nursing workforce on nurse supply are serious. In the near future the province will have more nurses retiring than new graduates to fill the positions (O’Brien-Pallas et al., 2003).

**Figure 5: Age Distribution of RNs and RPNs Registered with CNO in 2002**

---

3 Based on College of Nurses of Ontario data: the average age of RNs in 2001 and 2002 was 44.3 and 44.7 respectively, and the average age of RPNs was 43.6 and 44.1 respectively.
Are More Nurses Working Full-Time?

Ontario made some progress in increasing the proportion of nurses employed full-time. Between 1997 and 2002, the proportion of RNs working full-time increased from 51.2% to 56.8%. Over the same period, the proportion of RPNs working full-time decreased slightly, from 49.9% to 48.5% (NRU, 2003). Figures 6 and 7 illustrate the trends in the percentage distribution of employment status for RNs and RPNs.

Even with new government funding for nursing, the proportion of nurses working full-time in 2001 still fell far short of the 70% goal endorsed by J PNC (2000), by the RNAO and the RPNAO in Ensuring the Care Will be There (2000), by the CNA in Commitment to Care (2001), and by the Canadian Nursing Advisory Committee (CNAC) in their 2002 report entitled: Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses. According to the latter report “[g]overnments, employers and unions should collaborate to increase the proportion of nurses working full-time to at least 70% of the workforce in all healthcare settings by April 2004, with an improvement of at least 10% to be completed by January 2003” (p. 37). Ontario’s trends are in stark contrast to other jurisdictions, like the United States, where 71.6% of RNs work full-time. Even the U.S. rate may not be indicative of the “ideal” as the United States is also coping with a staffing crisis and high vacancy rates.

Figure 6: RN Employment Status, 1992-2002

![Figure 6: RN Employment Status, 1992-2002](image)

Figure 7: RPN Employment Status, 1992-2002

![Figure 7: RPN Employment Status, 1992-2002](image)
Some part-time nurses are essential to enable healthcare settings to staff effectively 24 x 7, to deal with workload fluctuations and to provide job opportunities for nurses who want to work part-time. However, the continued casualization of the nursing workforce and the over-reliance on part-time and agency nurses is affecting the quality of patient care, the viability of the healthcare system, and the nursing profession itself (Grinspun 2000; 2003).

The implications of heavy reliance on part-time and casual workers were evident in the recent SARS outbreak. Many nurses who have part-time jobs in different settings were directed to work in one place only. As a result, some settings had extreme difficulty finding nurses to work, the nurses on the jobs faced heavier workloads, and those who were unable to continue their usual work arrangements suffered financially (Unmasking SARS: celebrating resilience; exposing vulnerabilities, RNAO, 2003). SARS also highlighted how thinly stretched nursing resources are in Ontario, and the lack of capacity of the system to staff up in cases of emergency. In Voices from the Front Lines, the RPNAO discusses the casualization of nurses, and how this trend played a role in the system’s capacity to respond to SARS. To ensure quality of care and an adequate nurse supply and improve Ontario’s ability to respond to health emergencies, it is critical for the healthcare system to stop growing part-time positions and increase the number of full-time positions.

Understanding the Factors that Contribute to Casualization

In an effort to understand the problem of casualization, the RNAO recently completed a survey of RNs who are working part-time or casual to determine whether they do so by choice or because of lack of full-time opportunities. According to the findings, more than one-quarter of nurses who work part-time do so because of the lack of opportunities for full-time employment, and over 24% work more than one nursing job. If full-time positions were available, about 11,000 part-time or casual nurses report that they would take those jobs immediately, and that could shift about 4,000 part-time nurses into full-time positions and increase the current full-time nurse supply by 1,600. Under certain circumstances (e.g., more flexible scheduling, availability of work in their clinical or geographic area of choice, reasonable workloads, more opportunities for professional development, childcare in the workplace), about 15,000 more part-time nurses could be persuaded to work full-time, which could increase the current full-time nurse supply by 6,000.

While some part-time nurses want full-time work, many are focused on a particular type of practice and, if they can’t get a position in their area of choice, will not take another position. In a future survey, it would be useful to ask part-time nurses who want full-time employment whether they would take a position in any area or whether they are looking for a particular specialty and, if so, which one. This would help planners understand the factors that affect nurses’ employment decisions.

A significant proportion of nurses working part-time would also prefer to work a few more hours per week than they do now. More effective use of existing part-time nurses (i.e., 3.2 hours more per week) has the potential to lead to an increase of 2,900 more nurse full-time equivalents.

The Relationship Between Age and Full-time Employment

Of particular concern in terms of the stability of the nursing workforce is the fact that the majority of nurses who are working full time are older, usually in their 40s. Younger nurses, who require full-time work to integrate into the system and receive appropriate mentoring, find it extremely difficult to secure full-time positions. If this trend continues, the system is likely to continue losing its young nurses, who will look for nursing work elsewhere or, disillusioned, leave the profession altogether. Given the aging of the nursing workforce and the significant number of older nurses who will retire over the next 10 years, the system should be doing more to create full-time opportunities for younger nurses (Grinspun, 2002; O’Brien-Pallas et al, 2003).

The inability of the system to employ younger nurses is, in part, a union issue. Employers argue that, if they were not bound by collective agreements, they would offer full-time positions to new graduates. However, under the existing contracts, they are required to offer full-time positions first to internal part-time staff, who usually take them. The organizations then have to advertise for nurses (often recent graduates) for the part-time positions. Employers report that they would like to be able to “earmark” a proportion of new positions for new graduates, but that is not possible at this time.
Where are Nurses Working?

Over the past two years, the trend to provide more care outside of acute care hospitals has continued. The proportion of nurses working in the hospital sector today has either remained relatively stable (in the case of RNs) or dropped (in the case of RPNs). Over that same period, the proportion of RNs working in long-term care facilities has remained steady while the proportion of RPNs employed in long-term care has increased. We have also seen an increase in the proportion of nurses working in the community, and a large jump in the proportion of nurses working in other sectors, such as primary care (O’Brien-Pallas et al., 2003). These changes reflect the impact of healthcare reform.

Figure 8: Where RNs Work, 1992-2002

Figure 9: Where RPNs Work, 1992-2002

Although we are gradually seeing greater distribution of nurses across the various sectors, problems remain with geographic distribution. The greatest supply of nurses is concentrated in major urban centres. Rural and remote communities still have difficulty attracting the healthcare professionals they need, including nurses. While urban centres may have more nurses, they continue to have difficulty attracting and retaining nurses in particular practice areas, such as critical care, emergency, dialysis, long-term care and the community.
III. Impact by Sector

While the data indicate that there has been some increase in nurse supply and the proportion of nurses working full-time, the true test of the nursing initiatives is their impact on the average working nurse. Have they seen an improvement in their work environments? What progress has been made over the past four years? What challenges remain?

Hospital Sector

Progress

According to anecdotal reports, nurses working in hospitals report some progress, particularly in the area of nurse leadership.

Many hospitals are also offering nurses more opportunity for professional development and advancement, which may lead to greater job satisfaction. For example:

• Some hospitals are actively seeking nurses with advanced practice knowledge: nurses with specialized, Masters level education, in pediatrics, critical care, gerontology and mental health. These new positions, combined with new and expanded education programs, are giving nurses more opportunity for career development.

• Over the past two years, hospitals have received additional funding to augment emergency services. Many have used that funding to adjust staffing in emergency department, and hire nurses and nurse practitioners. Nurses are now playing an increasingly important role in delivering emergency services and responding to public concerns about delays and backlogs in emergency departments. The number of nurses working in emergency departments during peak hours has increased. However, it is not known yet whether these initiatives have had or will have a sustained impact.

• Regulations to the Public Hospitals Act were amended to allow PHCNPs to order and prescribe treatments for out-patients, including treatment delivered in emergency departments.

Nurses also report that the new funding to support ongoing professional development has been helpful.

Challenges

Most of the challenges for nurses in hospitals appear to stem from the increasing acuity and complexity of people cared for in these settings, the increase in workload, the over-reliance on casual, part-time and agency nursing staff, the lack of support staff and equipment, barriers to ongoing professional development, and the resulting impact of all these factors on safety, quality of care and nurses’ own health.

Acuity, Complexity and Workload

According to CIHI data, between 1994 and 2000, the acuity and complexity of people treated in acute hospitals (regardless of age) increased steadily (O’Brien-Pallas et al, 2003).\(^6\)

The acuity and complexity of patients in chronic care hospitals is also increasing. The average weighted patient day was 1.043 in 2000/01 and 1.077 in 2001/02.

The demand for care has increased over a period of time when the number of nurses working in hospitals has declined. This has resulted in a significant increase in workload.

\(^6\) CIHI data are available for all units within acute hospitals except chronic care, rehabilitation and mental health units. This type of data (complexity level or resource intensity weights) are not available for chronic care, rehabilitation or mental health hospitals.
The following table lists productivity levels of nurses in different hospital settings, based on worked hours. Because worked hours include paid coffee breaks, the maximum productivity value would be 93%. However, a value of 93% indicates that every nurse worked every minute of every day for the entire year. Units with productivity levels this high will likely see a drop in quality of care, an increase in adverse events, more patient complaints, an increase in staff absenteeism, and high staff turnover. A more appropriate productivity level to ensure high quality cost effective care is likely about 85% in units where workload is predictable and even lower in units where demand is unpredictable (e.g., emergency, labour and delivery) (O’Brien-Pallas et al, 2003).

According to these data, in a large proportion of units in all hospital settings (42% to 68%), nurses are working beyond capacity (Table 4).

**Table 4: Total Workload / Worked Hours by Hospital Type 00/01**

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Total # of hospitals</th>
<th>Potential # of FCs if all 8 types present in each hospital</th>
<th>Functional centres excluded b/c not applicable</th>
<th>Functional centres excluded b/c of extreme values*</th>
<th>Number of functional centres in analysis</th>
<th>Number of functional centres reporting values &gt;=85%</th>
<th>Number of functional centres reporting values &gt;=93%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic/ Rehab</td>
<td>20</td>
<td>160</td>
<td>114</td>
<td>5</td>
<td>41</td>
<td>19 (46%)</td>
<td>12 (29%)</td>
</tr>
<tr>
<td>Community</td>
<td>74</td>
<td>592</td>
<td>236</td>
<td>43</td>
<td>313</td>
<td>181 (58%)</td>
<td>107 (34%)</td>
</tr>
<tr>
<td>Small</td>
<td>52</td>
<td>416</td>
<td>272</td>
<td>31</td>
<td>113</td>
<td>47 (42%)</td>
<td>26 (23%)</td>
</tr>
<tr>
<td>Teaching</td>
<td>10</td>
<td>80</td>
<td>32</td>
<td>4</td>
<td>44</td>
<td>30 (68%)</td>
<td>14 (32%)</td>
</tr>
<tr>
<td><strong>ALL TYPES</strong></td>
<td><strong>156</strong></td>
<td><strong>1,248</strong></td>
<td><strong>654</strong></td>
<td><strong>83</strong></td>
<td><strong>511</strong></td>
<td><strong>277 (54%)</strong></td>
<td><strong>159 (31%)</strong></td>
</tr>
</tbody>
</table>

Source: O’Brien-Pallas et al, 2003

*Note: extreme workload / worked hours values are <40% or >110%
Lack of Support

Nurses report that one of the main reasons for the increase in their workload is lack of support services, such as clerical, portering and housekeeping. When these services are reduced or cut, hospital nurses have to spend a larger proportion of their time on non-nursing activities that could be done more cost effectively by other people. This finding was confirmed in the report of the Canadian Nursing Advisory Committee, which reported that nurses “spend up to three quarters of their time on work that does not contribute to patient care.” (Canadian Nursing Advisory Committee, 2002) Nursing workload is also affected by lack of tools, technology and equipment. According to a recent Workers Safety Insurance Board (WSIB) study, lack of equipment or problems with hospital equipment is a significant factor in the high rate of nurse injuries and absenteeism in the hospital setting. The report recommended that hospitals ensure that equipment is available and functioning, and that the WSIB establish a committee to rate and set standards for hospital equipment (Shamian, O’Brien-Pallas, et al., 2001).

Nurses’ workload is also directly affected by the availability of other health professional services. The shortage of physicians in hospitals is well documented. However, teaching hospitals have also seen a steady decline in the paid hours of care from occupational therapists, physiotherapists and other allied health professionals. Some of these changes may be due to the trend to shorter hospital stays and more rehabilitation services in the community, but the reduction in these services is increasing workload for nurses, who are expected to provide assistance with some rehabilitation services in the acute care setting.

Providing appropriate support services and equipment is one of the most efficient ways for hospitals to manage nurse workload, make more effective use of nursing skills / the nursing workforce, increase job satisfaction and retain nurses.

Over-Reliance on Part-time Nurses

Part-time employment has always been an important element of the nursing workforce. In the 1970s and 1980s, about one-third of nurses were employed part-time, and the workforce was relatively stable. In the 1990s, restructuring led to substantial involuntary part-time employment for nurses. By 1998, almost 47.6% of nurses were working part-time. In 1999, while the overall percentage of people in Canada working part-time was 18.5%, in nursing it was 45.3%. It is difficult to conceive of another highly skilled workforce in which almost 50% of its members work less than full-time hours (Grinspun, 2002, 2003).

Despite recent efforts to promote full-time employment opportunities for nurses, Ontario’s healthcare system continues to rely heavily on part-time nurses. Between 1998 and 2001, the proportion of hospital RNs who were working full-time increased slightly or remained relatively stable. Over the same period, the proportion of hospital RPNs working full-time declined in all hospital settings except chronic care. Even with the increase that occurred in RNs working full-time, the average is still lower than the 70% target endorsed by the J PNC. At the current time, there is no data to suggest that acute care staff mix patterns and trends are appropriate or adequate. In fact, a richer mix of regulated staff is associated with improvements in patient outcomes (McGillis Hall, et al., 2001).

The inability of the healthcare system to provide full-time work for nurses is having and will continue to have an adverse impact on patient care and on nurse retention and recruitment. Organizations with a higher proportion of full-time nurses are more likely to offer better continuity and quality of care (Grinspun, 2002). They are also likely to have fewer problems with recruitment and retention.

Table 5: Percentage of Full-time Staff by Category by Facility

<table>
<thead>
<tr>
<th></th>
<th>Chronic / Rehab</th>
<th>Community</th>
<th>Small</th>
<th>Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>98/99 99/00 00/01</td>
<td>98/99 99/00 00/01</td>
<td>98/99 99/00 00/01</td>
<td>98/99 99/00 00/01</td>
</tr>
<tr>
<td>RN</td>
<td>58 64 67</td>
<td>53 54 56</td>
<td>53 50 53</td>
<td>63 67 69</td>
</tr>
<tr>
<td>RPN</td>
<td>57 56 64</td>
<td>57 55 54</td>
<td>52 48 49</td>
<td>67 57 58</td>
</tr>
</tbody>
</table>

Source: O’Brien-Pallas et al., 2003
Hospitals continue to rely on non-permanent staff from nursing employment agencies, either in an effort to contain costs (non-permanent staff do not require benefit payments) or to deal with absences of permanent staff. However, the data indicate that the use of non-permanent staff does not lead to savings (O'Brien-Pallas, 2001). This strategy is used most extensively by larger hospitals in urban settings, although chronic / rehab and community hospitals also purchase a substantial number of hours each year (Table 6). To ensure quality of care, the goal should be to minimize the use of agency nurses in hospitals and long-term care facilities.

### Table 6: Use of Agency Nurses 2000/01

<table>
<thead>
<tr>
<th></th>
<th>Total Number of hospitals</th>
<th>Hospitals reporting zero agency hours</th>
<th>Total Number of hospitals in analysis</th>
<th>Annual agency hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sum</td>
<td>Mean</td>
<td>Min.</td>
<td>Max.</td>
</tr>
<tr>
<td>Chronic/Rehab</td>
<td>20</td>
<td>6</td>
<td>14</td>
<td>211,688</td>
</tr>
<tr>
<td>Community</td>
<td>74</td>
<td>29</td>
<td>45</td>
<td>856,091</td>
</tr>
<tr>
<td>Small</td>
<td>52</td>
<td>38</td>
<td>14</td>
<td>8,125</td>
</tr>
<tr>
<td>Teaching</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>1,090,364</td>
</tr>
</tbody>
</table>

Source: O'Brien-Pallas et al., 2003

While organizations may think that using casual, part-time or agency nurses makes them “more flexible”, they often have difficulty finding casual and part-time staff when needed. This has resulted in significant overtime and related sick time for existing full-time nurses, and high overtime costs. The cost to the system in 1998-1999 alone was estimated by O'Brien-Pallas, et al. (2001) to be in excess of $171 million on overtime hours for inpatient nurses alone (about 2,250 FTEs), including $57 million on overtime premium; close to $39 million (765 FTEs) was spent on related sick time, and about $19 million (375 FTEs) on agency nurses.7

By hiring full-time employees who work 1,950 to 2,000 hours per year instead of relying on agency, casual and part-time nurses and overtime, hospitals could significantly increase the proportion of nurses working full-time, decrease staffing costs, and provide greater continuity of care.

**Ongoing Education**

Despite the funding now available for ongoing professional education, many hospital nurses find it difficult to participate because the staffing levels within their organizations are not adequate to enable nurses to be granted time off to attend courses.

**Safety**

In its 1999 publication, To Err is Human, the Institute of Medicine (IOM) reported between 44,000 and 98,000 deaths in one year in the United States due to adverse events and called on all healthcare organizations to establish patient safety programs.

It is difficult to know whether there has been a marked increase in the rate of adverse events, or whether quality improvement and reporting programs are simply doing a better job of capturing them when they occur. However, it is reasonable to assume that the risk of adverse events will increase as complexity of care and workloads increase and as the number of staff decreases. A survey of Canadian nurses8 working in academic health science centres identified a number of factors in the working environment that nurses believe are putting people at risk, including low staff to patient ratios, heavy workloads, heavy reliance on part-time and casual staff, high occupancy levels, placing patients on off-service wards, lack of support services (especially clerical staff, housekeeping and preventive maintenance of equipment) and the physical environment.

---

7 Effective April 2002, health service organizations are required to report overtime hours to the MOHLTC. This information will greatly assist in understanding how financial resources are used for human resources.

The nurse participants unanimously stated that the safety risks have escalated in recent years, and must be addressed by dealing with workload issues and staffing. Most healthcare settings also need more effective ways to capture and report near misses as well as adverse events, so staff can assess current practices and make improvements before an event occurs. Because of the systemic nature of many risks, strategies to improve safety will have a positive impact on working environments, workload, continuity of care and nurse retention/recruitment.

This issue was highlighted in the 2003 First Ministers Accord on Health, which recommends developing a national strategy to improve patient safety as well as setting targets to reduce medical errors/adverse events.

**Long-Term Care Sector**

**Progress**

Nurses in the long-term care sector report some progress in their position in the nursing world. They are now at more nursing decision making tables, and find that the profession is not as hospital driven as it was in the past. Nurses who were able to take advantage of the Nursing Education Initiative appreciated the fellowship opportunities, and the ability to attend conferences and receive more education. However, because of the lack of colleagues to cover for them, it is difficult for large numbers of nurses from this sector to obtain the time away from work to attend education courses.

Some education and leadership initiatives, such as RNAO’s Elder Care: Are We Ready for the Future? conference and think tank, focus specifically on nursing care for the elderly and help enhance both best practices in long-term care and nursing in this setting. Although the Orientation Program for long-term care is a good start, it has not been in place long enough to assess its impact.

With healthcare reform, long-term care facilities are increasingly nurse managed and run. The field is creating more opportunities for independent nursing practice, and for unique specializations, such as psychogeriatric nursing practice.

Within the last two years, 17 nurse practitioners were recruited by long-term care facilities as part of a pilot project. Results of the pilots were so positive that the positions were converted to permanent full-time and are funded by the ministry. Other facilities have now requested funding for an RN(EC), highlighting a potential new role for PHCNPs in this sector. With the planned expansions in long-term care, these trends should be encouraged. Anecdotal information also indicates that residents in facilities that have an in-house PHCNP require fewer visits to emergency.

The Ontario Stroke Strategy, Alzheimer Strategy and the MOHLTC Seniors and Diabetes initiatives provided nurses with education on best practices in the management of residents with these conditions in long-term care. The Alzheimer Strategy created seven permanent full-time nurse educator positions (i.e., psychogeriatric resource persons) to support long-term care nurses.

JPNC initiatives have also led to increasing interest in practice-based research in long-term care. For example:

- long-term care facilities are collaborating in the development and pilot testing of the RNAO Best Practice Guidelines
- eight long-term facilities are involved in the Nursing and Health Outcomes Project
- the Canadian Health Services Research Foundation (CHSRF) has awarded grants for nursing research in this sector.
In the last year, long-term care facilities have also seen an increase in nursing and personal care (NPC) staff as a result of an increase in the NPC envelope of $6.33 per resident (effective August 1, 2002, and based on a case mix index [CMI] of 100). (The amount that long-term care facilities receive for NPC each year varies depending on the facility's annual CMI which indicates the level of care the facility's residents require. Each year facilities may increase or decrease staff according to their CMI.) On average, 65.8% of each facility's increase was allocated to salaries for direct care staff. According to a survey (Sigma-3 Policy Research Inc., 2003) designed to assess how the funding was used:

- long-term care facilities increased the number of full or part-time NPC staff from about 42,738 in July 2002 to 45,088 by March 2003, an increase of 2,350 individuals or 1,782 FTEs. Of those 1,782 FTEs, 92.67 were RNs, 268.23 were RPNs, and 1,273.90 were PSWs. This very modest increase in regulated nursing staff is not enough to compensate for the significant increase in acuity and complexity of residents care needs.
- facilities were able to avoid a total of 544.9 layoffs when they had a lower CMI than in the previous year
- benefits to residents included “increased time and quality programming” (particularly more time for nurses and personal support workers to focus on resident care, admissions, orientation, assessment, personal grooming, and social interaction; an increased capacity to attend to residents with dementia and behavioural issues; and improved bathing services for residents.

Challenges

The challenges for nurses in the long-term care sector largely stem from a significant increase in the acuity and complexity of long-term care residents, and a funding system that does not support the required care and service needs of this population. While long-term care is the largest healthcare sector in the province, it is extremely difficult to recruit nurses and PHCNPs to this area of practice. This is due to working conditions, lack of wage parity with the hospital sector, lack of nursing curriculum that focuses on geriatrics and care of the aging person in a long-term care setting, and the lack of a common information technology infrastructure.

Nursing education does not adequately prepare registered staff to assume the unique leadership / collaborative role required to work effectively with unregulated healthcare staff who provide most of the care in long-term care facilities. As a result, there is a gap between the skill levels required and the ability to address professional practice issues, develop career paths, and establish standards based on practice-based research in long-term care.

Acuity, Complexity and Workload

Residents in Ontario's long-term care facilities are older, frailer and have more complex healthcare needs than ever before (Ministry of Health and Long-Term Care, 1999). About 53% have dementia or Alzheimer Disease, over 30% are depressed, and a significant proportion suffer from arthritis, stroke and congestive heart failure. The rate of depression in Ontario long-term care facilities (30.5%) was higher than all other jurisdictions other than the Netherlands (34.6%), double the rate noted for Manitoba (15.4%) and almost three times the rate in Michigan (12.2%). The proportion of residents who are clinically complex is higher (26.1%) than in other Canadian jurisdictions (Manitoba 16.8%; Saskatchewan 22.9%). The proportion who are cognitively impaired (44%) is also higher than in Saskatchewan (35.2%) and Manitoba (39.2%). (PricewaterhouseCoopers, 2001; O'Brien-Pallas et al, 2003).

This represents a significant increase in demand for more complex nursing services, which has been complicated by the shift of approximately 10% of the acute care hospital population to long-term care settings. Based on the Ontario Patient Classification System for long-term care (i.e., residents who require the least amount of service are classified as “A” and those who require the most are classified as “G”), approximately 75% of long-term care residents in the province now fall in the “E” and “F” categories (O'Brien-Pallas et al., 2003)
Figure 11: Homes for the Aged Resident Classification

Ontario Patient Classification System for long-term care: residents who require the least amount of service are classified as “A” and those who require the greatest amount of service are classified as “G”.

Figure 12: Nursing Home Resident Classification

The following table illustrates the steady increase in resident acuity and complexity (by case mix measure) from 1993 to 2002 (OANHSS, 2003), which has gone up by an average of 17.6% in all long-term care settings.
Table 7: Trends in Case Mix Measure in Long-Term Care Facilities
Proportion of Residents Classified in Categories “E” to “G”, 1993-2002

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
<td>76.39</td>
<td>76.31</td>
<td>78.88</td>
<td>79.63</td>
<td>80.99</td>
<td>82.12</td>
<td>83.30</td>
<td>85.07</td>
<td>86.82</td>
<td>88.84</td>
<td>12.35 17.6%</td>
</tr>
<tr>
<td>MHFA</td>
<td></td>
<td>73.40</td>
<td>73.34</td>
<td>76.62</td>
<td>76.83</td>
<td>78.48</td>
<td>79.95</td>
<td>80.98</td>
<td>82.18</td>
<td>84.39</td>
<td>86.33</td>
<td>12.93 17.6%</td>
</tr>
<tr>
<td>CHFA</td>
<td></td>
<td>63.79</td>
<td>65.45</td>
<td>69.69</td>
<td>72.79</td>
<td>74.08</td>
<td>76.08</td>
<td>78.00</td>
<td>80.36</td>
<td>83.41</td>
<td>85.96</td>
<td>22.17 34.8%</td>
</tr>
<tr>
<td>NH</td>
<td></td>
<td>81.39</td>
<td>80.82</td>
<td>82.49</td>
<td>83.23</td>
<td>84.26</td>
<td>84.96</td>
<td>86.00</td>
<td>87.89</td>
<td>89.03</td>
<td>90.90</td>
<td>9.51 11.7%</td>
</tr>
<tr>
<td>Total %</td>
<td></td>
<td>50.6</td>
<td>51.5</td>
<td>54.9</td>
<td>57.3</td>
<td>60.0</td>
<td>62.2</td>
<td>64.1</td>
<td>67.9</td>
<td>71.2</td>
<td>75.0</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

* Case Mix Measure – All residents in long-term care facilities are classified into categories to reflect their nursing and personal care requirements. The proportion of residents in each category is multiplied by resource use weighting factors to determine the case mix measure.
MHFA – Municipal Home for the Aged
CHFA – Charitable Home for the Aged
NH – Nursing Home

Because of the increasing volume and complexity of care required, nursing staff in long-term care facilities are now spending more time in direct care activities. Front-line nursing staff are particularly concerned about resident acuity and complexity, and their impact on workload, which should be monitored and tracked in order to ensure that funding allocation decisions accurately reflect staffing requirements. Staffing decisions and nurse-to-resident ratios are often based on the assumption that residents remain stable over time and their needs do not change. (O’Brien-Pallas, et al., 1995).

The RNs and RPNs working in long-term care also report that the environments themselves are having a direct impact on their workload. For example, lack of elevators and other equipment can increase the nursing time required to move residents from one part of the facility to another and to provide other services. Lack of technology and other supports also has an adverse effect on workload.

Capacity
For the past few years, Ontario has had a backlog of people waiting for places in long-term care facilities. In December 1998, 483 people in chronic care, 2,353 people in acute care hospital beds and 12,153 people in the community were waiting for placements to a long-term care facility. By December 2001, these numbers had risen to 589, 2,881 and 20,078 respectively – an increase of 22% for the first two groups and 65% for the third (OANHHS, 2002). During that same time period, clients waiting in long-term care facilities for placement to a more appropriate setting increased 62% from 6,124 to 9,936 (OANHSS, 2002).
Impact of New Long-Term Care Beds on Demand for Nurses

In 1998, the government announced plans to build 20,000 new long-term care beds and redevelop approximately 16,000 beds in older facilities that do not meet legislated structural standards by 2006. The table below shows the projected roll out of the new beds.

Table 8: Projected Roll Out of New Long-Term Care Beds

<table>
<thead>
<tr>
<th>Month</th>
<th>Pre-2003</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>7,452</td>
<td>7,752</td>
<td>4,636</td>
<td>160</td>
<td>0</td>
<td>20,000</td>
</tr>
<tr>
<td>Facilities</td>
<td>74</td>
<td>78</td>
<td>46</td>
<td>2</td>
<td>0</td>
<td>200</td>
</tr>
</tbody>
</table>

More long-term care beds will require more nurses. According to a staffing model developed by the Ontario Association of Non-profit Homes and Services for Seniors (OANHHS), a 100-bed facility requires a staffing complement of 9 RNs and 9 RPNs (12 RNs and 11 RPNs when the model includes casual nursing staff). Projecting this staffing model over the new beds, the system will require over 3,600 nurses over the next four years.

Table 9: Number of Nurses Required to Staff New Long-Term Care Beds

<table>
<thead>
<tr>
<th></th>
<th>Pre-2003</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>7,452</td>
<td>7,752</td>
<td>4,636</td>
<td>160</td>
<td>0</td>
<td>20,000</td>
</tr>
<tr>
<td>Facilities</td>
<td>74</td>
<td>78</td>
<td>46</td>
<td>2</td>
<td>0</td>
<td>200</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>671</td>
<td>698</td>
<td>417</td>
<td>18</td>
<td>0</td>
<td>1,804</td>
</tr>
<tr>
<td>RPN</td>
<td>671</td>
<td>698</td>
<td>417</td>
<td>18</td>
<td>0</td>
<td>1,804</td>
</tr>
</tbody>
</table>

Staff needed for 100 Beds; Registered Nurse 9, RPN 9.

As a result of the planned increase in beds and capacity, long-term care facility-based initiatives are also underway to provide innovative short stay programs to support the Ontario Stroke Strategy and meet the needs of certain groups of residents, including people with Parkinson’s Disease, mental health problems, a developmental disability and those on dialysis. Increased bed capacity is also creating opportunities for programs that may have a positive impact on retention and recruitment, because success is directly tied to nursing capacity.

http://www.health.gov.on.ca/english/program/ltc/redev/redev_mn.html
Retention and Recruitment
A number of initiatives are underway to address retention and recruitment in long-term care:

• As noted at the beginning of this section, the increase in funding for long-term care allowed facilities to recruit an additional 361 full-time equivalent nurses, and avoid layoffs.
• In November 2002, the MOHLTC funded the Actively Building Capacity in Long-Term Care (“ABC in LTC”) Project to: look at recruitment and retention of nurse practitioners, family physicians and pharmacists in long-term care, design a collaborative service delivery model, and develop a collaborative curriculum for educating these three professions in the care of residents in long-term care facilities. The project was based on a partnership among the McMaster University Department of Family Medicine, School of Nursing and Faculty of Pharmacy and Shalom Village (a long-term care facility).
• The MOHLTC Turning on the Lights initiative included recruitment of nurses to long-term care.
• The new website, LTC careers, (http://www.ltccareers.com/english/index.asp), which describes the sector and posts job openings, is a joint effort by the Ontario Long-Term Care Association (OLTCA), the Ontario Association of Non-profit Homes and Services for Seniors (OANHSS) and the MOHLTC.
• The implementation of MDS 2.0 in long-term care (planned for 2004) is also likely to have positive impact on nurse retention and recruitment.

Working Conditions
Although the proportion of nurses working full-time in long-term care has increased since 1993,\textsuperscript{10} CNO data show that a larger proportion of nurses who work in long-term care (17.6\% of RNs and 22.5\% of RPNs) work for multiple employers, compared to the proportion of nurses in the hospital sector who work for two or more employers (13.4\% of RNs and 14.2\% of RPNs).

Nurses in this sector\textsuperscript{11} tend to be older (44.8) than their peers in community (44.6) and hospital (43.8) settings. (based on CNO 2002 data). With the heavy workload and age of the nurses, workplace injuries are more common. Nurses in this sector also report physical abuse by clients\textsuperscript{12} and physical injury due to caring for people with impaired mobility.

Wage Disparities
Although nurses working in long-term care are paid at a higher rate than those in the community, they still do not have wage parity with nurses in the hospital sector, and the long-term care sector is not able to offer the same hiring bonuses or education grants as some acute care hospitals. In times of nursing shortages, this disparity makes it difficult for long-term care facilities to compete with hospitals for available nurses.

Funding Model
The casualization and over-reliance on part-time nursing staff in long-term care may be reinforced by the existing funding mechanism which is based on an annual resident classification that is indexed and does not fully capture resident acuity and complexity. As a result, funding for long-term care facilities can fluctuate significantly year-to-year, which makes facilities reluctant to commit to hiring permanent staff who may have to be laid off within a year. The funding model may discourage facilities from doing long-range planning for nursing resources, and may limit the hours and incentives that long-term care organizations can offer nurses (RNAO, 2000).

Education Issues
Residents with dementia and cognitive impairment require not only more care, but more specialized care (Burl et al., 1998). Undergraduate nursing education programs do not provide extensive education in gerontology, geriatrics or psychogeriatrics. In the past, nurses in long-term care had little access to programs to help them gain this expertise (PricewaterhouseCoopers, 2001). However, with recent education initiatives, such as those provided as part of Ontario’s Alzheimer Strategy, this situation is improving. MOHLTC has funded the development of programs on dementia for RNs and RPNs. These programs, which have been approved by the Ministry of Training, Colleges and Universities, are now being offered in the college system.

Because the percentage of nurses in long-term care facilities is significantly lower than in any other sector, it is difficult for facilities to provide coverage for nurses, which hampers their ability to participate in ongoing education opportunities.

\textsuperscript{10} From 46.3\% to 53.6\% for RNs and from 48.1\% to 48.6\% for RPNs.
\textsuperscript{11} These data are based on nurses employed in nursing in or outside Ontario with no age restrictions.
\textsuperscript{12} The PricewaterhouseCoopers (2001) study showed that 39\% of residents exhibit aggressive or angry behaviour that often result in staff injuries.
Community Care

Progress

Nurses working in community care also report progress in carving out their role in the healthcare system. They are participating in more nursing planning tables, and have a stronger voice in the profession. The community offers the opportunity for autonomous holistic practice, which is extremely attractive to many nurses. Given the ongoing advances in care and treatment, community care is an interesting, challenging and expanding field. It also gives nurses the chance to deliver care where people most want to be, and to support people in their efforts to stay independent as long as possible.

The Commission on the Future of Health Care in Canada strongly supported community care and recommended more funding for this sector. In the 2003 First Ministers Accord on Health Care, the federal government announced a substantial increase in funding for home care services, and the provincial governments agreed to provide and expand coverage for home care services, including post-acute, mental health and palliative home care. This has the potential to significantly improve both care and job satisfaction in the community, and should help address some of the challenges discussed below.

Challenges

The challenges for nurses working in community care stem primarily from:

- increasing patient acuity and complexity
- the destabilization of funding sources, which have resulted in heavier workloads, lack of capacity, lack of wage parity with other nurses, and a management structure that limits nurses’ ability to use their clinical judgement.

Acuity, Complexity and Workload

With the move to shorter hospital stays and more care closer to home, the number of people requiring community care has increased dramatically, and their care requirements have increased in intensity, acuity and complexity. More people receiving care in the community now having greater physical or mental healthcare requirements and will need care for a longer period of time (Ontario Association of Community Care Access Centres, 2000; O’Brien-Pallas et al, 2003).

Between 1991/92 and 2000/01 admissions to home care increased by 33% from 212,328 to 282,275 cases, but admissions tell only part of the story. The number of visits required by people referred to home care for chronic health problems also increased by 110% from 3.2 million to 6.8 million per year. Over the same period, the number of visits for people with acute health problems increased until 1994/95 and then dropped again (O’Brien-Pallas et al, 2003).

Figure 14: Trends in Number of Home Care Visits, 1991-2001

Home Care Visits: Nursing 1991/92-2000/01

Source: Ontario Ministry of Health, Long-Term Care Division

34
**Funding**

In 2001, the MOHLTC announced a funding freeze for Community Care Access Centres and also required CCACs to stay within their budgets. Despite the fact that demand for nursing services was increasing, this directive meant that most CCACs had to cut services (Toronto Star, 2002). For example, the Toronto CCAC reported that, due to a $15 million dollar shortfall between need and funding, the Board was forced to implement changes to eligibility criteria for some services, which resulted in service cutbacks (Ontario Health Coalition, 2001).

Across the province, these cutbacks led to a 30% reduction in the volume of services. About 115,000 people lost their service and, since April 2001, the equivalent of 1,704 nursing positions have been eliminated in the home and community care system. The loss of nurses and other workers is driven by funding constraints. The organizations that provide community care services – both commercial and non-profit – hire staff based on the service volumes in their CCAC contracts. Because of the funding freeze, companies have not received the service volumes guaranteed in their contracts, which compromises the price structure of their bid and means they have to let staff go. At a time when the demand for nursing services is increasing, many full-time RNs and RPNs have been laid off, and the number of part-time and casual hours has also decreased. This situation is the direct result of destabilized funding for the home and community sector.

As a result of the funding freeze and lay off of nurses, provider organizations report that waiting lists for service are increasing (Canadian Institute for Health Information, 2000). Although the Ministry of Health and Long-Term Care's policy is that there cannot be a waiting list for nursing services in the community, waiting lists for nursing care are a growing reality (Ontario Association of Community Care Access Centres, 2000).

In a documentary series on the Health Care System, the Toronto Star (May 28, 2002) reported that the funding freeze has caused Community Care East York in Toronto as well as other service providers throughout the province to test people's ability to use family or their own money to cover their care.

**Supports / Working Conditions**

The supports for community nurses have also been cut, including clinical support, competitive mileage reimbursement, staff reimbursement, and participation in student placement programs (Falk Rafael, 1998; Ontario Health Coalition, 2001).

The funding freeze within the community care system highlighted the interdependency of health services, and the key role that community care can play in avoiding other healthcare costs. For example, the recent increase in emergency department visits may be due, in part, to home care clients being advised to visit emergency when CCACs could not arrange appropriate nursing services (Community Care Access Centre - Toronto District Health Council Working Group, 2001).

Limits on community care services also affect hospital services. In Toronto, almost 20% of people for whom home care nursing services could not be arranged had a delayed discharge from hospital (Community Care Access Centre - Toronto District Health Council Working Group, 2001). This gap in service was evident during the recent SARS crisis, during which community home care nurses played a critical role in ensuring that people were able to get the care they needed at home. However, shortages of staff and other factors (including the loss of part-time nurses to the hospital and long-term sector) prevented the community care system from doing as much as it could have.

**Impact on Retention and Recruitment**

The lack of support for community care may be having an impact on the number of nurses who are pursuing community nursing as a career option. The CNO reports that 12.6% of newly registered RNs chose community nursing in 1999 and 2000, compared to 14.5% of new nurses before 1999 (O’Brien-Pallas et al., 2003).

The declining structural supports in the community may also be a factor in the increase in absenteeism, long-term disability claims, and higher worker compensation fees. (Ontario Community Support Association, 2000). Workers who rush through their visits may experience illness, stress, and accidents on the job.
Given poor / uncertain working conditions and better opportunities in other sectors, community nurses are migrating. Over the past few years, CCACs and home care providers reported turnover rates that ranged between 20% and 75% for RNs and 16% to 61% for RPNs. Reasons for nurses leaving community nursing included concerns about compensation and job security, and stress. Of those who left community care, 40% took jobs in the hospital or long-term care sector (Ontario Association of Community Care Access Centres, 2000).

According to the CNO, fewer nurses worked in community nursing in 2001 than 2000, and more reported that they were not employed in nursing at all between 2000 and 2001.

Wage Disparity
Wages paid to community nurses have not kept pace with wages in other sectors. For the past few years, the top salary for community nurses is $4 to $7 lower than that of hospital nurses, and their benefits package is also lower (Ontario Association of Community Care Access Centres, 2000). Wages for community nurses are also less predictable than those for nurses in other sectors, because community nurses are paid by the visit rather than a set salary.

Management Structure
The addition of nurse managers in the CCAC system has added an extra level of management that may be having a detrimental effect on community nursing practice and job satisfaction. Nurses often choose community nursing because of the opportunity for autonomous holistic practice. The current management structure appears to be limiting nurses’ autonomy and their ability to use their clinical judgement on the job or practice to their full scope.

Public Health

Progress
Public health nurses work within a complex healthcare environment and function with a high degree of autonomy in planning and delivering programs and services. Nurses working in public health have the opportunity to be involved in an expanded practice based on community development and broad determinants of health. They are developing new skills, and are more involved in multidisciplinary teams. The practice of public health nursing is evolving into a dynamic nursing specialty.

The growing focus on health promotion and disease prevention is making careers in public health more attractive. New early intervention programs, such as Healthy Babies Healthy Children, allow nurses to work with high risk families to strengthen early child development and avoid health and social problems in the future. With these programs, there is a sense among nurses that public health is getting “back to its roots” and addressing the factors that affect health. Many public health nurses believe they should be using the same approach to support the elderly in the community. The 2003 First Ministers Accord on Health Care acknowledged the important role of health promotion, and directed all health ministers to “continue their work on healthy living strategies and other initiatives to reduce disparities in health status”. This will likely mean even more emphasis on public health programs in the future.

Public health nurses are also at the forefront in dealing with new diseases, such as West Nile virus, antibiotic resistant TB and – most recently – severe acute respiratory syndrome (SARS), and in planning for all the unknowns associated with any bio-terrorism threats, such as smallpox and anthrax.

In February 2000, the Chief Medical Officer of Health called on medical officers of health to support nursing leadership in their units by designating a senior nurse responsible for nursing quality assurance, a nursing practice leader or a chief nursing officer. According to an ANDSOOHA survey in September 2001, 50% of the 22 health units that responded have a chief nursing officer or equivalent. All public health units were asked to designate a senior nursing officer. As of 2002, only 6 to 10 of the province’s 37 health units had done so (ANDSOOHA, 2002).
Challenges
The challenges in public health are due to workload, the shortage of nurses to handle new initiatives, and competition for limited public health funding.

Workload
Public health units are being asked to respond to a growing number of health and social problems without adequate resources. Programs, such as Healthy Babies Healthy Children, which are effective and satisfying, are also extremely demanding. Funding for these programs has not kept pace with demand. As a result, nurses carrying heavy workloads are suffering from signs of stress. As the recent SARS outbreak demonstrated, there is no excess capacity in the public health system to respond to serious emergency situations. Health units affected by the outbreak were forced to “borrow” staff from other units. Had the outbreak been more widespread, the situation would have been untenable, the province's ability to contain the disease would have been severely limited, and public health would have suffered.

Recruitment
Although most public health units have funding to hire more nurses, they are having difficulty recruiting. This may be due to the general overall shortage of nurses, to the low profile of public health nursing in recent years, and/or to the relatively low investment in public health programs and services.

Competition for Public Health Funding
Public health units are required to ensure their communities have access to an extensive array of mandatory programs and services within limited budgets. In some cases, this means that public health nursing services must compete with other emerging public health issues, such as drinking water monitoring and West Nile virus monitoring, for available funds.

Primary Care

Progress
Over the past two years, the number of nurses actively delivering primary care increased significantly (O’Brien-Pallas et al., 2003). This is due in part to primary healthcare reform, which actively promotes the use of interdisciplinary teams and collaborative practice models to improve the public’s access to care and use of the most appropriate care provider. Nurses, in particular Primary Healthcare Nurse Practitioners (Registered Nurses in the Extended Class), are core members of these teams.

PHCNP Positions
In 2002, the government announced funding for 137 new RN(EC) or PHCNP positions, and made a commitment to create 252 more positions by 2005. These commitments will bring the total number of RN(EC) positions created since 1998 to over 650. Twenty of the 137 funded positions are for demonstration projects in 12 communities that have little or no access to family physicians. In many of these communities, PHCNPs will be the first access point for primary care services, and some PHCNPs will be working in stand-alone clinics. Recruitment for these positions began in January 2003. As of September 2003, 19 of the 20 positions had been filled. The PHCNPs who fill the remaining 117 positions will provide access to primary healthcare in small, rural and underserviced communities. Recruitment for these positions began in June 2003. As of September 2003, over 50% had been filled.

In 2002, to support Primary Healthcare Nurse Practitioners, the MOHLTC reviewed the legislative, regulatory and policy barriers to RN(EC)s’ current scope of practice. As a result of that review, the ministry approved a number of legislative amendments that took effect in March 2003. The changes give patients in hospitals and residents in long-term care facilities more access to primary care services provided by PHCNPs. For example, in hospitals, PHCNPs can admit patients to emergency departments, and order and prescribe treatments for them as well as for out-patients. In long-term care facilities, PHCNPs can now provide a number of services within their scope of practice, and residents can choose to have an RN(EC) along with an attending physician provide their health/medical care.

In 2003, the government re-iterated its commitment to break down the legislative, regulatory and policy barriers to RN(EC) practice.
**RNs and RPNs**
A significant number of RNs and RPNs provide primary healthcare in family practice settings, and play a valuable role in the primary healthcare system.

**Telehealth Services**
A growing number of registered nurses are now working for Telehealth Ontario, a primary care, consumer health information / referral service staffed and managed by nurses. Telehealth Ontario now employs more than 325 registered nurses. A longitudinal evaluation of Telehealth Ontario to assess the performance of the service, identify opportunities to increase its effectiveness, and assess its overall impact on access to appropriate information and use of the healthcare system was initiated in April 2003.

**Challenges**
Although progress has been made in integrating the role of RN(EC)s in delivering primary healthcare, a number of challenges still exist including: wage disparities between PHCNP positions, insufficient funding for the overhead costs associated with PHCNP practice, and barriers to PHCNP working to their full scope of practice. These challenges affect the healthcare system's ability to retain and recruit PHCNP, particularly in underserviced communities.

Most of the RN/RPNs in primary care are employed by the physicians with whom they work. There are significant disparities between the wages these nurses earn, and those paid by MOHLTC to nurses in primary healthcare settings. Primary care RNs/RPNs have asked to be recognized as integral members of interdisciplinary teams and included in primary care reform.

**Nursing Education**

**Progress**
The education sector is committed to helping nurses stay current with changes in the field, and develop the skills they need for nursing practice in the 21st century, and its achievements over the last four years have been remarkable. Nursing education programs at both the RN and RPN level have been significantly upgraded. Effective 2005, entry to practice requirements will be at the baccalaureate level for all RNs, and it is proposed that, effective the same year, RPN entry to practice requirements be at the diploma (rather than certificate) level. As part of a province-wide effort to ensure nurses have access to undergraduate, graduate and continuing education, faculty in the province's nursing programs have developed both collaborative and distance education programs.

In an effort to increase the supply of nurses in the province, Ontario has also removed limits on enrolment in RPN education programs, and increased funding for positions at the Masters level. To increase the number of College nursing faculty with Masters degrees, Ontario has offered College nursing faculty enrolled in a masters of science in nursing programs a tuition waiver. In the future, the province must also produce more PhD prepared nurses to replace those who will retire over the next few years.

**Challenges**
While the changes in nursing education will strengthen the profession, they have also created a number of challenges, including problems reaching expected enrolment levels in the collaborative RN programs, barriers facing RPNs who want to pursue a BScN, lack of appropriate clinical placements, lack of physical space, lack of funding for ongoing education, and the aging of nursing faculty. One of the main barriers to increasing enrolment is the fact that the current basic income unit (BIU) funding (i.e., the funding providing by government) for nursing education does not adequately cover the cost of educating a BScN student. This makes it difficult to maintain much less expand the number of graduates or ensure that Ontario has an adequate supply of RNs.
Enrolments
The new educational requirements for RNs and RPNs will mean a more skilled and effective workforce. Initially, however, the changes created some stresses in the system. For example, the implementation period for the collaborative baccalaureate RN program did not allow enough time for all secondary students – many of whom were in the process of obtaining the credits required for the previous college RN diploma program – to meet the necessary requirements for the university degree program. This, combined with lack of time for marketing and promotion, meant that the first year (2001/02) enrolment in the collaborative program was 1,850, which was short of the expected 4,000. However, in that same year, total intake in RN-level programs was over 4,600 because the final College diploma programs enrolled over 2,600, as students sought to complete the program before the new entry-to-practice requirements. By 2002/03, intake into the collaborative program had increased to 2,500, and 2003/04 data indicate that confirmed acceptances of students into RN programs were up 43.9% over 2002 levels.

Figure 15: Enrolment in RN Programs, 1990-91 to 2002-03

Educational Requirements for RPNs Seeking a BScN
The increasing educational requirements also pose problems for RPNs who want to obtain a BScN. In the past, RPNs could build on their past learning to become RNs by pursuing a college nursing diploma. Now, they are required to enter the baccalaureate program through the same stream as high school graduates, with varying recognition of their previous nursing education or work experience. Currently, there is no program in Ontario that will enable them to bridge from RPN to RN, and the only way they can obtain a BScN is to enter the baccalaureate program. The RPNAO and the Innovative Models working group of JPNC are addressing this issue.

Clinical Education / Placements
The challenges in securing sufficient and appropriate clinical placements continue to limit enrolment in both RN and RPN programs. The major barrier to secure these clinical placements is lack of funding for clinical education. Nursing programs do not receive funding through the MOHLTC Clinical Education Budget, and current BIU funding does not cover the cost of delivering clinical education. In most cases, nurses voluntarily take on the role of preceptor for students with no monetary compensation. Given the heavy workloads and other challenges in healthcare settings, it has become increasingly difficult to find nurses willing to be preceptors.
In its 1999 report, the Nursing Education Implementation Committee (NEIC) recommended that the ministry’s Clinical Education Budget “be expanded to include financial support for employers of nursing services to ensure that clinical placements and an adequate number of preceptors will be available for nursing students in the course of their nursing education”. This recommendation has not been addressed in any of the government’s funding announcements related to nursing education.

**Aging of the Nursing Faculty**
The faculty at Ontario’s nursing schools is aging. In September 2003, 100 tenure track nursing positions will be open in Ontario. According to a 2001 Ontario environmental scan by the Association of Colleges of Applied Arts and Technology, 49.6% of university nursing faculty and 37.7% of college nursing faculty are due to retire by 2010 (CNAC, 2002). At the current time, Ontario does not have enough nurses prepared at the masters and doctoral levels to fill the void.

**Physical Space**
Efforts to increase enrolment levels are limited by lack of physical space and infrastructure at some colleges and universities. A number of nursing education programs do not have the physical space to provide demonstration labs or support larger teaching programs.
IV. Recommendations

The nursing profession and the government have made significant progress in implementing both the recommendations of the Nursing Task Force (1999), and those developed by the Implementation Monitoring Subcommittee (2001). The challenge now is to ensure that all those initiatives have a measurable impact on nurses in all sectors, on the organizations that employ nurses, on public perceptions of nurses, and on people considering nursing as a profession.

1. To continue to enhance nurses’ readiness to practice, the Implementation Monitoring Subcommittee recommends that:

   1.1 The MOHLTC with the Ministry of Training Colleges and Universities (MTCU):
   • continue to support the Nursing Education Initiative, and work with the profession to assess whether more funding is required to ensure all nurses have access to continuing education
   • develop incentives that will encourage employers to free up acute care, public health, community and long-term care nurses to participate in continuing education and leadership programs
   • increase the support for the Clinical Best Practices Guidelines project
   • continue to support the Advanced Clinical Fellowships program.

   1.2 The schools of nursing continue to change to meet changing needs.

   1.3 The nursing profession continue to promote best practices, and assess their impact on practice, and on patient and system outcomes in all settings.

2. To increase the capacity and ability of the universities and colleges to capture applicants and prepare new nurses, the Implementation Monitoring Subcommittee recommends that:

   2.1 MTCU work with MOHLTC, the universities, colleges, employers, and the nursing associations to identify and implement strategies to increase capacity and enrolment in BScN programs, including:
   • increasing government funding for nursing programs to reflect the actual costs of delivering a baccalaureate nursing program, including the cost of clinical education
   • ensuring schools of nursing have adequate physical space
   • providing operating grants and tuition waivers that will allow nurses to be released to complete their PhDs within four years (to address faculty aging / retirement)
   • promoting cross-appointments between the educational institutions and employers for nurses working in community and long-term care (to address faculty shortages, strengthen the link between education and non-acute settings, and increase the profile of these sectors)
   • developing local recruitment initiatives to attract students to the collaborative programs
   • developing a system-wide pre-health program that would give students the pre-requisite knowledge and skills to enter nursing programs.
2.2 MTCU work with MOHLTC, the colleges, employers, and the nursing associations to identify and implement strategies to increase capacity and enrolment in RPN programs, including:

- ensuring schools of nursing have adequate physical space
- developing local recruitment initiatives to attract students to RPN programs
- developing a system-wide pre-health program that would give students the pre-requisite knowledge and skills to enter nursing programs.

2.3 The colleges and universities work together to develop a laddering approach that RPNs can use to enter the BScN program.

3. To ensure the healthcare system has access to the full range of nursing skills, the Implementation Monitoring Committee recommends that the MOHLTC and nursing profession:

- continue the regulatory review of all nursing roles with a view to expanding scope of practice
- explore the potential to develop and recognize other advanced practice nursing roles, including acute care nurse practitioners
- review employer practices to determine whether all categories of nurses are working to their full scope
- evaluate the impact of the CCAC model on community nursing practice, scope of practice, nurses’ job satisfaction, and client satisfaction and outcomes.

4. To achieve and maintain the staffing levels and working environment required to retain existing nurses and attract new ones, reduce turnover, reduce overtime and sick time, minimize the use of agency nurses, and eliminate competition between sectors for nurses, the Implementation Monitoring Subcommittee recommends that:

4.1 The MOHLTC work with employers and the profession to:

- increase by 5% over the next five years the current target nurse / patient and nurse / resident ratios used to guide staffing in hospitals and long-term care facilities to reflect the increase in patient acuity / complexity
- establish a benchmark of 85% productivity for staff nurses and nurse managers in all sectors and promote other staffing policies that will ensure the system has the surge capacity and flexibility to respond to short-term crisis situations
- provide appropriate wages that are consistent between and within sectors
- ensure all healthcare organizations comply with regulatory requirements and the ministry request to have a nurse leader at all senior management tables.

4.2 The MOHLTC provide stable, multi-year funding for all sectors, which takes into account the demand for services, increasing patient or resident acuity / complexity, and changing patient / resident needs, and addresses funding inequities within sectors.

4.3 The MOHLTC work with the community sector and the nursing profession to assess the impact of the competitive contracting model used in community care on nurse supply, employment status (over-reliance on casual and part-time nurses), nursing practices – including continuity / consistency and safety of care, nurse and client satisfaction, and patient outcomes.
5. To make the most effective use of existing nurse supply and improve continuity of care, the Implementation Monitoring Committee recommends that:

5.1 The MOHLTC work with employers and the profession to:
   • achieve the target of 70% full-time employment for registered nurses, and identify strategies and incentives to achieve that goal. Once the target for RNs has been achieved, this work should then be extended to the RPN category.
   • offer part-time nurses more hours per week
   • encourage all organizations to survey their staff to identify the hours that nurses “want” and other staff characteristics, and develop a staffing plan that is responsive to patients / clients and employee's needs
   • encourage employment of existing RPNs, RNs, and RN(EC)s and promote full scope of practice
   • launch and continue to support initiatives designed to increase the profile of long-term care, community and public health nursing, and attract and retain more nurses to these sectors
   • continue to invest in existing recruitment and retention initiatives that have proven effective, and develop new ones targeted to sectors most in need
   • help all settings develop the human resource expertise they need to manage a diverse workforce
   • continue to reduce the barriers to employing foreign-educated nurses who are permanent residents in Ontario
   • avoid competing with other provinces and countries for nurses.

5.2 The MOHLTC, employers, the union and the professionals associations work together to:
   • assess the potential for implementing a phased retirement plan for nurses between the ages of 55 and 65, similar to the one recently announced in New Brunswick, which offers nurses the opportunity to work fewer hours and access their pension to supplement their income
   • ensure that young nurses / new graduates have access to full-time employment in nursing including identifying strategies that will improve senior nurses' work lives and give junior nurses better employment opportunities (e.g., negotiating with nurse pension plans to allow older nurses to reduce their hours without affecting their pensions, addressing barriers that prevent junior nurses from obtaining full-time positions).

6. To create working environments that promote high quality care, patient / resident and nurse safety in the workplace, and improved patient / resident outcomes, the Implementation Monitoring Subcommittee recommends that:

6.1 Employers:
   • ensure nurses in all sectors have access to the equipment, supports and technology that will enable them to provide quality care and maximize safety in the workplace
   • identify strategies designed to limit / reduce overtime (and related sick time), thus improving patient outcomes
   • develop a three year staffing plan that identifies the changes required to minimize the use of agency nurses
   • develop a non-punitive working environment, which will support effective reporting of near misses and lead to improvements in safety and quality of care.

6.2 The MOHLTC work with employers and the profession to:
   • ensure all organizations have a valid and reliable WMS tool in place
   • support the recommendations of the 2003 First Ministers Accord on Health to develop a national strategy to improve patient safety and set targets to reduce adverse events
   • develop reporting systems that capture near misses as well as adverse events and encourage all settings to use the data to assess current practices, including staffing levels and mix, and make improvements.
6.3 The MOHLTC and the profession continue to support and evaluate effective nursing leadership initiatives, such as the Dorothy L. Wylie Institute, the RPN leadership certificate program, and the RNAO’s leadership programs.

7. To ensure the healthcare system has the information and tools it needs to plan and manage nurse supply, the Implementation Monitoring Committee recommends that:

7.1 The MOHLTC, employers, nurse leaders and researchers:
- accelerate efforts to collect administrative data in the community healthcare and long-term care sectors
- play a lead role in gathering data on RPNs (e.g., RPN/patient ratios, nursing hours, clinical outcomes)
- establish mechanisms to capture data on the supply, workload, and utilization of public health nurses and community mental health nurses
- analyze why nurses choose to work for an agency rather than a healthcare organization, and identify the changes required to attract those nurses to stable, consistent positions in healthcare organizations
- implement the recent recommendations from the Canadian Institute for Health Information (CIHI) to improve the quality of nursing data and enhance the Canadian Nurses Database
- identify and collect more population health needs-based data to drive health human resources planning
- identify the information required on nursing vacancies to support strategic health human resource planning, and develop a standard instrument for collecting that data.

7.2 The profession work with the College of Nurses to identify data that would support nursing resource planning for all settings.

7.3 Nursing researchers:
- develop an approach to determining adequate staffing levels and mix in all settings based on workload, which would reflect patient / resident acuity and complexity, an appropriate full-time / part-time mix to ensure continuity of care and care-giver, and improve patient safety and outcomes, the availability of supports and technology, and opportunities for nurses to participate in continuing education
- develop a definition of supply shortage or underservicing for nursing – both geographically and by practice area – and develop targeted strategies to close any gaps.

7.4 The Ministry of Health and Long-Term Care:
- continue to fund the Nursing Effectiveness utilization and Outcomes Research Unit (NRU) to provide a ready source of analysis and leading edge research on systems issues that affect client, provider and system outcomes.
References


Nicklin, W., McVeety J. (2002). Canadian Nurses’ Perceptions of Patient Safety in Hospitals. CJNL. Vol. 15 No. 3.


PricewaterhouseCoopers. (2001). Report of a study to review levels of service and responses to need in a sample of Ontario Long-Term Care facilities and selected comparators. Toronto, Ontario, Canada.


