

GOOD NURSING, GOOD HEALTH: A GOOD INVESTMENT.

Joint Provincial
Nursing Committee

Summer 2001

Your Health

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JPNC Co-Chairs

Shirlee Sharkey, President, Registered Nurses Association of Ontario

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Dear Colin and Shirlee,

On behalf of the Implementation Monitoring Subcommittee (IMS) of the Joint Provincial Nursing Committee (JPNC), we are pleased to present you with the first 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, health provider and Ministry of Health and Long-Term Care representatives on the IMS. It is also evidence of our accountability to the people of Ontario.

The report is good news for Ontario. It indicates that strategic investments in nursing in response to the Nursing Task Force report are serving to strengthen and stabilize the nursing profession in this province. Nursing in Ontario has made important advances in the last two years: there are more nurses working in Ontario, increased permanent and full-time employment, revived nursing leadership, RN and RPN education is being modernized, there is increasing value being placed on nursing as a knowledge profession, and nursing research is yielding results to guide evidence-based planning and policy. Applications for RN programs are up considerably for 2001/2002 and fewer nurses retired than anticipated in 2000, indicating the positive ripple effect of Ontario's investments in nursing.

The nursing strategy is in the early stages and, although substantive gains have been made, these are not equally felt across all sectors of the health system resulting in a growing shortage of nurses in the home care sector. There is still much work to be done. An increasingly complex health care 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 for ensuring Ontarians have access to high quality nursing services when and where they are needed.

Sincerely,



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We would also like to recognize the following individuals and groups: the members of the JPNC Implementation Monitoring Subcommittee and the Reviewers who helped verify facts and provide input (listed in appendices), and Judy Ponti-Sgargi and Lianne Jeffs, who were key members of the editorial team at the Ministry of Health and Long-Term Care.

Executive Summary

INTRODUCTION

Health care reforms in the 1990s caused some dramatic changes that negatively affected the nursing profession. Impacts included fewer nurses in the system, fewer permanent nursing positions, increased casualization of the nursing workforce, nurses leaving Ontario or the profession all together, and decreased nursing enrollments and graduates. Many of these changes, in addition to the aging nursing workforce, have had, and continue to have, a significant influence on access to nursing services in Ontario.

The Minister of Health, Elizabeth Witmer, established the Nursing Task Force (NTF) in September 1998 in response to growing concerns about the instability of the current nursing workforce, consultations between nursing professional organizations¹ and the government, a significant predicted nursing shortage, and nurses' concerns about their ability to provide safe care. The NTF was mandated to examine the impact of health care reform on both the delivery of nursing services and the nursing profession in Ontario and to recommend strategies to ensure and enhance quality of care through effective use of nursing human resources.

In January 1999, the NTF presented its report “Good Nursing, Good Health: An Investment for the 21st Century”

to the Minister of Health. The NTF report provided eight short, medium and long-term recommendations to improve nursing services in Ontario. NTF recommendation #1 was a permanent, annual investment of \$375 M to create 10,000 new front-line and permanent nursing positions. The Ministry of Health and Long-Term Care (MOHLTC) accepted all recommendations and announced an increase in funding for new nursing positions to approximately \$484 M in fiscal 2000/2001. The government announced in March 1999 that its investments would support the creation of 12,000 new, permanent nursing positions – 2,000 more than the NTF report recommended. Other recommendations supported basic education reform for RNs and RPNs, increased clinical and ongoing education opportunities in priority areas, support for nursing scientists to conduct research to guide human resources planning for nurses in Ontario, and an aggressive recruitment and retention strategy to attract students and nurses who have left the profession in Ontario as well as to promote professional development and practice for nurses.

ABOUT THIS REPORT

One NTF recommendation (Recommendation #8) was that a process be established to monitor the implementation, effectiveness and outcomes of, and ensure accountability for, the NTF recommendations. The Nursing Task Force charged

¹ RNAO submitted a proposal to, and met with, the Premier in March 1998 regarding the need for provincial strategies to stabilize and invest in nursing services.

the Joint Provincial Nursing Committee (JPNC) with this responsibility. The JPNC then established the Implementation Monitoring Subcommittee (IMS), co-chaired by representatives of the nursing profession and the MOHLTC. As part of its mandate, the IMS is responsible for providing progress reports on all eight NTF recommendations and the advancement of the provincial nursing strategy. This first progress report summarizes the most current information available on the implementation of the NTF recommendations.

METHODOLOGY

Data/information on the implementation status of the NTF recommendations was collected from a variety of sources including an Audit and Review of selected health care organizations, hospital Nursing Plans, surveys, hospital Management Information Systems (MIS) data, College of Nurses of Ontario registration statistics, statistical reports to MOHLTC, progress reports and verification from leads for each recommendation to MOHLTC, and input from various stakeholders involved in implementation.

THE CURRENT ENVIRONMENT

In Ontario, as in many jurisdictions, significant nursing human resource problems persist and are costly to the system. These include: continued casual employment (although this has decreased marginally, full-time employment is still

approximately 50% for nurses), understaffing, and increased overtime and use of purchased nursing services from agencies. In many cases, these factors lead to increased absenteeism due to illness or injury and difficulty securing nurses with the required knowledge and skill sets for positions. There is a current shortage of highly specialized nurses in priority areas such as oncology, cardiac care, dialysis, critical care and emergency nursing, while some nurses, particularly new graduates, are unemployed or underemployed. Difficulties recruiting and retaining nurses in the community sector persist largely as a result of inequities in remuneration and unstable working conditions compared to other sectors, particularly hospitals. Mitigating efforts to address current and predicted shortages are underway, largely as a result of the implementation of the NTF recommendations and the provincial nursing strategy. The main goal of Ontario's nursing strategy is to stabilize nursing human resources through effective recruitment and retention strategies.

HIGHLIGHTS

The findings in this report demonstrate that progress has been made in the last two years since the NTF submitted its report. The Ministry of Health and Long-Term Care projects that implementation of all eight recommendations will be completed by the 2004/2005 fiscal year.

Overall, the progress towards meeting the objectives outlined in "Good Nursing, Good Health: An Investment for the 21st Century," the original report of the Nursing Task Force, points to positive trends in addressing nursing issues in this province. These trends include the following:

- Improved participation rate in terms of nurses working in their own profession.
- Improvements in employment opportunities for all classifications of nursing in hospitals, home care, long-term care, primary care and public health.
- Overall improvement in permanent employment opportunities.
- Improved accountability of government-funded agencies regarding their efforts to implement Nursing Plans and other related activities.
- Improvements in research in nursing human resources and the relationship between nursing services and outcomes to better inform future health policy, planning and human resource practices.
- Improvements in continuing and clinical educational opportunities in terms of both the number and type of courses/programs available.
- Enhanced knowledge and awareness of nursing issues among the profession, other professionals and health care practitioners, health sector management, health services providers, the provincial government and the

- public at large.
 - Progress in reforming basic education for RNs and RPNs to meet new practice competencies for today's health system.
- There remain some significant unresolved issues, which are also addressed in this report. These issues include the following:
- High rates of casualization and part-time employment, although improving, continue to persist in all sectors of the health services delivery system, but most particularly in the home health care sector where the model of service delivery significantly reduces opportunities for improvement in full-time employment.
 - Under-utilization of nurses in roles that maximize the use of their knowledge and skills remains an issue, as well as the lack of recognition by some providers of the potential health and economic benefits associated with appropriate utilization.
 - Increasing rates of overtime with corresponding increases in absenteeism due to illness and injury.
 - While the wages, salaries and benefits levels associated with different sectors and providers within the health services delivery system have converged somewhat, there remains significant disparity leading to staff shortages and costly competition for nurses between the various sectors and employers.
 - Nurses' participation in key decision-making roles within

the health sector, while improving, could improve significantly more.

- Problems with inconsistent nursing human resource data quality, availability and standards across the health sectors impede effective HR planning and management. However, Ontario’s strategy is resulting in improvements in data quality and consistency and in its relevance to nursing HR planning.

Key Findings

RECOMMENDATION #1:

“Ensure that no further losses to aggregate professional nursing take place across all spectrums of health care delivery and immediately invest, on a permanent basis, \$375 million to create additional permanent front line nursing positions before the Year 2000. The first \$125 million of this investment should be made, no later than March 31, 1999, to create additional permanent front line nursing positions across all sectors of the health care system. While there may be areas of urgent need for nursing services in the short term, the remainder of the investment (\$250 million) will be determined by a method of funding nursing services that ensures health care consumers receive appropriate nursing care regardless of the setting in which it is received. It is further recommended that a specific portion of the \$375 million be directed to the employment of trained and qualified nurse practitioners.”

FUNDING

Since the Nursing Task Force report was submitted in January 1999, the government invested \$463.6 M in new base funding in fiscal 98/99 and fiscal 99/00 plus an additional \$399.5 M in new base funding in 00/01 for new nursing positions. Funding includes the Nursing Enhancement Fund (NEF) and other funding through new and existing programs that supported increasing nursing care.

The Nursing Enhancement Fund (NEF) is a direct response to the NTF recommendation to provide an immediate investment in permanent, sustainable front-line positions. It is also a new method of funding nursing services in the province because it is earmarked and includes accountability requirements to ensure the investment supports permanent nursing positions. The NEF consists of the \$177 M annually, targeted specifically for the creation of new, permanent full-time and part-time nursing positions. The NEF expenditure is tracked through Nursing Plans/Agreements with recipient health organizations.

The \$177 M NEF is allocated as follows:

- Hospitals \$130 M;
- LTC facilities \$20 M; and
- CCACs \$27 M.²

Other Funding: In addition, there was approximately \$291.9 M in annual, new base funding in fiscal 98/99 and 99/00 and \$394.2 M in annual, new base funding in fiscal 00/01 that supported new nursing positions for new and enhanced programs, and growth for hospitals, LTC facilities, CCACs and public health. “Other funding” for nursing positions was estimated based on the assumption that a percentage of total investments – approximately 40% on average, ranging from 25% to 100% depending on the type of program or service – for other programs was allocated for nursing human resources. Further, in 99/00 the government began investing \$10 M annually for 106 nurse practitioner positions.³

INVESTMENT TARGETS:

- 12,000 new, permanent nursing positions by March 31, 2001
- Stabilize the nursing workforce through creating permanent, new nursing positions and reducing casualization
- Increase RN to population ratio to 1997 national average – 7.6 RNs/1000 population (There are no reliable data to make national comparisons for RPNs)
- Increase level of nursing per unit of service

NURSING EMPLOYMENT

Over 98/99 and 99/00, more nursing positions have been created across all sectors of the health system, and there has been a significant increase in the hours of nursing

care provided to patients.

There were approximately 8,555 additional nursing full time equivalents (FTEs) created from fiscal 98/99 to December 2000.

The FTE is the only common unit used across sectors to measure nursing staffing. No sectors collect and report individual nursing positions. One FTE typically equals 1,950 hours over one year. One FTE may be covered by full-time, part-time and casual nurses. Individual nursing positions are estimated by multiplying the FTEs by 1.5 (50% PT and 50% FT).

The College of Nurses of Ontario reports individual nurses registered at a point in time. There is no way to link individuals with positions.

In the two-year period, fiscal 98/99 to year-end fiscal 99/00, the number of nursing FTEs grew by 7,211 among all health care sectors. About two thirds of this growth or 4,765 FTEs occurred in the hospital sector and the remainder in the community, LTC, and public health sectors.

Based on a preliminary estimate from the Management Information Systems (MIS) 00/01 third quarter report compared with 99/00 year-end MIS trial balance data, there was a further increase of 1,344 FTEs in hospitals in fiscal 00/01.

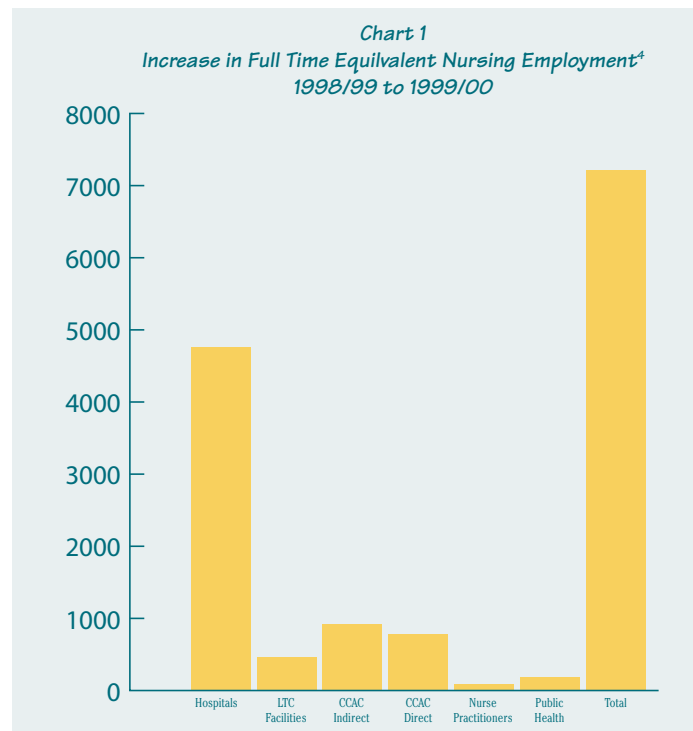
² In 99/00, \$171.7M flowed and the remainder of \$2.3 M for LTC facilities and \$3 M for CCACs flowed in 00/01. The total annual NEF for each sector is now part of the base funding for hospitals, CCACs and LTC facilities.

³ In 99/00, \$0.2 flowed for nurse practitioners because the Request For Proposals (RFPs) were finalized late in the fiscal year. The remaining \$9.8 in new funding flowed in 00/01 and the full investment of \$10 M will flow annually thereafter.

When this preliminary estimate for the third quarter of 00/01 is added to the prior two fiscal years, a total increase of about 8,555 FTEs (actually 16.7 M paid hours) can be accounted for up until December 31, 2000. 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 and sick time hours.

The actual number of new positions, however, cannot be verified because current data systems do not capture nursing positions. Empirical evidence in this report and other sources indicates that overtime for nurses is increasing and there are high rates of casualization, especially in the home health care and LTC sectors.

There are a number of positive trends in nursing employment in addition to the estimated increase in the number of FTEs created.



According to College of Nurses of Ontario (CNO) 2000 registration data, there was a higher percentage of nurses – both RN and RPN - employed in nursing in Ontario than in any of the previous ten years.⁵

- 77.9% of RNs reported working in nursing in Ontario compared with 73.8% in 1999; 79.1% of RPNs reported working in nursing in Ontario compared with 76% in 1999.

⁴ METHODOLOGY FOR DETERMINING NURSING FTEs PER SECTOR

Hospitals: MIS data trial balance data – Unit Producing Personnel (UPP) and Management and Operations (M&O) cost centres. 1 FTE equals 1,950 earned hours (worked, benefit and purchased hours). This includes full time, part time, and casual for RNs, RPNs, and unregulated staff.

LTC Facilities: 1 FTE equals 1,950 hours worked. LTC facilities submitted two surveys: February 2000 and September 2000.

FTEs are based on combined sample from the February and September 2000 LTC surveys (98% total response rate).

CCAC Indirect: Estimated based on case management cases between March 31, 1998 (actual) and March 31, 2000 (budget) as reported in the quarterly Community Support System (CSS) report on 29/11/00. 1 FTE equals 150 cases.

CCAC Direct: Estimated based on actual nursing visits between March 31, 1998 and March 31, 2000 as reported in CSS on 29/11/00. One nursing visit equals 1.2 hours. 1 FTE equals 2,000 hours worked.

Public Health Units: Healthy Babies Healthy Children Program – Health Child Development Branch, Integrated Services for Children Division, MOHLTC.

FTEs include FT/PT/overtime/agency/sick time hours.

⁵ College of Nurses of Ontario registration data represents the employment situation at the end of the previous year (Oct-Dec). Registration data for 2000 is based on the nursing employment status in December 1999.

- There is a reduction in the number of nurses working in a casual employment status: 11.1% in 2000 compared with 13.6% in 1999 for RNs and 13.8% in 2000 compared with 15.8% in 1999 for RPNs.
- There is an increase in the number of RNs and RPNs working full time: 53% of RNs worked full time in 2000 compared with 50% in 1999, and 47.7% of RPNs worked full time in 2000 compared with 47.1% in 1999.
- The nurse to population ratio has increased over the previous year: 7.1 RNs per 1000 population in 2000 compared with 6.8 RNs per 1000 population in 1999 and 2.24 RPNs per 1000 population in 2000 compared with 2.18 per 1000 population in 1999.

As a result of data limitations and inconsistencies among the different sectors and time periods, it is not possible to gather equivalent trend data for all sectors. An analysis of available data does, however, elucidate some human resources trends and issues.

CASUALIZATION

While these data indicate a positive trend towards stabilization and more permanent nursing employment, relatively high rates of casualization persist, particularly in the home care and LTC sectors.

The overall rate of casual and part-time employment combined

compared with full-time employment has also remained fairly constant in 1999 and 2000 and higher than recommended by nursing research and professional organizations.

- Of the total increase of 691 nursing positions (461 FTEs) created in LTC facilities in 98/99 and 99/00, 18% were casual. The NEF did not increase the proportion of full-time and part-time positions. Distribution remained steady over the three years, at 39% (FT), 47% (PT), and 14% (casual). (See table in Appendix 5)
- Data from 99/00 year-end hospital financial statements indicate that 62% of RNs worked full time during that fiscal year, 32% part time and 6% casual. The same data indicate that 57% of RPNs worked full time, 35% part time and 8% casual.
- Further, the NEF Audit and Review indicates that the number of purchased nursing service hours from agencies in hospitals increased by 22.9% in 99/00 compared with 98/99. In the 16 hospital sites involved in the Audit and Review, nursing agency hours comprised 1.3% of the total number of nursing hours.
- According to a survey of a sample of home care provider agencies (approx. 75% of agencies responded), 65% of new RPN positions and 67% of new RN positions were reported as casual from March 31, 1999 to November 2000.

As of November 2000, 60% of total RN and RPN positions were casual, 16% were permanent full time (FT), 19% were permanent part time (PT) and 5% contract (FT & PT). This includes all direct nursing care and nursing administration at the agencies. The accuracy of this survey is negatively influenced by the fact that some agencies also provide nursing services to sectors other than home care.

Other Trends by Sector

HOSPITALS

The hospital data indicate a number of other important nursing staffing and human resource trends over the last few years, including increased overtime and nursing hours per patient.

- Overtime has increased since the NTF report, suggesting that not all new FTEs represent new nursing positions. The 16 hospitals participating in the Audit and Review had a 14.2 % increase in overtime hours from 98/99 to 99/00. Overtime hours as a percentage of total nursing hours increased by 8.7% over this time period.

Impact of Inefficient Nursing Human Resource Practices in Hospitals

- The Nursing Effectiveness, Utilization and Outcomes Research Unit reports in the “Economic Impact of Nurse

Staffing Decisions: Time to Turn Down Another Road” paper that, in 1998/99, Ontario’s acute care hospitals spent an estimated \$171 M on overtime for inpatient nurses, which is equivalent to 2,250 FTEs.⁶ Also, an estimated \$19 M was spent on inpatient nursing agency personnel (approximately 375 FTEs) and close to \$39 M was spent on inpatient nurses’ sick time (approximately 765 FTEs).

- Researchers found that “overtime costs correlated almost perfectly with cost of sick time.”⁷
- The 2000 College of Nurses of Ontario data shows that there were 2,305 RNs and 1,348 RPNs in Ontario, not including initial registrants, seeking employment in nursing at the time of registration, further indicating that nursing human resources are not being planned and managed to their full potential.
- Hospital MIS trial balance data shows that nursing hours per ER visit and in-patient nursing hours per patient day increased markedly in fiscal 99/00, reflecting changes in the level of acuity and complexity of patients in the acute care sector, more intensive nursing being provided and decreased length of hospital stays.

LTC FACILITIES

According to the September 2000 survey of 396 (80%) of LTC facilities, 61% (or 86 of 140) of the LTC facilities that did not provide 24-hour RN coverage prior to the NEF were able to provide 24-hour RN coverage with this new targeted funding.

(Table 1) The deletion of the 24-hour on-site RN coverage from the Nursing Home Act affects compliance with the NEF requirement that facilities use the funding to increase 24-hour RN coverage.

Type of Facility ⁸	# Without 24 Hr. RN Coverage prior to NEF (1998/1999)	# With 24 Hr. RN Coverage as a result of NEF (as of Mar. 2000)	# Without 24Hr. RN Coverage after the NEF (as of Mar. 2000)
CHFA	13	12	1
MHFA	18	15	3
NH	109	59	50
Total	140	86	54

COMMUNITY CARE ACCESS CENTRES (CCACs)

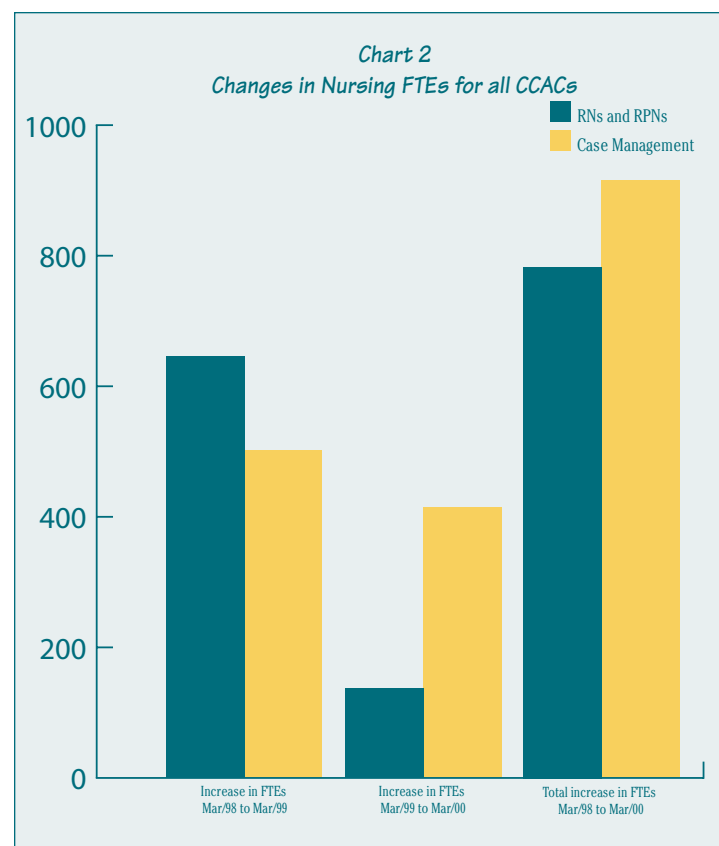
Data reported quarterly to the MOHLTC indicate that the NEF has had a greater impact on CCAC case management staff levels than on direct care nursing levels, based on the significantly higher increase in CCAC FTEs in 99/00 compared with direct care RNs and RPNs. (See Chart 2)

The survey of home care provider agencies suggests that all new funding to CCACs over the last few years has had a slightly greater impact on increasing permanent employment for direct care RNs than RPNs.

⁶ Data for this study originated from the Outcomes of Hospital Staffing Project (1998).

⁷ O'Brien-Pallas, L., Thomson, D., Alksnis, C., Bruce, S. (2001) The economic impact of nurse staffing decisions: Time to turn down another road?, Hospital Quarterly. 4 (3).

⁸ Charitable Homes for the Aged (CHFA); Municipal Homes for the Aged (MHFA); and Nursing Homes (NH)



ACCOUNTABILITY

- The government and the JPNC IMS created a number of new monitoring and accountability systems and tools for investments in nursing. These include:
- An Audit and Review of 30 selected health care organizations including hospitals, LTC facilities and CCACs that were Nursing Enhancement Fund (NEF) recipients regarding their usage of the 99/00 NEF
- Hospital Nursing Plans approved by Provincial Chief Nursing Officer and Hospital Chief Nursing Officers. Nursing Plans must allocate funding to create permanent, new positions. The MOHLTC advised hospitals in 00/01 that

the NEF would be recovered from those organizations that do not use the funding in accordance with their approved Nursing Plan. All but 2 Nursing Plans for 00/01 have been approved.⁹

- Nursing Staffing Schedules – LTC facilities and CCACs
- Special Staffing Surveys – LTC facilities, Public Health Units, Home Care Provider Agencies
- Any portion of the NEF not applied to nursing positions is subject to recovery from LTC facilities in the annual reconciliation process.

BENEFITS OF NURSING ENHANCEMENT FUNDING

- Front-line nurses and nurse administrators report that the NEF funding method made a positive difference in terms of decreasing workload, communicating the value of nursing, adding direct nursing care, improving staff morale, fostering stability, and leveraging nursing leadership positions for human resource management and financial decisions.
- Nurses and organizations report that the NEF has contributed to improving patient care.
- The Audit and Review has had a positive impact on perceptions and behaviours regarding accountability for investments in nursing.

BARRIERS TO MEETING THE OBJECTIVES OF THE NEF

- All sectors reported, to varying degrees, that they had difficulty filling new positions because of a combination of shortages of nurses with specialized knowledge and skills, competition from other sectors within and outside health care, and difficulty attracting and retaining nurses. All sectors report that overall funding fluctuations and uncertainties regarding future funding inhibit the creation and maintenance of permanent, stable employment.
- Other frequently cited recruitment and retention barriers are:
 - Lack of supports for new nurses, such as mentoring and internships, are a disincentive to recruiting and retaining a future supply of nurses in all sectors.
 - Shortages of specialized nurses is being mentioned particularly by LTC facilities, hospitals and public health.
 - LTC facilities and hospitals emphasized high workloads and staff-to-patient ratios.
 - Competition with other sectors is a particular problem for the home care and LTC sectors.
 - LTC facilities and CCACs indicated that fluctuations with other sources of funding other than the NEF (i.e., Case Mix Index adjustments for LTC facilities, and volume adjustments) confounds and may potentially negate the impact of the NEF.

- Home care and LTC stakeholders, in particular, report that short-term and/or volume-driven funding makes it difficult to plan and sustain permanent nursing positions.
- Salary differentials compared with other sectors, mainly reported in home care sector and also in LTC, is a significant retention and recruitment impediment.
- Job insecurity is frequently cited by home care provider agencies.
- Preference of some nurses for casual employment because it allows them more control over their work schedules, and often better wages, and allows them to avoid stressful practice environments and workloads.
- Hospitals reported that a side effect of increasing the nursing hours per patient day was a corresponding increase in the cost per weighted case. This may disadvantage some hospitals as it is considered to be an indicator of inefficiency.
- Structural, financial and attitudinal barriers prevent some RNs, NPs and RPNs from practicing to their full scope.
- Organizations in all sectors receiving the NEF expressed confusion about the intent of the funding when it was first administered in 99/00 and found the MOHLTC’s initial instructions vague. The MOHLTC has taken a number of steps to clarify the objectives and criteria for the NEF. For example, hospital Nursing Plan templates were modified in

⁹ The two remaining Nursing Plans anticipated to be approved pending minor revisions and resubmission.

consultation with Chief Nursing Officers.

DATA QUALITY AND REPORTING¹⁰

- **Estimates of nursing positions must be interpreted cautiously based on available data and reporting systems.** Data systems in all sectors were not designed to track human resources and, despite modifications in 99/00 (i.e., ability to categorize nurses according to employment status and type – RN, RPN, FT, PT, casual – in hospital MIS data), have some reliability and comparability problems. The FTE is the only common and the most accurate measure of nursing staffing.
- The MIS trial balance functional centres used to assess hospital nursing staff (Ambulatory, Nursing Inpatient and Community) include a small percentage of support staff working in traditional nursing areas (6.3% in 99/00).
- Since this analysis does not include the Diagnostic and Therapeutic functional centre, which mostly employs mostly non-nursing staff, it excludes any nurses working in that functional centre.
- Current comparisons of nurses by category are unreliable because there are no comparable baseline data from previous years.
- The lack of comprehensive data on human resource management trends and impacts (i.e., turnover and redeploy-

ment) hinders human resource planning.

- The MOHLTC's tracking and reporting requirements for hospitals, LTC facilities and CCACs for the NEF are not integrated with other reporting systems and, in some ways, do not fit the structure and needs of the sectors.

NURSE PRACTITIONERS

In March 1999, the government announced \$10 M in annual funding to support 106 FTE nurse practitioner positions. Following an RFP process, 106 positions were awarded in under-serviced areas, Aboriginal Health Centres, LTC facilities and Primary Care pilots - 52 in northern Ontario and the remainder for southern Ontario. As of June 2001, 95 of the 106 positions have been filled (Table 2).

The MOHLTC is conducting an evaluation of the 106 NP positions to better understand the integration of NPs into the health system and health outcomes resulting from NP care. A sufficient number of NP positions to constitute a critical mass was needed in order to have a coordinated evaluation. The first phase of the evaluation will focus on NPs in LTC facilities.

Many of the sponsors and service providers in all the priority areas have indicated that the integration of the NPs has had a positive impact on the communities in which

they provide primary care. The integration of NPs has relieved some system pressures in underserved communities and increased access to basic health services.

The North Bay Victorian Order of Nurses reported that there were 881 client contacts in the past year, 234 of which resulted from physician referrals. The NP at the Grimsby site reported an average of 1000 client encounters per quarter in addition to providing workshops and seminars and introducing secondary school primary health care Reproductive Services Programs.

Preliminary feedback from the LTC sites regarding the contributions of the NP role include more timely assessments

of residents with acute medical episodes, which reduces the need for ER visits; comprehensive admission assessments; facility staff support; effective communication with residents and family members; more effective and efficient communication with physicians; the development of collaborative practice with physicians; and community outreach.

The MOHLTC reviewed the situation with respect to the unfilled positions and has decided to allow six of the sites to continue recruiting, including providing support for some RNs on staff to pursue NP certification. It will reallocate, by appointment, two positions in underserved areas. It will also reallocate three NP positions in LTC facilities - two to communities that are able to recruit NPs and one to a northern urban facility to develop a link to these facilities and other sites through a wireless communication system to address retention and recruitment and educational issues affecting northern NPs.

While recent efforts have increased opportunities for nurse practitioners, there are approximately 182 nurse practitioners (of the total 401 registered in the extended class) who reported to the College of Nurses of Ontario in 2000 that they were not employed as nurse practitioners. However, NPs are required to meet the College of Nurses of Ontario's Quality Assurance requirements of 1800 hours of practice as

Priority Area	Target	Filled
Underserviced Areas	76	69
LTC Facilities	20	17
Aboriginal Health Centres	5	5
Primary Care	5	4
Total	106	95

¹⁰ Data sources utilized to assess nursing employment and service levels include:
 • MIS trial balance and year-end supplementary data up to the end of fiscal 99/00

• Hospital 99/00 Nursing Plans and revised 00/01 Nursing Plans
 • Third quarter 2000/2001 reports from hospitals
 • Community Support Systems (CSS) for CCACs

• Staffing survey of home care provider agencies
 • Two LTC facility staffing surveys – as of Q3 99/0 and Q4 99/00
 • Staffing survey of Public Health Units

an NP within three years of graduation or, at the three-year point, completing a substantial portion of the 1800 hours of practice as an NP.

There are some barriers that may be hindering full subscription of the NP programs and further integration of NPs in the health system, including:

- Some organizations had difficulty accessing and fulfilling the request for proposal (RFP) process.
- Some communities did not fully understand the role of the NP and had difficulty attracting candidates for the position.
- Relocation, lower salaries than expected and limited implementation of the scope of practice affect the ability to recruit and retain NPs.
- Access to education resources to maintain and upgrade skills on an ongoing basis is needed in areas that do not have ready access to the Universities.
- Currently, consultation with physicians and referrals to specialists by a nurse practitioner is not covered under the Ontario Health Insurance Plan (OHIP) billing system. Physicians must take uncompensated time out of their practice to consult and specialists may not accept referrals from NPs because they cannot be compensated for the full referral fee. In the latter case, in order to get the full referral fee, the physician must sign the referral to a specialist, resulting in duplication of services. This barrier would need to be addressed by physician groups with

government support.

- The Public Hospitals Act does not allow autonomous admissions and treatment of appropriate patients by NPs in hospitals.

RECOMMENDATION #2

“It is recommended that on-going structured opportunities be provided for RNs and RPNs to participate in a meaningful way in decisions that affect patient care on both a corporate and an operational level. In addition, health care delivery organizations must ensure that there is specific responsibility and accountability, at a senior management level, for professional nursing resources. It is recommended that this be achieved through amendments to relevant legislation. It is also recommended that the Ministry of Health work with health care facilities and educational institutions to ensure nurses are prepared for their ongoing leadership roles.”

The MOHLTC asked hospitals, CCACs and LTC facilities to identify nursing leadership positions, implement strategies to encourage leadership and participation in decision-making, and to indicate these positions/roles and nursing leadership strategies in their Nursing Plans or Agreements. Further, the government’s Blueprint plan

states, “in order to give a greater voice in hospitals, we’ll insist on the creation of a Chief Nursing Officer as a key executive position in hospitals.” Kathleen MacMillan, the Provincial Chief Nursing Officer and Dr. Colin D’Cunha, Chief Medical Officer of Health, sent a letter to Public Health Units (PHUs) asking them to support this strategy by creating “a visible leadership position” within each PHU.

Other strategies to support nursing leadership in Ontario include:

- **The creation of the first Provincial Chief Nursing Officer (PCNO) in Ontario in December 1999 to role model nursing leadership for health organizations throughout the health system.** A Nursing Secretariat was created in June 2000 to support the role of the PCNO. The mandate of the PCNO and the Nursing Secretariat is to: advise the Ministry of Health and Long-Term Care and other areas of government about health and relevant public policy from a nursing perspective; foster collaboration among the MOHLTC, other areas of government and nursing stakeholders; support the implementation and monitoring of the Nursing Task Force recommendations; and support the development of strategies to strengthen the nursing profession.
- The RNAO Centre for Professional Nursing Excellence, in conjunction with the Nursing Leadership Network, has developed and is offering leadership workshops for

advance practice nurses and middle managers, chief nursing officers, and staff nurses.

- Funding for the Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU) to establish the Dorothy Wylie Leadership Institute for Ontario nurses in August 2001. The objectives of the institute are to build nursing leadership capacity in the province, support succession planning in health care agencies, identify and nurture “up and coming” nursing leaders and leadership aspirants, improve the quality of patient care and nurse-related outcomes and promote evidence-based organizational decision-making.

NURSING LEADERSHIP IN HOSPITALS

The review of the 00/01 Nursing Plans found that the responsibility for Nursing Plan development and implementation rests with the Chief Nursing Officer in most organizations. Also, many hospitals struck a Nursing Plan Task Force to decide/recommend how the NEF would be used. In most sites, direct care providers were involved to some degree in planning the NEF allocation.

NURSING LEADERSHIP IN LTC FACILITIES

Since the sites visited as part of the Audit and Review are part of larger corporate entities, planning and decision-making regarding the NEF, for the most part, took place at “head

office.” One barrier noted by LTC facilities was the limited number of new and existing RNs with management experience.

NURSING LEADERSHIP IN CCACs

The Audit and Review of the 99/00 NEF found that there was relatively little involvement of staff nurses at CCACs in the allocation of the NEF, largely because of tight timelines. There were few opportunities for staff to participate in committees or other decision-making bodies generally. This could be related to the relative youth of CCACs. CCAC management at the sites recognizes the need for improvements, but service delivery pressures have taken priority and the CCACs have only recently begun to focus on organization improvements.

NURSING LEADERSHIP IN HOME CARE PROVIDER AGENCIES

The JPNC IMS survey of home care provider agencies in February 2001 asked a series of questions about nursing leadership and involvement of staff nurses in decision-making. Overall there has been an effort to maintain and/or create senior nursing positions. Seventy-eight % of respondents (68 out of 87) indicated that their agency had or created a Chief Nursing Officer or equivalent senior nursing position since the beginning of fiscal 99/00. These senior nurses have a variety of responsibilities including establishing nursing direction at agency and sectoral levels, decision-

making at the agency level, creating supportive professional practice environments, inspiring leadership within the organization, developing nursing policies and procedures, and Continuous Quality Improvement efforts. However, not all senior nurse leaders report directly at the senior management levels – 46% of respondents reported directly to the Chief Executive Officer or equivalent senior position at the time of the survey.

The results from the nursing staff survey indicate that home care staff nurses are involved in decision-making in their agencies, particularly with respect to policies and procedures, quality improvement and nursing practice. However, there are a number of structural and fiscal constraints that impede their ability to participate in a concrete and meaningful way.

NURSING LEADERSHIP IN PUBLIC HEALTH UNITS

The IMS survey of public health units found that 50% of respondents (10 out of 20) had or created a Chief Nursing Officer or equivalent senior nursing position since February 2000. Of these 10 respondents, titles include “Director” (program areas included Nursing, Family Health, Public Health Nursing and Nutrition, Communicable Diseases and Sexuality, etc.) and “Manager.” Responsibilities of the senior nurse position included developing professional nursing standards and policies and procedures, developing quality

work environments, nursing human resources planning and quality assurance initiatives.

Only two of the 10 respondents who had a Chief Nursing Officer or equivalent indicated that they reported directly to the Medical Officer of Health or the Associate Medical Officer of Health.

The responses regarding nursing staff indicate that they are involved in decision-making opportunities in their public health units. Staff nurses are involved with policies and procedures; team meetings and a variety of committees; project management including budget and resource allocation; program planning, development and evaluation; and the development of operational plans.

There are barriers that impede concrete and meaningful staff involvement in decision-making. The main barriers include relatively few nurses educated at a Bachelor of Science in Nursing (BScN) level, and lack of mentors and supervisors in restructured units.

The JPNC is monitoring and evaluating the creation of leadership positions in health organizations across all sectors.

RECOMMENDATION #3

“It is recommended that the Ministry of Health invest an additional \$1 million annually for

research to support a comprehensive nursing resource database. This database can be used to determine the appropriate number and skill mix of professional nurses and non-professional providers for optimal client outcomes.”

FUNDING

The MOHLTC is providing \$1 M annually for five years beginning in fiscal 99/00 to the Nursing Effectiveness, Utilization and Outcomes Research Unit (NRU) for nursing human resources research and the development of nursing databases.

In response to the NTF report, the MOHLTC, asked the NRU to provide a work plan spanning five years from 99/00 to 03/04.

ACHIEVEMENTS

The NRU research program addresses the following components:

- Examining current databases for modeling nursing human resources
- Testing and validating strengths and weaknesses of current HHR (Health Human Resources) modeling approaches
- Defining current practice demands and resource utilization in the restructured practice setting for RNs and RPNs
- Determining the impact of restructuring changes occurring in

- the health care system on supply of registrants for practice
- Building computer models of HHR that examine the impact of HHR relative to system, caregiver, and client outcomes
 - Conducting studies that examine production and management of nursing human resources.

Over fiscal 99/00 and for the first nine months of fiscal 00/01, the NRU undertook and completed various research studies that supported and are relevant to all eight Nursing Task Force recommendations. In addition to research projects, the NRU disseminates research findings and evidence-based analyses related to the NTF recommendations through a number of activities and vehicles including peer-reviewed publications, presentations to committees and decision-making bodies, and producing reports and fact sheets.

Core funding from the MOHLTC for research supporting Ontario's nursing strategy has enabled the NRU to secure additional funding from other research bodies. This is resulting in a higher return on investment for the MOHLTC than the MOHLTC funding alone.

BARRIERS

Time-consuming processes required to gain access to complete and up-to-date databases – i.e., developing database access agreements and negotiating for access - increased time spent on non-research activities.

RECOMMENDATION #4

“It is recommended that employers of nurses mount pilot projects to test alternative models of nursing care (e.g., flexible hours, environments that enable nurses to develop clinical skills, etc.), and that these models be evaluated to assess the impact on client outcomes and the working environment for nurses. It is recommended that the professional associations, with the support of the Ministry of Health, mount a comprehensive marketing and communications plan. It is recommended that the Ministry of Health, employers and nurses work together to address inequities in the remuneration of nurses for home nursing services.”

FUNDING

In March 1999, the MOHLTC announced \$10 M in annual funding for Nursing Education, and Recruitment and Retention Initiatives as follows:

- Nursing Education Initiative¹¹ –
Lead: RNAO/RPNAO \$7.5 M
- Best Practice Guidelines –
Lead: RNAO \$1.5 M
- Advanced Nursing Clinical Fellowships –

- Lead: RNAO \$0.5 M
- Retention and Recruitment –
Lead: RNAO and RPNAO \$0.5 M
- One-time additional funding for 2000/2001 \$0.2 M

NURSING EDUCATION INITIATIVE

Employers have reduced continuing education support for nurses because of fiscal restraint and lack of available clinical teachers. As a result, employers report a gap between nurses' skill sets and employer requirements, particularly in clinical specialty areas. The intent of the Nursing Education Initiative (NEI) is to provide grants to RNs and RPNs to support continuing education and training so that nurses can improve their knowledge and skills, meet practice setting demands, and improve the quality of care they provide.

The Nursing Education Initiative was launched mid-February 2000 under the administration of the RNAO and RPNAO. The MOHLTC distributed funds to both organizations proportionate to the ratio of RNs and RPNs registered with the College of Nurses of Ontario (i.e., 76% RNs and 24% RPNs).

In the first year, recipients could receive a grant up to \$1,500 toward the tuition costs associated with specialty education in the area in which the nurse was employed, or towards other continuing education (i.e, BScN, certificate in area of interest). Priority was assigned to those in permanent posi-

tions, full-time positions and to nurses who had not received training funds in the previous two years. The first item was weighted as the most important.

For 00/01, following stakeholder consultations, the criteria were broadened to include employed and unemployed nurses. A portion of funding is also now being allocated for programs to meet the learning needs of nurses in northern or rural communities.

ACHIEVEMENTS IN 99/00

In total, there were 4,283 applications received for the first cycle, March 31, 2000 deadline. Of these, almost all (4,187) received a grant. The distribution of applications and grants was consistent with the RN:RPN ratio in Ontario.

Other key achievements in 99/00 include:

- Most grant recipients were employed in permanent and /or full-time positions – 89% RNs and 85% RPNs
- About half of the RN and two-thirds of the RPN grant recipients took courses in priority clinical areas identified for this initiative.
- Nurses in all sectors benefited from the grants. However, a disproportionately higher number of nurses in hospitals (71%) received grant funding compared with the percentage working in hospitals (59% according to CNO 2000 registration data).

¹¹ In 99/00, \$5.5 M was flowwed to the NEI and \$0.5 M for Best Practice Guidelines, since the programs were launched in February 2000. The full, annual funding commitment was invested in 00/01.

ACHIEVEMENTS IN 00/01

Applications for 00/01 indicate the grant will be fully subscribed for that year and that demand is surpassing current supply of grant funding. The RNAO and RPNAO have received more than 11,000 applications for support in 00/01.

The program will be evaluated through long-term tracking of nurses and employer organizations. The MOHLTC is working with RNAO and RPNAO to develop a methodology to evaluate the impact of the NEI on retention, clinical competencies and outcomes.

OTHER INITIATIVES TO SUPPORT NURSING CLINICAL AND ONGOING EDUCATION

- Orientation of nurse practitioners in LTC facilities. This program, administered by the RNAO in September 2000,

- supports NPs participating in the LTC pilot project sites.
- The RNAO also administered the Healthy Babies/Healthy Children Postpartum Screening Training Initiative in June 2000.
- Orientation of Nurses in the LTC sector. On January 26, 2001, the Minister announced one-time funding of \$300,000 to the RNAO to develop an orientation module for LTC nurses. Structured orientation programs have been identified as a key ingredient to attract and retain nurses, and to integrate new nurses in their clinical setting.

BEST PRACTICE GUIDELINES

The Best Practice Guidelines (BPGs) Initiative is part of the response to NTF recommendation #4 and #7 (e) to support practice environments that enable nurses to develop clinical skills. The project, led by the RNAO, is intended to develop,

implement, evaluate and disseminate province-wide best practice guidelines in nursing.

The RNAO and MOHLTC agreed to focus on the areas of gerontology, mental health, emergency, home health care and primary health care because they are areas of high and/or emerging need where nurses require evidence-based supports.

The first guideline cycle focused on gerontology, the second on primary health care, mental health and home health care.

The four gerontology guidelines are on the following:

- continence management - promoting continence using prompted voiding;
- reducing constipation;
- risk assessment and prevention of pressure ulcers; and
- risk assessment and prevention of falls in the high-risk elderly.

The second cycle focuses on:

- enhancing healthy adolescent development;
- client centered care;
- crisis intervention;
- supporting/strengthening families through expected and unexpected life events;
- pain assessment and management;
- establishing therapeutic relationships; and
- assessment and management of pressure ulcers.

The third cycle includes BPGs on:

- breastfeeding;
- self-management care for adults with asthma;
- smoking cessation;
- geriatric mental health assessment;
- venous leg ulcers management;
- diabetes education; and
- implementing clinical best practice guidelines.

ACHIEVEMENTS

The first BPG cycle implementation commenced in May 2000, and the second cycle was launched beginning in September 2000. Development began on the third cycle in February 2001.

BPGs for the first two cycles have been pilot tested in 36 sites across all sectors, in close proportion to the number of nurses employed in the sectors. The third cycle of BPGs in the areas of primary care and gerontology is slated for pilot testing by September 31, 2001.

Over the last 15 months, the initiative has created excitement among nurses in Ontario – most of whom have devoted significant voluntary time to the project. **The level of involvement by individuals and organizations with the first 11 BPGs attests to the interest in this initiative.**

	# of RNs	RNs % Of Total	#RPNs	RPNs % of Total	Total #	%
Applications Received	3,327	77.7%	956	22.3%	4,283	100.0%
Grants Awarded	3,302	78.9%	885	21.1%	4,187	100.0%
Avg. Amount of Grant	\$725		\$587		\$695	

Other BPG achievements:

- The BPG project has attracted out of province and international attention. Potential opportunities to conduct national and international activities exist.
- The initiative is being presented at the International Council of Nurses (ICN) conference in Copenhagen in June 2001.
- RNAO is seeking partnership with the World Health Organization (WHO), as RNAO is currently involved with the WHO in a similar project in four Latin American countries.
- The RNAO will host an international conference on best practice guidelines from October 16 to 19, 2001
- The project has led RNAO and nursing experts to undertake the development of a unique best practice guideline on “Implementing Clinical Guidelines.” This guideline is a value-added benefit of the project in Canada and other countries.

BARRIERS

There are inherent difficulties in managing the wide breadth of the BPG evaluation:

- Anticipated data sources did not materialize in measurable indicators;
- The multiple sites for each guideline implementation make it challenging to identify comparable indicators;

- Initial projected resource allocation was less than actual requirements;
- Health care organizations need to have nursing-sensitive, valid and reliable evaluation indicators and measurement systems;
- Inconsistent evaluation indicators and data gathering across health care organizations and sectors may negatively effect program evaluation.

RNAO has made a number of modifications to mitigate these barriers. Specifically, it has increased project human resources for the development and evaluation phases, streamlined processes for identifying indicators, and developed stricter and more precise evaluation requirements (i.e., data sources) in the RFPs.

ADVANCED CLINICAL FELLOWSHIPS (ACFs)

The ACF Program is part of the response to NTF recommendations #4 and #7 e. In the ACF Program, Clinical Fellows partner with a recognized clinical expert or clinical teams for an intensive 12-week full-time experience to develop/ further develop clinical knowledge and skills in a chosen area of clinical nursing practice.

The ACF program focuses on priority areas such as emergency, palliative, neonatal and psycho-geriatric care. Fellowships can be used for academic credit in a post-RN

degree program.

To date, 48 RNs from all sectors have been awarded a Clinical Fellowship

- 18 nurses have completed their fellowship experience;
- 28 nurses are in the process of conducting their fellowship experience; and
- 2 nurses dropped out after being approved (award not provided).

Clinical Fellows have made numerous presentations to immediate colleagues within their organizations, as well as with regional programs, professional conferences and other opportunities. Educational, planning and research materials produced by the Fellows provide an important resource for nursing practice.

One of the ACF's most important benefits is that it is viewed as a retention incentive by participating nurses.

A number of barriers were encountered particularly during the program's first year. Many of these were rectified in the subsequent year.

In particular, it was difficult for nurses to initiate a response to the request for proposals because of the short time line between budget approval and the deadline for funding utilization. Further, many nurses are not familiar with devel-

oping proposals of this nature. The RNAO addressed this obstacle by holding mini-proposal writing sessions by tele-conference. It also developed a detailed instruction guideline available on its web site and with the RFP documents.

In 99/00 there was a lack of support for nurses to identify appropriate Mentors. RNAO has subsequently developed an inventory of available Mentors.

Shortages of nurses in specific areas continue to prevent managers from allowing nurses the time off to pursue education.

The RNAO is intensively marketing the program with employers as an incentive to re-energize the work force. Improved project funding to employers facilitates replacement of RNs participating in the ACF program. Stakeholders have also provided consistent and proactive support in marketing the ACF program to their constituencies through vehicles including websites, newsletters and flyers with their mailings.

The ACF evaluation framework will assess the clinical area, geographic area and employment category of the Fellows and all aspects of program implementation. It will evaluate concrete outcomes and the extent to which the Fellows' practice changed as a result of the fellowship experience.

RECRUITMENT AND RETENTION

The MOHLTC invested \$500,000 in 99/00 and \$700,000 in 00/01 for the RNAO and RPNAO to implement a comprehensive recruitment and retention nursing strategy. The components of this program are:

- developing a comprehensive report on the causes of and strategies for addressing recruitment and retention challenges;
- marketing the nursing profession to elementary and secondary school students, parents, guidance counselors, teachers, boards of education, the public and Ontario nurses;
- attracting Ontario nurses who have left the profession in Ontario;
- supporting Ontario nurses in career advancement and career recruitment; and
- promoting supportive work environments for nurses.

COMPREHENSIVE REPORT ON RECRUITMENT AND RETENTION

In March 2000, the professional associations submitted to the MOHLTC a comprehensive report, “Ensuring the Care will be There,” regarding recruitment and retention issues and strategic options to bring in and keep more nurses in Ontario’s health system. Some activities are being funded

by the MOHLTC as part of the NTF strategy, others are being funded and pursued by the RNAO, RPNAO and other organizations.

KEY RECRUITMENT AND RETENTION ACHIEVEMENTS

- “Putting Patients First” - a program to offer resources and educational support for nurses and provide care delivery models that promote continuity of care and caregiver – A steering committee has been established and the project is currently in the planning stages.
- “Healthy Work Environments” project – A multi-stakeholder working group has been created with a mandate to develop and encourage employers to implement healthy work environment strategies. A “Healthy Work Places in Action” conference is scheduled in November 2001 to profile initiatives underway in employment settings.
- The College of Nurses of Ontario, in conjunction with the RNAO and RPNAO, created and distributed the “Nursing and You” newsletter in August 2000.
- Nine career fairs have been held since May 1999 in various areas of the province with over 6,000 nurses attending as well as numerous employers and academic programs.
- The most recent data indicate that 430 positions have been posted, and 3,001 callers accessed the RNAO CareerLine since its inception. The RPNAO’s Career Line has received

1813 calls for 77 posted positions since its inception.

- The Career Counseling Services at RNAO and RPNAO have served approximately 3,700 RNs and RPNs as of the most recent reports in winter 2001.
- A “Career Ladders Discussion Paper” to be distributed in the spring 2001.
- The “Nurses Back Home” USA job fair led by the RNAO was a concerted effort among nursing stakeholders, employer organizations and the government to attract back the high proportion of Ontario registered nurses who are working in Houston, Texas. This followed the results of a survey of Ontario RNs working in other countries. **The survey found that a majority of these nurses (78%) would consider returning to nursing in Ontario. The most important factor cited for returning to Ontario is available full-time employment (65.5%). Over 60% mentioned relocation expenses as an incentive to return.**
- A print campaign is underway to promote nursing. As of January 2001, brochures have been printed and distributed to all English elementary and secondary schools, libraries, and college and university nursing programs. The material was distributed to French language schools in the spring 2001.
- A media relations campaign commenced in the fall/winter 2000.
- A Career Awareness Program and Speakers Bureau is

underway, including a full speakers curricula, and the launch of a video in September 2001 to support teachers and guidance counselors to raise awareness about a career in nursing.

- The RNAO hosted a booth at the Ontario Universities Fair in September 2000, and both professional organizations participated in the College Information Fair and promoted the “Nursing A Career for Life” theme.
- As of January 2001, Terms of Reference for a Student Placement Working Group have been developed. The purpose of the group is to increase opportunities for interested high school students to become exposed to the nursing career through participation in short-term and/or co-op placements in hospitals, community agencies and long-term care organizations.
- To kick-off nursing week in 2001, a public awareness and marketing campaign was launched including subway posters, radio public service announcements, and television advertisements.

To assess achievements, the RNAO will review College of Nurses of Ontario statistics on nurses’ employment i.e., full time, part time and casual and will collect information on number of attendees and any hires from Nurse Back Home U.S. job fairs.

The professional nursing organizations and the MOHLTC are developing an evaluation component to gauge the impact of RNAO/RPNAO's recruitment and retention activities.

STABILIZING NURSING HUMAN RESOURCES IN THE COMMUNITY SECTOR

Recommendation #4 calls for the Ministry of Health and Long-Term Care to work with employers and nurses to address retention and recruitment issues and noncompetitive compensation in the community sector. The government responded by asking the Joint Provincial Nursing Committee (JPNC) to review the issue of retention and recruitment and remuneration of nurses in the home health sector. In the Spring 2000, JPNC convened a working group, with representation from ONA, RNAO, RPNAO, Ontario Association of CCACs, and representatives of the for-profit and not-for-profit home health care provider organizations, to provide background and recommendations about these challenges in the community sector.

The JPNC working group submitted the "Stabilizing Nursing Human Resources in Home Nursing Services" report to the Minister and the CCAC Review committee in July 2000. The report contains recommendations to stabilize the community sector, including addressing working conditions, technology needs, training, professional development and inequities

in the remuneration and benefits of home care nurses compared to nurses in other sectors, particularly hospitals. This report, along with other stakeholder reports is being reviewed by the Ministry staff as part of its policy deliberations regarding human resources in the community sector.

To date, there has been no specific policy or government response for retention and recruitment of nurses in the community. However, the \$92.5 M announced in September 2000 to address increasing service pressures in CCACs and other community agencies is permitting wage increases and is being used to improve retention in some agencies and geographic areas.

Nursing stakeholders believe it is critical to build on this momentum throughout the sector. As of January 2001, approximately eight CCACs reported to MOHLTC that they have or may open service contracts to adjust rates or increase rates when contracts are renegotiated to enable salary increases for nurses and personal support workers.

Nursing groups and other stakeholders report that significant instability in nursing human resources in the community sector remains because recent salary increases in the community are not occurring in all agencies or geographic areas. Further, they report that home care agencies are finding it increasingly difficult to compete with the institutional sectors and CCACs

because of poor and insecure working conditions, and markedly lower wages and benefits. CCACs, home care agencies and hospitals, in particular, report delays in services and pressures related to shortages of nurses in the community sector.

The MOHLTC believes that addressing this issue is complex as nursing services are just one part of the wide range of services delivered in the community sector and it is difficult to deal with nursing human resources in isolation. Nursing stakeholders assert that it is crucial to address community nursing in order to improve overall service utilization.

The nursing community continues to press the government to respond to the "Stabilizing Nursing Human Resources in Home Nursing Services" report.

BARRIERS

Although there has been increased funding to the community sector over the last few years to address volume and service pressures, this funding has generally not addressed workload of nurses or nursing recruitment issues in the sector.

There is a general lack of understanding of the true cost drivers in delivering care in the community, and complexity has not been sufficiently captured since data related to service delivery in the community sector are relatively primitive.

Nursing stakeholders believe that there is also a need for a strategy to address retention and recruitment issues in the

LTC sector, including wage and benefit differentials and working conditions.

RECOMMENDATION # 5 & 6

"To ensure that health care consumers have access to appropriate nursing services, regardless of the setting in which they receive them, the Ministry of Health must develop a comprehensive model of funding nursing services by November 1999. The funding method should be: responsive to changing needs of the health care consumer; based on performance standards for nursing services that promote quality outcomes; and based on health information systems that provide comprehensive and reliable data on nursing services, workload and productivity. To ensure that decisions are based upon the best information available, information systems used for health care planning, delivery of services and funding must provide comprehensive data on health care consumer status, nursing interventions and client outcomes. These information systems must include comprehensive and realistic information on nursing workload and productivity and should support client outcomes identified above."

The Nursing and Health Outcomes project was created in response to recommendations 5 and 6 of the “Good Nursing, Good Health: An Investment of the 21st Century” report.

The overall objectives of this project are to identify the impact of nursing services on health outcomes across the health system; identify data elements and indicators for nursing services and health outcomes in all sectors; and to inform a funding approach for nursing services identified as contributing to good health outcomes.

This would allow administrators and researchers to, in the future, describe how different nursing interventions and numbers and types of nurses effect patient outcomes.

THE PROJECT HAS THREE PHASES:

Phase I – Information gathering/inventory and outcomes for each sector, measures, databases and data elements.

Phase II – Pilot studies in all sectors to assess feasibility of capturing data and cost of additional assessments, recording/abstracting data elements.

Phase III – System-wide roll out to collect nursing inputs and identified nurse-sensitive outcomes and identification of lessons learned and models which may be generalized to the broader health system. Databases with nursing inputs and outcomes will permit research to further understand the relationship between nursing inputs and patient outcomes.

The Nursing and Health Outcomes Project is on schedule to complete Phase I by the Summer of 2001.

The RFP for analyzing specific nurse-sensitive outcomes and where they are currently captured on databases was awarded in August 2000 to a team of researchers led by Dr. Diane Irvine at the Faculty of Nursing at the University of Toronto in partnership with the School of Nursing at the University of Western Ontario.

The work of the Nursing and Health Outcomes Project will support the inclusion of nurse sensitive indicators on Report Cards and health care atlases, from which nursing has been absent. The Project team has been working with MOHLTC staff and hospital sector stakeholders to include a range of indicators describing nursing performance in the development of the Hospital Report Cards.

The Nursing and Health Outcomes Project is also examining the relationship between nursing services and HR management practices, and adverse occurrences in the health system. Further, the Project is making linkages with other initiatives in Canada and internationally which will fortify its work. Recently the Nursing and Health Outcomes Project hosted a symposium with leading national and international outcomes experts.

As an emerging field of research, outcomes for nursing interventions can be a challenge. The outcomes are multifaceted and are affected not only by the care provided, but by factors related to the patient, the interpersonal aspects of care and the practice setting and environment in which care is provided. (Irvine, Sidani & McGillis Hall, 1998)

Data availability is a challenge because different data recording systems exist within the health care system. Hospitals, long-term care facilities and community organizations record and report a variety of data elements regularly, but not in a uniform, systematic manner. Current databases do not capture the minimum data elements that have been researched and agreed upon by the nursing profession as reflective of good nursing practice. It is essential that valid reliable data that are reflective of nursing practice be included in order to understand the contribution of nursing on patient and system outcomes.

RECOMMENDATION #7

“In the future, to ensure that professional nurses have the right mix of knowledge, skills and experience, the following is recommended:

- a) Make the Bachelor of Science in Nursing (BScN) (or equivalent), the College of Nurses of Ontario (CNO) minimum entry-to-practice requirement for*

new RNs beginning in the year 2005, consistent with the CNO’s recent recommendation on RN entry to practice competencies, and confirm that all RNs registered with the CNO before that time continue to be eligible under the new system.

- b) Lengthen the college program for future RPNs from three to four semesters (pending completion of the CNO’s work on competencies and education requirements for RPNs) and confirm that all RPNs registered with the CNO before that time continue to be eligible under the new system.*

- c) Remove barriers and add financial incentives for partnering between community colleges and universities to provide relevant, accessible and portable education programs for RNs and RPNs.*

- d) Provide a flexible environment through financial incentives for nurses and their employers, to ensure timely and affordable access to continuing and advanced education. This flexible environment should include designated funds to support and facilitate continuing and advanced education for nurses, including sabbaticals, job exchanges, etc.*

- e) Establish clinical models in practice environments to allow nurses to gain expertise in clinical areas and be recognized for these additional skills.*

- f) Provide sufficient financial resources to employers*

to support the ability of experienced nurses to teach new nurses.”

BACCALAUREATE AS

ENTRY-TO-PRACTICE FOR RNs

In 94/95, all Canadian jurisdictions participated in the National Nursing Competencies Project (NNCP) – a federally funded initiative to examine current and projected competencies for new nursing graduates. Each jurisdictional regulatory body committed to immediately embark on a competency review project. The NNCP identified university baccalaureate degrees as the most appropriate basic RN preparation.

Following an extensive consultation process involving nurse educators, employers/administrators and the public, the College of Nurses of Ontario developed and approved new entry-level competencies to prepare future nurses for providing safe and high quality nursing care in an increasingly complex health care system.

In April 1999, the MOH (now MOHLTC) and Ministry of Education and Training (now Ministry of Training, Colleges and Universities or MTCU) announced the establishment of the Nursing Education Implementation Committee (NEIC), composed primarily of college and university presidents, vice presidents academic, and deans and directors of Health

Sciences and Nursing Programs in the college and university sectors, with a mandate to advise on strategies for removing barriers to achieving collaborative college-university baccalaureate degree programs.

MOHLTC and MTCU proceeded to develop a funding framework based on the NEIC’s recommendations.

On April 12, 2000, the Ministers of Health and Long-Term Care and Training, Colleges and Universities announced the regulation amendment to the Nursing Act, 1991, to make the BScN the entry to practice requirement for registered nurses starting on January 1, 2005.

FUNDING

Funding was announced in April 2000 to enable the start-up and expansion of the collaborative university-college BScN programs. This included:

TRANSITIONAL GRANTS

- \$10 M in Start-up and Expansion Grants to be available in 00/01 with collaborative partners receiving \$3,000 for each first-year full-time nursing student expected to enrol in a collaborative degree program in September 2001
- \$5.6 M over seven years in College Faculty Upgrading Grants to enable universities to expand graduate studies

for up to 180 college nursing faculty teaching in collaborative nursing programs

- \$2.1 M over seven years in College Faculty Tuition Offset Grants to subsidize tuition for the college nursing faculty benefiting from the operating funding made available in the College Faculty Upgrading Program, beginning in 01/02
- \$4.9 M over seven years in Faculty Renewal Grants to enable universities to expand graduate enrollments by up to 140 students to ensure that an adequate supply of faculty beginning in 01/02

OPERATING GRANTS

Collaborative partners will receive Operating Grants for all nursing students in collaborative programs (additional to a baseline three-year average enrollment for existing enrollment levels in university nursing programs) at the university level of funding for all four years of the program and in all collaborative models. The incremental cost resulting from higher nursing enrollments, the higher university level of funding and the additional year of education required, will be considered annually by the government in setting college and university operating grants.

On January 19, 2001, MOHLTC and MTCU announced an additional \$49 M in funding beginning in 01/02 to mitigate funding pressures, support increased enrollments and address the impact of the partial missing cohort in 03/04.

Funding includes:

- An additional \$10 M in Start-up and Expansion Grants over two years to support the costs of moving to collaborative programs.
- \$14.7 M over three years for universities that wish to offer accelerated nursing programs, where students complete a four-year program in a shorter period of time, through such means as summer programs. This provides one-time funding equivalent to \$7,700 per full-time degree nursing student per two-semester year.
- \$24.3 M over three years to fund one more class of students in three-year college diploma programs. This funding will provide one-time funding equivalent to \$5,700 per full-time nursing student per two-semester year, provided the student enters a college diploma-nursing program on or after May 1, 2001. These diploma programs will be phased out as the new baccalaureate program takes effect.

ACHIEVEMENTS

In March 2001, MTCU confirmed with Presidents of CAATs and heads of universities its approval of the Final Diploma Intake and Compressed Degree Programs.

All but one of the universities now offering nursing programs in Ontario have or intend to put forward collaborative

nursing proposals. The University of Toronto now only offers a second-entry RN program. Three universities that have not previously offered nursing programs (Brock, Nipissing, and Trent) will start nursing programs in 2001. All of the 22 colleges offering diploma nursing in 00/02 are ready to enrol students in September 2001 in collaborative degree programs or are working towards a September 2002 start.

As of June 2001, 12 Ontario universities and 21 colleges have finalized or are in the stages of approvals for their BScN collaborative programs. In March 2001, MTCU approved a collaboration between Humber College and the University of New Brunswick, and gave the University of New Brunswick a Ministerial Consent to offer a degree program in Ontario.

STATUS OF PROGRAM APPROVALS

AS OF JUNE 2001

Approved by MTCU and Institutions Governing Bodies

- Laurentian-Cambrian-Sault (English)
- Nipissing-Canadore
- Trent-Sir Sandford Fleming
- York-Georgian-Seneca-Durham
- Brock-Loyalist
- Western-Fanshawe
- Windsor-Lambton, St. Clair
- Ottawa-Algonquin (English)

- Ottawa-La Cité collégiale (French)
- Ryerson-George Brown, Centennial
- McMaster-Mohawk, Conestoga
- Queen's-St. Lawrence
- Laurentian-Boreal (French)

Ministerial Consent

- University of New Brunswick - Humber partnership – granted in March 2001

Deferred Until September 2002

- Laurentian-Northern
- Lakehead-Confederation (memorandum of understanding has been signed)

The university and college partners are highly committed to overcoming structural and cultural barriers to successful collaborative programs. Further, there is significant, successful experience in other provinces with collaborative BScN programs. The experiences in other jurisdictions demonstrate that collaborative programs are an effective strategy to bring together the strengths of nursing diploma and degree programs and are a cost-effective approach to delivering baccalaureate nursing education. Further, this model increases geographic access to degree nursing programs.

Interest in RN nursing programs has increased for 01/02. Applications to nursing programs for 01/02 have increased over the previous year and preliminary projections indicate that Ontario will exceed the target of 2,800 RN graduates in 03/04. There is a 25% increase in first-choice applications to university nursing programs over 00/01. Further, the additional funding for the final diploma intake will enable prospective students who have not had time to acquire the required number of Ontario Academic Credits (OACs) the opportunity to become RNs and will mitigate the partially missing cohort issue.

Since OACs will no longer be required in 2004, and secondary school students will have had time to prepare for post-secondary degree programs, academic preparedness should no longer be at issue. Also, there will be a double cohort of graduates from Ontario secondary schools in 2004 to recruit into nursing programs.

BARRIERS

Despite the success in bringing universities and colleges together to develop collaborative BScN programs, there are a number of barriers that affect these programs.

- **Lack of clinical/practicum placement opportunities continues to be a barrier for many programs in expanding enrollments.**

- **The supply of faculty with graduate preparation in nursing continues to be a challenge for many faculties.**
- A lag between the NEIC recommendations in July 1999 and the initial announcement of one-year transitional funding in April 2000, followed by further funding in January 2001, created uncertainty about the adequacy of funding and potential resources available to plan and implement collaboration by September 2001.
- A delay in the announcement of the apportionment of funding for faculty renewal made it difficult for universities to plan for expansion of graduate programs to improve access for college faculty to upgrade.
- Because of delays in the negotiation process, partly based on uncertainty about the levels of funding, some potential students were not informed before application deadlines about the requirements for university entry into RN programs. Also, delays in passing the regulation shortened the implementation period such that secondary students did not have time to prepare themselves for entry to baccalaureate programs. The decision announced in January 2001 to provide full special-purpose funding for diploma programs for one more year, may have, in some cases, further added to confusion among potential collaborative program students.

- College faculty have considerable new demands with the change to collaborative baccalaureate education and final diploma intakes.
- There are a number of institutional barriers to collaboration, most of which have or are being addressed by program partners.

The experience so far has demonstrated that collaboration takes time and having clear guidelines, simultaneous communication with all partners, and stable funding greatly facilitates the process.

LENGTHEN AND ENHANCE THE COLLEGE PROGRAM FOR RPNS

The National Nursing Competency Project (NNCP) in 94/95 identified that the role of the PN has evolved. The College of Nurses of Ontario reviewed the RPN Competency Profile and began the development of a profile in Ontario that would meet the expected future role of RPNs to meet increasingly complex patient care needs. The NTF also recommended that the PN program be lengthened from three to four semesters pending the College of Nurses of Ontario's work on competencies and educational requirements for RPNs. In May 1999, the Heads of Nursing and the Heads of Health Sciences requested that MTCU develop program standards for practical nursing programs in the

Colleges of Applied Arts and Technology (CAATs).

The College of Nurses of Ontario adopted new entry-level practical nursing competencies in September 1999 for January 1, 2005. MTCU began development of a program standard for the PN program in Ontario's Colleges of Applied Arts and Technology once the competencies were released .

ACHIEVEMENTS

MTCU established the PN Program Standards Committee (PSC) in September 1999 to draft the program standard. The standards were completed in May 2000 and, after a consultation process involving RPNs, RNs, college sector stakeholders and employers, the program standards were endorsed by the CNO and RPNAO.

A Working Group of the Heads of Nursing of the Colleges conducted a gap analysis in the summer of 2000 and presented their findings to the Heads of Nursing in October. The working group recommended that the new entry to practice competencies and the new program standards be adopted and that the entry to practice for PN would be a college diploma. This recommendation was also endorsed by the Heads of Health Science programs in November 2000. There was agreement that the program should be at least 4 semesters in length.

In March 2001, the CNO Council recommended that entry to practice should be a diploma in PN.

Colleges are working with MTCU to finalize the program modification proposals, with the aim of releasing the program standard in 2001. The majority (17-18) colleges will be submitting program modifications that are at 4.4 semesters. It is expected that all Colleges will offer PN diploma programs by 2002.

It is anticipated that graduates of a diploma practical nursing program will have the knowledge, skills, attitudes, and professional judgment required for an effective role in the health care system of the future. A diploma credential is expected to be beneficial for the graduates seeking to enhance their foundational education, and specialized clinical education.

On January 19, 2001, MTCU announced the elimination of quotas on Practical Nursing programs, effective immediately. This reflects changes in health system demands now and in the future, and in the needs of particular communities and sectors (e.g., the opening of 20,000 long-term care beds over the next four years and other health system changes).

BARRIERS

Barriers that impact education reform for RPNs include:

- Ensuring access for students related to higher tuition costs with the longer program and the availability of PN teaching faculty.
- Access to clinical placements for RPNs in all sectors, and particular difficulties in acute care organizations that do not employ RPNs, impedes the new PN programs.

RECOMMENDATION # 8

“To ensure that these recommendations are continuously reviewed, evaluated and adjusted as required to meet changing needs, we recommend that a process be established to monitor their implementation, effectiveness and outcomes. We further recommend that the Joint Provincial Nursing Committee be charged with this responsibility.”

The Nursing Task Force report charged the JPNC with the responsibility to monitor the implementation of the NTF recommendations. In turn, the JPNC created the Implementation Monitoring Subcommittee with representation from various nursing organizations, the Ontario Health Providers Alliance and government.

The JPNC IMS's responsibilities include:

- The development of a process for monitoring and evaluating the NTF recommendations;

- The development of interim reports on the status of the implementation of the NTF recommendations;
- Evaluation of the status and outcomes of the NTF and recommendation of options to improve implementation and outcomes;
- Ensure completion of an Audit and Review of a sample of health care agencies. In November 2000, the MOHLTC, following an open RFP process, contracted the Hay Health Care Consulting Group to undertake the Audit and Review of the 99/00 NEF. The IMS was the Steering Committee for the review. The Audit and Review is a key tool to evaluate the impact and allocation of the NEF and to improve accountability, data collection and reporting.

In addition to setting up the process for monitoring and

evaluation, and overseeing evaluation reports and Audit and Review, the IMS collects data and conducts inquiries to address information gaps, i.e., baseline data about nursing human resources, nursing leadership and retention and recruitment in the public health and home health care sectors.

The process for developing the first progress report on the NTF recommendations provided an opportunity for multiple stakeholders to further explore data quality issues, identify data gaps and develop mechanisms to integrate and harmonize data across the sectors.

Other jurisdictions are likely to be very interested in this report and Ontario's experience with developing accountability mechanisms for nursing investments.

Priorities for Action

Another critical part of the JPNC's mandate was to provide recommendations for improvements in both the implementation of and monitoring and accountability mechanisms for each of the NTF recommendations. These priorities for action are summarized in this section.

RECOMMENDATION #1:

(a) Invest on a permanent basis, \$375 million to create additional permanent, front-line nursing positions

(b) Support employment of nurse practitioners

- (A)**
- Stable funding that is multi-year in nature is important to allow long-term nursing human resource planning in all sectors.
 - It is recommended that the MOHLTC develop customized approaches to targeting and distributing funding and accountability that are appropriate to the

structure and needs of each sector.

- The MOHLTC needs to continue to provide clear and consistent guidelines for the use of the NEF.
- CEOs/CFOs and human resource departments work with senior nurse managers to improve nursing human resource management practices across all sectors, such as reducing overtime, better utilization of experienced nurses, better supports for novice nurses, decreased risk factors for injury and illness, improved scheduling that meets the needs of individual nurses as well as continuity of patient care, to enhance efficiencies, reduce health costs and improve patient care.
- Health organizations support nurses to practice to their full scope in order to ensure cost-efficient utilization of human resources and best patient outcomes.
- There is a need for more integrated reporting systems regarding nursing staffing and the NEF.
- There is a need for a more effective measure than nurse to population ratio for human resource planning that includes an assessment of skills mix, optimal productivity, retention, patient outcomes and population health needs.
- Comparable national data on the RPN per population ratio is needed.
- There is a need for more consistent data collection and reporting systems, definitions, standards, indica-

tors and performance measures for nursing human resources across sectors.

- The outcomes of investments on patients, nurses and the health system need to be evaluated in order to better understand the value of the NTF strategy.
 - There is a need to capture worked hours per patient day, rather than just paid hours per patient day, to determine the extent and costs of absenteeism, injury and overtime.
- (B)**
- NPs, sponsors and service providers should all be actively involved in the development and implementation of the RFP for NP positions.
 - In areas that have difficulties recruiting NPs, the option should be retained for the Ministry to approve the funding to "backfill" while the existing nursing staff member upgrades to a nurse practitioner.
 - Consider funding NP positions as a standard benefit of the MOHLTC Underserved Area Program.
 - Explore the utilization and implementation of NPs in the home health care sector.
 - Proceed with the planned evaluation of the NP role and contribution.
 - Support employment opportunities/integration of the approximately 200 nurse practitioners in Ontario not employed as NPs. Employment of NPs in non-RN(EC)

roles compromises their ability to maintain their competencies.

- Educate physicians and other about the clinical and economic benefits of NP utilization.

**RECOMMENDATION #2:
Increased Decision-Making and Leadership
Opportunities for Nurses**

- Conduct a survey to better understand the role of the Chief Nursing Officer (or equivalent) position across all sectors.
- Explore the option to amend the Public Hospitals Act and other relevant legislation to designate nursing professionals with the authority and accountability for professional nursing practice, resource utilization and decisions affecting the health care consumer.

**RECOMMENDATION #3:
Funding to the Nursing Effectiveness, Utilization
and Outcomes Research Unit (NRU) to support
comprehensive nursing research databases**

- MOHLTC review and facilitate access to databases - i.e., on-site database access at the NRU - while recognizing privacy legislation.
- MOHLTC create more transparent and clearer policies and

procedures regarding the handling of data requests.

- Additional investments will be required to capture data across all sectors.
- There is a need for databases for the community sector.
- There is a need for a long-term capacity in nursing research.

**RECOMMENDATION #4:
MOHLTC support employers and nurses to
create work environments that offer flexibility
and professional satisfaction, address inequities
in remuneration of nurses across the sectors
and support the professional nursing associations
to mount a comprehensive recruitment and
retention campaign.**

NURSING EDUCATION INITIATIVE

- Continue funding and implementation of the NEI.

BEST PRACTICE GUIDELINES

- Continue the BPG initiative and continuously integrate lessons learned to strengthen its impact.
- Concentrate resources on maximizing the impact of the BPGs created to date.
- Develop a continuous process of updating the BPGs.
- Develop a process for continued commitment of Ontario

nurses and the provincial government to this project.

- Encourage employers to address barriers to implementation of the BPGs in the practice setting.
- Seek new funding sources for longitudinal evaluation of client outcomes associated with evidence-based nursing practices.

ADVANCED CLINICAL FELLOWSHIPS

- Continue funding and implementation of the ACF program.
- Hold frequent RFP cycles – 3 per year.
- Have a streamlined and consistent process for evaluating proposals.
- Continue with aggressive marketing of the ACF program.

RECRUITMENT AND RETENTION

- Create and promote opportunities for employers to share practical strategies that have been successful in their organizations.
- Continue to foster nursing leadership development at all levels of nursing management, as it is a success factor for retention and recruitment of nursing staff.

**STABILIZING NURSING HUMAN
RESOURCES IN THE COMMUNITY SECTOR**

- Recommend that the government provide targeted incentives to CCACs and homecare agencies to improve reten-

tion of nurses by addressing the factors outlined in the “Stabilizing Nursing Human Resources in Home Nursing Services” report.

- Consider similar incentives to address instability in the LTC sector.

**RECOMMENDATIONS # 5 & 6:
Nursing Outcomes Research**

- Support ongoing funding for this project.
- Ensure links between this project and the Hospital Report Cards and Best Practices Guidelines, the NRU and other nursing human resources research.

**RECOMMENDATION # 7:
Educational Reform for Registered Nurses
and Registered Practical Nurses**

- Baccalaureate as entry-to-practice for RNs
- Develop a strong and coordinated marketing initiative to promote interest in RN programs, initial and continuing education.
 - Develop a strong and coordinated marketing initiative to promote understanding of the role that graduates of RN programs can play in the current and emerging health care system.

- Establish a mechanism to ensure the collection of consistent, accurate data on nursing enrollments, attrition and graduates to support planning.
- Publicize the provincial admission requirements for the collaborative degree programs as determined by the college/university partnerships.
- Universities, in particular, require assistance in implementing Prior Learning Assessment strategies to allow fast-tracking of RPNs who wish to pursue BScN study and for second-entry candidates.
- Encourage universities to communicate to stakeholders their plans to expand their graduate programs.
- Consider funding for second entry programs beyond 2004, as an opportunity to bring more students into degree nursing programs and to draw from a new cohort of post-secondary students.
- Recognize the challenges posed by clinical education for nurses, to both the educational institutions and clinical agencies, by supporting lower workloads among preceptors when students are on units and providing mechanisms to recognize that student placements slow/impede home care nurses, who are funded on a per-visit basis.
- Undertake human resource planning for nurses at both a provincial and a regional level.
- Study different and innovative models to fund and deliver clinical education for post-secondary students, building on

the “Background Paper on Funding Nursing Clinical Education” developed by COUPN and the NRU in fall 2000.

- Clinical placements in all sectors should start earlier in the nursing program, as this would enable students to determine earlier their area of interest.

NEW PN PROGRAM STANDARD

- Develop a strong and coordinated marketing initiative to promote interest in practical nursing programs, initial and continuing education.
- Develop a strong and coordinated marketing initiative to promote understanding of the role that graduates of practical nursing programs can play in the current and emerging health care system.
- Support the College of Nurses of Ontario in its mandate to develop an approval process for PN diploma programs.
- Establish a mechanism to ensure the collection of consistent, accurate data on PN enrollments, attrition and graduates to support planning.
- Publicize the entry requirements for diploma PN programs as Ontario Secondary School Diploma.
- Recognize the challenges posed by clinical education for nurses, to both the educational institutions and clinical agencies, by supporting lower workloads among preceptors when students are on units and providing mechanisms to recognize that student placements slow/impede

- home care nurses, who are funded on a per-visit basis.
- Undertake human resource planning for nurses at both a provincial and a regional level
- Clinical placements in all sectors should start earlier in the nursing program, as this would enable students to determine earlier their area of interest.

**RECOMMENDATION # 8:
Joint Provincial Nursing Committee process
for monitoring the implementation, effectiveness
and outcomes of the Nursing Task Force
recommendations**

- IMS continue to have the responsibility to monitor the implementation of NTF recommendations.
- The IMS provide a status report every 12-18 months.

Conclusion

The experience of developing the first progress report on the nursing strategy in Ontario reinforced the continued need for relevant, high quality, accessible data on nursing human resources. It is our hope that this collaborative effort

will enhance the quality and rigour of future decision-making regarding nursing services and health system reform in Ontario. We are proud to be the first province that is conducting a comprehensive evaluation of the impact of investments in nursing and look forward to continuing this important work in Ontario.

Appendix 1

Joint Provincial Nursing Committee (JPNC) Members

CO-CHAIRS:

Barbara Wahl (up to May 31, 2001)

President
Ontario Nurses' Association

Colin Andersen

Assistant Deputy Minister
Integrated Policy & Planning
Ministry of Health & Long-Term Care

MEMBERS:

Mary MacLeod

Council President
College of Nurses of Ontario

George Zegarac

Executive Director
Integrated Policy & Planning
Ministry of Health & Long-Term Care

Lesley Bell

Chief Executive Officer
Ontario Nurses' Association

Ann Frances Allen

Provincial Planner
Health Planning Branch
Ministry of Health & Long-Term Care

Doris Grinspun

Executive Director
Registered Nurses Association of Ontario

Barbara Gough

Senior Policy Advisor
Ministry of Training, Colleges and Universities

Anne Coghlan

Executive Director
College of Nurses of Ontario

Helga Loechel

Manager
Health Planning Branch
Integrated Policy & Planning
Ministry of Health and Long-Term Care

Dr. Betty Cragg

Chair
Council of Ontario University Programs in Nursing

John McKinley

Director
Finance and Information Management Branch
Health Care Programs
Ministry of Health and Long-Term Care

Joanne Badgerow

Vice President
College of Nurses of Ontario

David Harvey

Program Manager, South West Region
Health Care Programs
Ministry of Health and Long-Term Care

Patricia Nesbitt

President
Registered Practical Nurses Association of Ontario

Peter Finkle

Director of the Eastern Region
Health Care Programs
Ministry of Health and Long-Term Care

Jo Ann Plummer

Member
Practical Nurses Federation of Ontario

Shirlee Sharkey

President
Registered Nurses Association of Ontario

Joanne Young Evans

Executive Director
Registered Practical Nurses Association of Ontario

Dr. Linda O'Brien-Pallas

Co-Director, Nursing Effectiveness, Utilization and
Outcomes Research Unit (University of Toronto)
CHSRF/CIHR National Chair, Nursing Human Resources

John King
 Assistant Deputy Minister
 Health Care Programs
 Ministry of Health and Long-Term Care

Micki Walters
 Dean, School of Health & Human Studies
 Durham College of Applied Arts and Technology
 Representing Heads of Nursing, Colleges
 of Applied Arts and Technology

Kathleen MacMillan
 Provincial Chief Nursing Officer
 The Nursing Secretariat
 Ministry of Health and Long-Term Care

Dr. Andrea Baumann
 Co-Director, Nursing Effectiveness, Utilization and
 Outcomes Research Unit (McMaster University)

David Trick
 Assistant Deputy Minister
 Post-Secondary Education Division
 Ministry of Training, Colleges and Universities

Lianne Jeffs
 Senior Policy Analyst
 Nursing Secretariat
 Ministry of Health and Long-Term Care

Janine Hopkins
 Senior Policy Analyst
 Nursing Secretariat
 Ministry of Health and Long-Term Care

Sharon Balsys
 Senior Communications Advisor
 Communications & Information Branch
 Ministry of Health and Long-Term Care

Barbara Thornber (up to December 31, 2000)
 Executive Director
 Registered Practical Nurses Association of Ontario

Appendix 2

JPNC IMS Members

CO-CHAIRS:

Doris Grinspun
 Executive Director
 Registered Nurses Association of Ontario

Peter Finkle

Director of the Eastern Region
 Health Care Programs
 Ministry of Health and Long-Term Care

MEMBERS:

Dr. Betty Cragg

Chair
 Council of Ontario University Programs in Nursing

Kathleen MacMillan

Provincial Chief Nursing Officer
 The Nursing Secretariat
 Ministry of Health and Long-Term Care

Patricia Nesbitt

President
 Registered Practical Nurses Association of Ontario

Dr. Linda O Brien-Pallas

Co-Director, Nursing Effectiveness, Utilization and
 Outcomes Research Unit
 CHSRF/CIHR National Chair, Nursing Human Resources

Jo Ann Plummer

Member
 Practical Nurses Federation of Ontario

Paul Reinhart

Director, Corporate Services
 College of Nurses of Ontario

Lianne Jeffs

Senior Policy Analyst
 Nursing Secretariat
 Ministry of Health and Long-Term Care

Margaret Ringland

Member, Ontario Health Providers Alliance

Shirlee Sharkey

President
 Registered Nurses Association of Ontario

Barbara Thornber (up to December 31, 2000)

Executive Director
 Registered Practical Nurses Association of Ontario

Vida Vaitonis

Member, Ontario Health Providers Alliance

Barbara Wahl

President

Ontario Nurses Association

Micki Walters

Dean, School of Health & Human Studies

Durham College of Applied Arts and Technology

Representing Heads of Nursing, Colleges

of Applied Arts and Technology

Joanne Young Evans

Executive Director

Registered Practical Nurses Association of Ontario

COMMITTEE SUPPORT:

Janine Hopkins

Senior Policy Analyst

Nursing Secretariat

Ministry of Health and Long-Term Care

Judy Ponti-Sgargi

RFP Coordinator, Consultant

Eastern Region

Health Care Programs

Ministry of Health and Long-Term Care

Appendix 3

Implementation Monitoring Sub-Committee

Terms of Reference

PREAMBLE:

January 1999's Report of the Nursing Task Force recommended a process be established to monitor the Report's implementation, effectiveness and outcomes and that the Joint Provincial Nursing Committee (JPNC) be charged with this responsibility.

Consistent with the Task Force's first recommendation, the Ontario Ministry of Health and Long-Term Care has invested \$375 M annually in nursing to create 10,000 nursing positions over two years ending March 31, 2001 and to convert casual nursing positions to permanent positions. This investment is across all sectors and includes support for nurse practitioners. The government wants to develop a process to ensure accountability for the appropriate expenditure of these funds for their intended purpose, which is to improve the availability of and public access to nursing services.

Moreover, the Ministry is strongly supportive of increasing the leadership and decision-making roles of nursing within management structures and operating processes. Similarly, the nursing community would like to ensure accountability for the proper implementation of all of the Nursing Task

Force recommendations.

To this end, the JPNC is establishing an Implementation Monitoring Sub-Committee reporting to the JPNC. The Committee will be co-chaired by the Registered Nurses Association of Ontario and the Ministry of Health.

TASKS:

1. To recommend evaluation criteria and indicators for all of the Nursing Task Force recommendations and initiatives.
2. To determine data requirements for monitoring and evaluating implementation of all of the recommendations and initiatives.
3. To identify progress and gaps in implementing all of the recommendations and to make suggestions for corrective actions.
4. To review the process for monitoring the number of nursing jobs and to make recommendations for effective future monitoring.
5. To review the process for monitoring training/education, recruitment, retention and research initiatives, and to make recommendations for improvements.
6. To review the process for the development, monitoring, and evaluation of nursing plans for the Year 2000/01 and to

make recommendations for improvement.

DELIVERABLES:

The Implementation Monitoring Sub-Committee will provide to the JPNC a work plan and biannual progress reports (October and April).

CO-CHAIRS:

- Doris Grinspun
Executive Director, Registered Nurses Assoc. of Ontario
- Peter Finkle
Director, Eastern Region, Ministry of Health and Long-Term Care

MEMBERSHIP:

- College of Nurses of Ontario (1)
- Ontario Nurses’ Association (1)
- Registered Nurses Association of Ontario (1)
- Registered Practical Nurses Association of Ontario (1)
- Practical Nurses Federation of Ontario (1)
- Council of Ontario University Programs in Nursing (1)
- Colleges of Applied Arts and Technology (1)

- Ontario Health Care Providers Alliance (2)
- Nursing Effectiveness Utilization and Outcome Research Unit (1)
- Ministry of Health and Long-Term Care (3) – including Kathleen MacMillan, Provincial Chief Nursing Officer; Janine Hopkins, Senior Policy Analyst, Nursing Secretariat and Sub-Committee support

TERM OF OFFICE:

Two years starting July 2000 or until the Joint Provincial Nursing Committee disbands the Sub-Committee.

FREQUENCY OF MEETINGS:

Once a month or at the call of the co-chairs.

Appendix 4

List of Reviewers for the Monitoring Report

Recommendation	Reviewer
Recommendation 1	Doris Grinspun, RNAO
	Peter Finkle, MOHLTC
	Kathleen MacMillan, MOHLTC
Recommendation 2	Peter Finkle, MOHLTC
	Kathleen MacMillan MOHLTC
Recommendation 3	Linda O’Brien-Pallas, NRU, University of Toronto
	Marcia Luba, NRU, University of Toronto
Recommendation 4	Doris Grinspun, RNAO
	Meaghan Obee, RNAO
	Julia Scott, RNAO
	Tazim Virani,, RNAO
	Joanne Young Evans, RPNAO
	Kelly Kay, RPNAO
	Sheri Oliver, RPNAO

Recommendation 5 Peggy White, MOHLTC

Dorothy Pringle, Faculty of Nursing, University of Toronto

Recommendation 6 Peggy White, MOHLTC

Dorothy Pringle, Faculty of Nursing, University of Toronto

Recommendation 7 Kathleen MacMillan, MOHLTC

Betty Cragg, University of Ottawa, COUPN

Micki Walters, Durham College, CAATs

Margaret Harrington, COUPN

Linda Buschmann, MTCU

Barbara Gough, MTCU

Nelsa Roberto, MTCU

Recommendation 8 Doris Grinspun, RNAO

Peter Finkle, MOHLTC

Kathleen MacMillan, MOHLTC

Appendix 5

Employment Status	Mar. 31, 1998	Mar. 31, 1999	Mar. 31, 2000 or Dec. 31, 1999	Three Year Change
RN FT	2,186	2,170	2,328	142
RN PT	2,590	2,602	2,640	50
RN Casual	844	893	893	49
Total RN	5,620	5,665	5,861	241
RPN FT	1,991	2,029	2,097	106
RPN PT	2,378	2,540	2,648	270
RPN Casual	685	758	759	74
RPN Total	5,054	5,327	5,504	450
Total FT	4,177	4,199	4,425	248
Total PT	4,968	5,142	5,288	320
Total Casual	1,529	1,651	1,652	123
Grand Total	10,674	10,992	11,365	691

1999/2000 ¹²	1999/2000 Actual FTEs	Distribution %
RN FT	23,736	62%
RN PT	12,343	32%
RN Casual	2,294	6%
Total RN	38,373	100%
RPN FT	5,041	57%
RPN PT	3,051	35%
RPN Casual	691	8%
RPN Total	8,783	100%
Total FT	28,777	61%
Total PT	15,394	33%
Total Casual	2,985	6%
Grand Total	47,156	100%

¹²This data is from UPP data Nursing, Ambulatory Care, and Community Services cost centres that employ most nurses. This breakdown includes RNs RPNs only and NOT "other staff" such as unregulated workers. It also does NOT include M&O nursing hours or any additional nursing FTEs in other cost centres in the hospital sector.