Public Health Sector
2006 Nursing Plan Report

Report created May 2007

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In addition, the operational and administrative support of the Research Department, Sheridan College Institute of Technology and Advanced Learning is greatly appreciated.

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Question or comments regarding this report can be directed to:

Sara Lankshear RN, M.Ed, PhD (student)
Email: slankshear@sympatico.ca
Phone: 905 – 570 – 3003

Report Summary

The purpose of the Public Health Nursing Plan Report is to provide senior nurse leaders and their colleagues with a valuable source of information depicting the current state of nursing within their organizations. The indicators included in the 2006 Public Health Nursing Plan were derived from consultations with Chief Nursing Officers who expressed a need to have access to data that went beyond nursing human resources (i.e. FTEs and head counts) and include important areas such as nursing leadership infrastructure, access to advanced practice nursing roles, manager span of control and strategies to address the orientation and education needs of current and future nursing staff. It is hoped that this broader collection of information can better inform current and future strategies for nursing at the organizational, professional, and provincial levels.

Upon review of the 2006 Public Health Nursing Plan submissions, four areas emerged that would benefit from reflection and ongoing dialogue within individual organizations as well as with nursing colleagues in the education, research and policy arenas.

1. *Nursing human resource planning*: The impending retirement of not only those nurses at the point of care, but also nurses who are currently in administrative roles is clearly evident in the Nursing Plan data presented here. Strategies for leadership succession planning are required along with recruitment and retention strategies at the point of care. Another area of interest is the trend of "retired" nurses who are returning to the workplace.
2. *Nursing leadership infrastructure and roles*: Although a Senior Nursing Leader position is present in 98.6% of the PHUs reporting here, there is significant variation in how the role is perceived and operationalized as evidenced by variety of reporting relationships.
3. *Support to nursing students*: Nursing student clinical placements (initial and consolidation placements) are concentrated in those areas which are proximal to the Ontario schools of nursing. This has implications not only for organizations that are frequently utilized as clinical placement sites, but also for those organizations that do not have access to nursing students (and therefore, a potential recruitment source) and the expertise of nursing faculty merely due to location. The issue of availability of preceptors for students in PHU also requires further investigation.

4. *Manager span of control*: Manager span of control was frequently identified by nursing leaders during the consultation process as being a key area for ongoing monitoring. Currently, approx 86% of managers are accountable for direct reports at more than one site have direct reports ranging from 1 – 30 individuals over a wide geographic area. This will be a key area for dialogue as we consider the impending need for recruitment of nurses in administrative roles. and

This report contains the results of the initial analysis conducted. There will be further opportunities for ongoing data collection and analysis of any or all of these items in order to continue building a valuable source of information to assist with future planning and evidence based decision making.

Nursing leaders are encouraged to utilize the information contained in this report to initiate dialogue regarding the current and future opportunities and challenges for the nursing profession within your individual organization, and throughout our complex health care environment.

PART 1

Introduction

The Nursing Plan was first implemented in 1999 as a result of recommendations generated from the Nursing Task Force Report: Good Nursing, Good Health: An investment for the 21st Century. The primary aim of the Nursing Plan is to collect meaningful data regarding the status of nursing services within acute care organizations in Ontario. In 2004, a series of consultations was undertaken with Chief Nursing Executives and other selected stakeholders in Ontario to ascertain the relevance of the information contained in the Nursing Plan. Those involved included nursing leaders representing a variety of sectors and geographic settings from hospitals (acute care, long term care, and rehabilitation and complex care facilities), academia, community agencies and government. Suggestions were invited for revisions to the data collection template and methods for dissemination of the results. A revised template was developed based on the suggestions and implemented in Fall 2005. The template was designed to include information about nursing human resources, support staff, reporting relationships and structures, among other human resources information.

In spring 2006, a Nursing Strategy Consultation meeting was held for the purpose of presenting the results of the Hospital Sector Nursing Plans. The participants included nursing leadership from across the province and the following sectors: Hospital (i.e. acute care complex continuing care, rehabilitation and other specialty areas such as pediatrics and mental health) and, Long-term care, Community and Public Health. The feedback from participants indicated a strong desire to expand the Nursing Plans to other sectors in order to provide a more comprehensive picture of nursing within Ontario.

This report contains the first series of data collected from the 2006 Public Health Nursing Plan.

Description of Public Health Units included in the analysis

This report contains the results from the first year of data collection using the Public Health Nursing Plan template. The data included in this report represents the data from the Nursing Plans submitted from 21 Public Health Unit, representing 58% of the total number of Public Health Units in Ontario.

Data analysis

The information presented here reflects the initial analysis of the data contained in the 2006 Public Health Nursing Plans submitted by Ontario Public Health Units in the Fall 2006. Data were analyzed using SPSS software (version 14.0). Initial descriptive statistics and frequency distributions were generated for each item. To enhance data quality, items with significant outliers were identified and requests for clarification were forwarded to the relevant organizations. Information contained in this report is based on data available as of March 1, 2007. Descriptive statistics were compiled for each item to obtain an overall provincial report.

How to use and read this report

The information in this Report reflects the 2005/06 Fiscal year. The information defines a wide range of nursing human resource, service delivery and quality of work life issues. It is intended that this presentation of data will be useful in planning, communicating and forecasting. To aid in this, the information included in this report provides a variety of perspectives regarding the state of nursing in Ontario Public Health Units. Nursing leaders are encouraged to discuss the Report widely regarding the current and future opportunities and challenges being presented by our complex health care environment.

Unless otherwise indicated, the data for each item are reported as the *mean scores*. Beyond the presentation of the mean scores, when relevant, additional levels of analyses are provided to enhance the information available regarding a particular item. Of note, is that some missing data may account for some frequencies not adding up to the total number of organizations responding (N= 21).

PART 2: Provincial Results (N= 21 PHU; 58%)

The results presented in this section are of the overall *Provincial* results for each of the items included in the Public Health Nursing Plan. Unless stated otherwise, all results are reported as the ***provincial mean*** for each item.

Section A: Facility Description and Nursing Leadership Structure

Population Descriptions

Number of sites per PHU	
Range	Mean
2 – 29	6.5
Population served by PHUs	
Range	Mean
73,680 – 2.8 million	386,941.66
Overall Nurse : Population Ratio	
1 : 2833	

Nursing Leadership Structure

	Provincial Mean	
Designated PHRED Unit : (Public Health Research, Education and Development	Yes N= 2 / 9.5%	No N= 19 / 90.5%
Senior Nursing Leader role in place	Yes N= 19 / 90.5%	No N= 2 / 9.5%
Title, Senior Nursing Leader	Director (specific program name) = 14/ 81% Other = 3 / 14.3% ; Senior Nursing Officer, Nursing Practice Leader, Program Coordinator)	
Senior Nursing Leader reporting relationships	Medical Officer of Health N= 14 / 73.4% Director / Manager N= 3 /15.8% Other (Board of Health, Executive Director) N = 2 /10.5%	
Title, Nurse managers	Manager N= 18 (86%) All Others N= 3 (14%) Others = Director, Coordinator, Supervisor	
Average age nurse manager	48	
% nurses who report to a nurse	53%	
Other roles filled by Nurses	Educator	Yes = 3 / 14.3%
	Quality Assurance	Yes = 3 / 14.3%
	Program Coordinator	Yes = 6 / 28.6%
	Other * See Comment # 3 below	Yes = 62%

	Provincial Mean	
Advanced Practice Roles	CNS	Yes = 6 / 28.6%
	Primary Health Care Nurse Practitioner	Yes = 11 / 52.4%
	Acute Care Nurse Practitioner	Yes = 0.0%
	Nurse Researcher	Yes = 4 / 19%
Presence of a Nursing Practice Council	Yes 12 /57.1%	No 9 / 42.9%
Use of external nursing resources for consultation, education, or other areas of expertise	Yes 14 / 66.7% * See comment # 5 below	No 7 / 33.3%

Additional analysis and areas for further consideration

1. Nursing leadership titles: Although Senior Nursing Leader roles were identified in 90.5% of the PHUs reporting here, there is significant variation in how the role is perceived and operationalized. Although the title "Chief Nursing Officer / Executive is common within the Hospital, Community and Long-term care sectors, this title is not yet present within the Public Health Sector. This area may benefit from further investigation and dialogue regarding the importance of a consistent designated nursing leadership position within PH sector.
2. Average age Nurse Manager: Although the mean age for Nurse Managers = 48 years, 44% of the current nurse managers are clustered within the 3 year age span of 47 – 50 years of age.
3. "Other nurses": There is a wide variety of nurses in "other" support roles such as Health Promotion Consultant, Epidemiologist, Health planner, Team Leaders, and Youth Development Specialist. Although "Educator" is listed as a distinct role in only 14.3% of respondents, initial consultations indicated that often internal Public Health Nurses will often assume the role of Educator depending on the topic. This area needs to be further defined and described to better understand the breath of nursing roles in place.
4. Presence of Nursing Practice Council: Of the 21 PHUs who submitted Nursing Plan data, 42.9% reported no current Nursing Practice Council (or similar structure) in place. With an increased focus on healthy work environments, evidence based practice and professional accountability, this area would benefit from further investigation as to the mechanism(s) for addressing nursing professional practice issues in the PH sector.
5. External collaboration was evident predominantly for education, research and project/program development. External links to universities, researchers, associations and clinical consultants were evident. The flowing lists the areas for external collaboration in the order of frequencies presented in the data: Universities, Consultants (i.e. Lactation, Research), College of Nurses of Ontario, ANDSOOHA membership and others).
6. Allied Professionals on staff : Only Social Work (9.5%), Dietitian (81%), and Epidemiologists (90.5%) were listed as allied professions being on staff at the PHUs.

Section B: Nursing Human Resources (N= 21 / 58%)

	Public Health Nurses*		Registered Nurses		Registered Practical Nurses	
	FTE	Head count	FTE	Head Count	FTE	Head Count
Full-time (Mean)	72.57	73.76	7.7	7.7	4.3	4.0
Full-time (Sum)	1524	1549	124.52	131	65	65
Part-time (Mean)	8.36	14.76	1.0	3.3	.35	.47
Part-time (Sum)	167.30	310	18.50	61	5.6	8.0
Total	1691.30	1859	143	192	70.6	73
Average Age	41 Range = 33 - 48		38.2 Range = 38 – 56		32.4 Range = 32 - 56	
Percentage > 55 years of age	12.28%		19%		15%	

* Public Health Nurses: Registered Nurses with a Bacc. degree in Nursing.

Additional analysis and areas for further consideration

1. Percentage of nurses > 55 years: Organizations may benefit from an increased emphasis on late career strategies to retain senior nursing staff, along with targeted succession planning strategies.
2. Frequency distributions for PHN, RN, and RPN average age revealed equal distribution across age groupings. No significant clustering / critical mass identified within a certain age range for either category of nursing.

Job share, Students and Unregulated Care providers	**Provincial Mean**	
Job share positions	Yes N= 13 / 62%	No N= 8 / 38%)
	FTE	Head count
	Mean = 2.8 Range = 1 – 13	Mean = 4.3 Range = 2 – 22
Unregulated Care provider positions (UCP)	Yes (N=52; 35.4%)	No (N=94; 63.9%)
	FTE	Head count
	17	23.4
Nursing students		
Consolidation students	Mean = 5.7 Range = 1 – 27	
Total number students	Mean = 21.6 Range = 2 – 89	
Nursing students (Sum)	535	

Additional analysis and areas for further consideration

1. Student placements: Only 9.5% of PHU reported no consolidation student placements and 100% reported student placements (group placements) for 2004/05. See Appendix for diagram depicting locations of schools and nursing and hospitals. Innovations in the location and focus of nursing student placements would enable greater opportunities for students and Public Health Units.
2. Qualitative comments re: Student placements revealed the following themes:
    - Levels/numbers of students: many requests, cannot accommodate all requests (staff shortages), only want 2 students /year, heavy PHU workload
    - Process for administering student placements: need a coordinator to support the process of student placement; provide linkages to nursing program curriculum and application to PH sector
    - Competition: given that there are also Nurse Practitioner and Masters Level students
    - Instructors/Preceptors: need more preceptors; need students who are Francophone/Bilingual; need preceptorship and mentoring programs
    - Student scheduling: would prefer that students have a longer community rotation (not single days of observation)
    - Other: some expressions related to hospital/PHU bias (i.e. bias against the value of public health nursing being of lesser value than clinical hospital placements).

New Hires (RN & RPN)	Provincial Mean
RN* New grads (Mean)	3.6
RN New grads (Sum)	65
RN New grads hired into FT positions	N= 37 / 57%
RPN New grads (Mean)	.18
RPN New grads (Sum)	3.0
RPN New grads hired into FT positions	N = 2 / 66%

* Registered Nurse here refers to RN designation according to CNO definitions; this does not differentiate between PHN and RN positions.

Additional analysis and areas for further consideration

1. The data in this section provide useful baseline information for ongoing discussion and monitoring of new graduate employment.

Section C: Utilization

Total Nursing Hours : PNH, RN, & RPN
Mean = 171,319.33
Sum = 3,426,386.60
Range = 35,035 – 1,092,182

Utilization of Agency Nurses	Yes	No
	6 / 28.6%	14 / 66.7%
Purpose / utilization of agency nurses	Most cited reason / use of agency nurses is for immunization clinics	

Section D: Wages, Benefits, Incidents and Attrition

Wages	Starting hourly rate	Maximum hourly rate
PHN	27.60 Range = 23.00 – 33.00	35.00 Range = 25.90 – 38.00
RN	25.72 Range = 22.00 – 31.00	32.66 Range = 24.07 – 36.00
RPN	21.48 Range = 18.00 – 25.00	24.52 Range = 22.00 – 27.00

Incidents	**Provincial Mean**
Total # Long term disability	1.75 Sum = 35
Total # on modified work	1.3 Sum = 26
Total # lost time hours due to work-related injuries (as reported to WSIB)	255.47 Range = 7.0 – 1820 Sum = 4854.00

Attrition	**Provincial Mean**	
RN Attrition rate	5.6%	
RPN Attrition rate	< 1%	
Retired Nurses Returning to Work	Yes N= 15 / 71.4%	No N= 5 / 23.8%
Types of roles assumed by returning nurses	Provision of Direct care 47.6%	Project Work 28.6%

Additional analysis and areas for further consideration

1. Reasons for turnover: Options were specified for respondents to choose applicable reasons for turnover in their PHU:
   - Relocating out of the district (71.4%)
   - Job advancement elsewhere (43%)
   - Job in the hospital sector (19%)
   - Retirement (48%)
   - Reason unknown (9.5%)

2. Nursing Strategy Consultation: participants of the March 28th Nursing Strategy Consultation meeting were asked to provide their feedback as to why nurses are returning to work after retiring. Responses included the following:

- Financial 33%
- Control over work patterns 63%
- Just can't stay way 5%

The reasons for nurses' leaving (attrition) and also for those who return to the workplace are areas that would benefit from further analysis and investigation at the unit, organization, professional and policy levels.

Section E: Education & Orientation

	Provincial Mean
	Hours
RN Paid education hours	376.35 Range = 7 – 2100
RPN Paid education hours	14.46 Range = 6 – 84
New grad : Average # orientation hours	145 (19 days) Range = 60 – 340
Experienced new hours: Average # orientation hours	133 (17 days) Range = 60 – 340
Internal transfer : Average # orientation hours	88 (12 days) Range = 14 – 340

Additional analysis and areas for further consideration

1. Patterns in orientation ranged from 2 days for internal transfers to a maximum of 9 weeks for new hires. Budget implications for orientation costs will need to be considered as current staff retire and are replaced by new hires.

Section F: Manager Span of Control

Manager Span of Control	**Provincial Mean**
Total # of managers who have clinical nurses (PHN, RN, RPN) as direct reports	10.95 Range = 3 – 62
Total number of managers whose background is not nursing	2.75 Range = 0.0 – 18
Percentage of nurse managers who report to a nurse	50% Range = 20% - 100%
Lowest number of direct reports / manager	7.3 Range = 1 – 13
Highest number of direct reports / manager	19.3 Range = 8 – 30

Manager Span of Control	Provincial Mean	
Direct reports at more than one site	Yes 18 / 85.7%	No 2 / 9.5%
Average number of mandatory health programs per manager	2.0 Range 1 – 3	
Resources available to managers	Clerical	95%
	HR Assistant	71.4%
	Finance	71.4%
	Tech support (i.e. computer)	95.2%

Additional analysis and areas for further consideration

1. Other types of supports described included : Epidemiology, Information specialists, corporae services (i.e. legal, policy specialists..)
2. The extensive range in manager span of control and wide variation in direct reports requires further exploration. Efforts may need to be undertaken to understand the effects of the above variations on nurse managers. Work life issues for managers may need to be a key focus in light of the need for building and sustaining strong and resilient managers.

Section G: Contributors & Narrative Comments

Input into Nursing plan submission						
	Senior Nurse	CFO	HR	ONA	RPN local	Other
Yes	81 %	71.4 %	71.4 %	4.8%	0	19%

Narrative comments

This version of the Nursing Plan included an opportunity for the respondents to provide comments on the following three areas: challenges, innovations and overall general comments. The results presented here provide a summary of the key themes generated from those responses.

Question# 1: In your opinion, what are predominant Nursing issues at this time?

The following provides a summary of the most frequently described challenges drawn from the Public Health Nursing plans.

Theme	Example of Qualitative comments
Recruitment and Retention : aging workforce, impending shortages and need for those with PH experience	Lack of surge capacity to meet demands in terms of skills and expertise;
Educational needs for PH Sector Nursing	Insufficient preparation in community/public health; limited exposure to PH Nursing EBP, evaluation, research, collaborative team development, Francophone nurses, masters prepared nurses, improved PH education in undergraduate curricula, 'supporting excellence', needs specific to northern settings
Workload/Quality of work life	Need for identification and development of nursing workload indicators for PH; workload, differences in pay levels, differences between PHUs, health threats, need more full time, workload indicators needed.
Professional Practice issues	Supporting nursing within the ID team, multiple skills required in a changing environment, determining PH "core competencies" ; increased population growth/diversity; Scope of practice and professional practice issues

Question #2: Description of innovative programs or strategies

Theme	Example of Qualitative comments
Practice innovations:	Competencies based on Canadian Community Health Nursing Standards; Nursing Practice Council and Interprofessional Practice Leaders Network to support practice; multi-media orientation package developed
Student supports	Centralized program for student preceptor including training and orientation for preceptors; Team Preceptorship model implemented with local university for 3rd year students – able to increase placements from 0 - 35

"Other" Comments

- The Nursing Plan itself (template not related well to PHUs, the importance of sharing findings, number of FTEs do not include supervisors, long length of time to prepare the survey
- Core competencies for practice were needed
- The issue that nurses >65 years of age may still work

PART 3: Summary report from March 28, 2007 Nursing Strategy Consultation meeting

The 2007 Nursing Strategy Consultation meeting held on March 28th brought together just fewer than 300 nursing leaders representing hospital, community, long term care and public health sectors and the 14 LHINs. The purpose of the meeting was to review the results from the 2006 Nursing Plans submitted by the various sectors and to discuss the key themes presented in the Nursing Plan data.

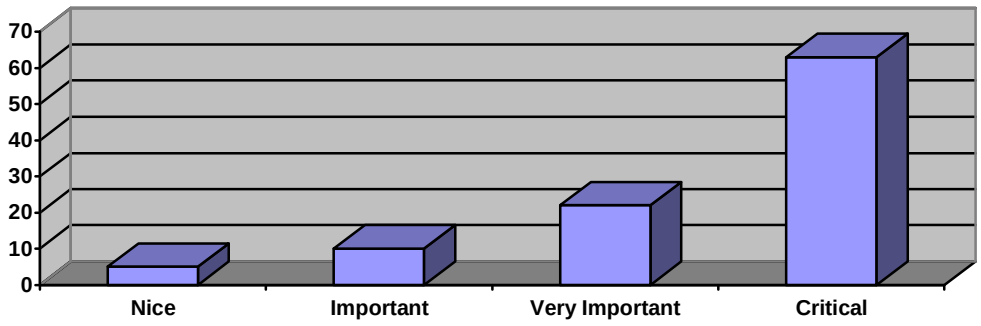
One of the key themes was ***nursing leadership success planning***. As nursing leaders, we know that succession planning is important not only for nursing at the point of care, but also for nursing leadership roles (i.e. manager, director, senior leadership roles). The question is…where to start and what strategies need to be developed?

The morning provided an opportunity for the nursing leaders to dialogue on four potential areas specific to nursing leadership success planning: Leadership role analysis; preparation and education, infrastructure supports for leadership roles and marketing the role to encourage new leaders.

Participants were given the opportunity to discuss these areas at their tables and then asked to come to consensus on the level of importance for each of the areas of focus. Electronic table polling allowed for instantaneous presentation of the results.

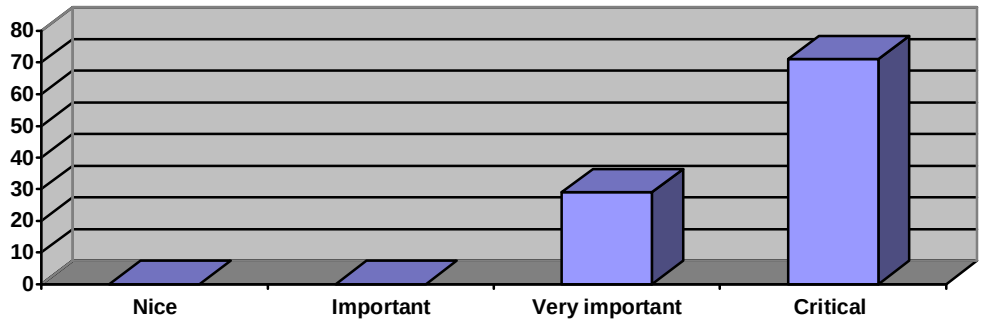
The tables below provide a summary of the areas discussed and the participants' rating of the level of importance.

Leadership role analysis: To determine the depth and breadth of the nursing leadership role(s) within and across the sectors.



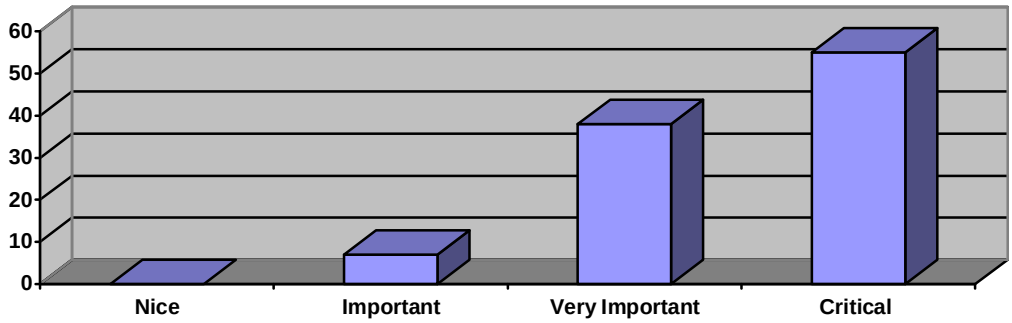
	Nice	Important	Very Important	Critical
Responses (%)	5	10	22	63

Preparation & Education: To determine the knowledge, skills, and competencies required for the manager role; identify the initial and ongoing education and development for manager/leadership roles.



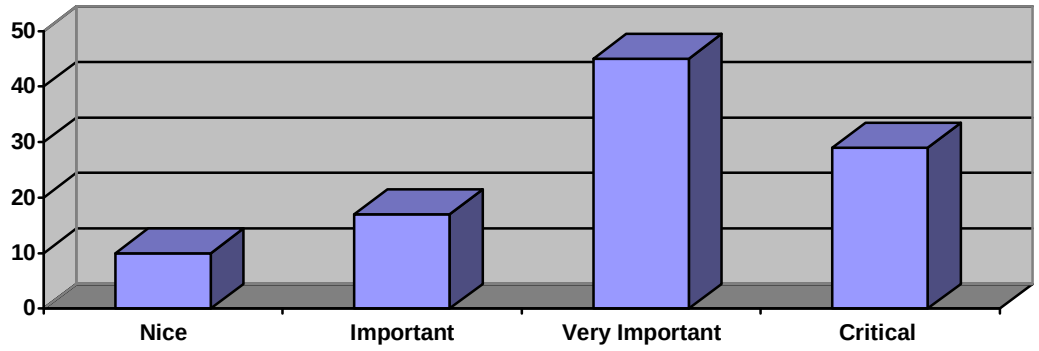
	Nice	Important	Very Important	Critical
Responses (%)	0	0	29	71

Infrastructure supports: Identifying the key infrastructure supports for managers; determine the operational and strategic supports that would best support the role.



	Nice	Important	Very Important	Critical
Responses (%)	0	7	38	55

Marketing: How is/should the role being marketed to encourage succession planning?



	Nice	Important	Very Important	Critical
Responses (%)	10	17	45	29

The results indicate that strategies to identify the education and ongoing development needs for manager roles as well as strategies to determine the depth and breath of the roles are viewed as being very important / critical by the nursing leaders present. The interconnection between these areas is apparent, as in order to fully understand the competencies and education required to be successful in the role, we must first develop a clear picture of exactly what the role now encompasses!

Further consultations are needed, but the results here provide a starting point for dialogue within the various domains of practice: administration, research, education…..and policy.

Appendices

Building a Case for Change: Resource List of Evidence and Strategies

Map depicting the location of Ontario Schools of Nursing and Hospitals

Building a Case for Change: Resource List of Evidence and Strategies

The following resources are intended to provide some examples of the evidence available to guide decision making and support change in organizations. This is not intended to be an exhaustive list of references or resources, but rather a glimpse into the literature available regarding the various areas contained within the Nursing Plans.
We hope you find this informative and helpful.

Section A – Nursing Infrastructure

Reference	**RNAO. (2006). *Healthy Work Environments Best Practice Guidelines: Developing and Sustaining Nursing Leadership*. Toronto, ON: Author.**
Online source	http://www.rnao.org/Storage/16/1067_BPG_Sustain_Leadership.pdf
Sector(s)	All
Abstract	The BPG identifies and describes leadership practices that result in healthy outcomes for nurses, patients/clients, organizations and systems; system resources that support effective leadership practices, organizational culture, values and resources that support effective leadership, personal resources and potential outcomes of effective nursing leadership. The BPG is based on an extensive review of the literature by an expert panel with input from numerous reviewers in leadership roles from across Canada and abroad.
Reference	**Laschinger, H. & Wong, C. (2006). *A Profile of the Structure and Impact of Nursing Management in Canadian Hospitals: Executive Summary* (also see Key Messages)**
Online source	http://publish.uwo.ca/~hkl/national_leadership_study/updates.htm
Sector(s)	Hospitals
Abstract	The purpose of this study was to profile nursing leadership structures in Canadian hospitals in relation to organizational and structural characteristics of nursing management roles. Data were collected in 10 provinces from acute care inpatient units within 28 Academic Health Centres and 38 community hospitals. Of the original 2015 surveys, 1164 surveys were returned for an overall response rate of 58%.
Reference	**Mass, H., Brunke, L., Thorne, S.& Parslow, H. (2006). Preparing the next generation of senior nurse leaders in Canada: Perceptions of role competencies and barriers from the perspectives of inhabitants and aspirants. *Canadian Journal of Nursing Leadership,* 16 (2), 75-91.**
Online source	NA
Sector(s)	All
Abstract	This paper describes the findings of a 2-part study designed to elicit preliminary answers to the following questions: How do incumbents and potential aspirants describe key role functions and competencies associated with senior nursing leadership positions in Canada? and What lessons can be drawn for considerations of leadership succession planning? The study was undertaken to develop a grounded knowledge framework upon which to develop national and local strategies and to support proactive succession planning strategies an sustain senior nursing leadership positions in Canadian nursing. Sample included 34 senior nurse leaders and 33 nurses in middle-level positions in health services across Canada.
Reference	**Tourangeau, A. (2004, January). *Final Report to The Change Foundation Evaluation Study of a Leadership Development Intervention for Nurses*. Toronto, ON: Author.**
Online source	http://www.dwnli.ca/FinalReportTourangeau.pdf
Sector(s)	All
Abstract	The main purpose of this study was to increase our understanding of the effectiveness of leadership development interventions for nurses. The study objective was to empirically determine immediate through long-term effects of the Dorothy M. Wylie Nursing Leadership Institute. Descriptive statistics for all outcomes at all four evaluation periods throughout the study are reported. However, analysis of changes in outcomes over the longer-term have not been possible because of declining numbers of responses from participants during the third and fourth testing periods. In addition, we

	examined the organizational environment within which nurses were functioning, as well as the commitment and readiness of key management personnel to accept the leadership development of nurses within their organization. The study sample consisted of 30 established leaders and 37 aspiring leaders.
Reference	**Kilty, H. (2005). *Nursing Leadership Development in Canada*. Ottawa, ON: Canadian Nurses Association.**
Online source	http://www.cna-nurses.ca/CNA/documents/pdf/publications/succession_planning_e.pdf
Sector(s)	All
Abstract	The report was produced to determine if current Canadian nursing leadership development programs are providing the skills and knowledge required for tomorrow's leaders. Internet searched, a review of the published research and literature and key informant interviews were conducted with representatives and contact persons from relevant programs to gather information on existing leadership development approaches.

Section B – Students and New Grads

Reference	**Cho, J., Laschinger, H. & Wong, C. (2006). Workplace Empowerment, Work Engagement and Organizational Commitment of New Graduate Nurses. *Canadian Journal of Nursing Leadership, 19* (3), 43-60.**
Online source	NA
Sector(s)	Hospitals
Abstract	The authors used a predictive, non-experimental survey design to test a theoretical model in a sample of new graduate nurses. More specifically, the relationships among structural empowerment, six areas of work life (conceptualized as antecedents of work engagement), emotional exhaustion and organizational commitment were examined. As predicted, structural empowerment had a direct positive effect on the areas of work life, which in turn had a direct negative effect on emotional exhaustion. Subsequently, emotional exhaustion had a direct negative effect on commitment. Implications of these findings for nursing administrators are discussed. Four hundred ninety-six new graduate nurses (<2.5 years nursing experience) working in acute care areas within hospital settings were randomly selected from a registry list obtained from the College of Nurses of Ontario (CNO).
Reference	**Cleverley, K., Baumann, A., Blythe, J., Grinspun, D. & Tompkins, C. (2004, November). *Educated and Underemployed: The Paradox for Nursing Graduands-Interim Report.* Hamilton, ON: Nursing Health Services Research Unit, McMaster University.**
Online source	http://www.nhsru.com/documents/graduating%20nursing%20students.pdf
Sector(s)	All
Abstract	Two human resources issues have particular relevance to a study of nursing graduates: the difficulty that graduands experience in finding full-time work and the propensity of young Canadian nurses to migrate to the US. Although the ratio of full-time to part-time nurses improved after 1998, only 56.9% of nurses in Ontario were working full-time in 2002 (Canadian Institute for Health Information [CIHI], 2003). The purpose of this study is to gather demographic and employment information about nursing graduates in Ontario to inform decision and policy makers at the Ontario Ministry of Health and Long-Term Care; the Ontario Ministry of Training, Colleges, and Universities; professional associations such as the RNAO; and recruiters for health care organizations. The sample consisted of all schools of nursing in Ontario with graduating classes of diploma or degree prepared nurses. Data were collected at 29 nursing schools (some with multiple sites) for a total of 34 sites. A large sample size was achieved (n=1957; response rate 63.8%).

Section C – Staff Mix, Overtime and Agency Use

Reference	**Canadian Nurses Association. (2005). Nursing Staff Mix: A Key Link to Patient Safety. *Nursing Now*, 19.**
Online source	http://www.cna-nurses.ca/CNA/documents/pdf/publications/NN_Nursing_Staff_Mix_05_e.pdf
Sector(s)	All
Abstract	The Canadian Nurses Association (CNA) has prepared this resource to highlight some of the important issues concerning nursing staff mix decision-making and patient safety. The focus of this article is on the mix of RNs and LPNs; however, the issues discussed are also relevant to registered psychiatric nurses and unregulated health care workers. You will find sources for obtaining further information at the end of this article.
Reference	**McGillis Hall, L., Irvine Doran, D., Baker, G. R., Pink, G. H., Sidani, S., O'Brien-Pallas, L., & Donner, G. J. (2003). Nurse staffing models as predictors of patient outcomes. *Medical Care, 41*(9), 1096-1109.**
Online source	NA
Sector(s)	Hospitals
Abstract	The objective of this study was to evaluate the impact of different nurse staffing models on the patient outcomes of functional status, pain control, and patient satisfaction with nursing care. A repeated-measures study was conducted in all 19 teaching hospitals in Ontario, Canada. The sample comprised hospitals and adult medical–surgical and obstetric inpatients within those hospitals. The patient's functional health outcomes were assessed with the Functional Independence Measure (FIM) and the Medical Outcome Study SF-36. Pain was assessed with the Brief Pain Inventory and patient perceptions of nursing care were measured with the nursing care quality subscale of the Patient Judgment of Hospital Quality Questionnaire. The proportion of regulated nursing staff on the unit was associated with better FIM scores and better social function scores at hospital discharge. In addition, a mix of staff that included RNs and unregulated workers was associated with better pain outcomes at discharge than a mix that involved RNs/RPNs and unregulated workers. Finally, patients were more satisfied with their obstetric nursing care on units where there was a higher proportion of regulated staff. The results of this study suggest that a higher proportion of RNs/RPNs on inpatient units in Ontario teaching hospitals is associated with better clinical outcomes at the time of hospital discharge.
Reference	**Tourangeau, A. E., Giovannetti, P., Tu, J. V., & Wood, M. (2002). Nursing related determinants of 30-day mortality for hospitalized patients. *Canadian Journal of Nursing Research, 33*(4), 71-88.**
Online source	NA
Sector(s)	Hospitals
Abstract	The purpose of this study was to further our understanding of the effects of nursing-related hospital variables on 30-day mortality rates for hospitalized patients. A retrospective design was used to test the proposed 30-day mortality model. The sample consisted of 75 acute care hospitals in Ontario. To develop hospoital morality rates, 46,941 patients discharged from these hospitals who had a most responsible diagnosis of acute myocardial infarction, stroke, pneumonia, or septicemia were included. To develop hospital-level nursing predictor variables, 3,998 responses to the Ontario Registered Nurse Survey of Hospital Characteristics were also included. The findings support a relationship between lower 30-day mortality and 3 predictors: a richer RN skill mix, more years of experience on the clinical unit and reported larger number of shifts missed. The findings can be used to predict the effects of hospital changes in nursing skill mix and years of RN experience on patient mortality.
Reference	**McGillis Hall, L., Doran, D., & Pink, G . (2004). Nurse staffing models, nursing hours and patient safety outcomes. *Journal of Nursing Administration. 34*(1), 41-45.**
Online source	NA

Sector(s)	Hospitals
Abstract	The objective of this study was to evaluate the effect of different nurse staffing models on costs and the patient outcomes of patient falls, medication errors, wound infections, and urinary tract infections. A descriptive correlational study was conducted in all of the 19 teaching hospitals in Ontario. The sample comprised hospitals and adult medical, surgical, and obstetric inpatients within those hospitals. The lower the proportion of professional nursing staff employed on a unit, the higher the number of medication errors and wound infections. The less experienced the nurse, the higher the number of wound infections. Nurse staffing models that included a lower proportion of professional nursing staff in the mix used more nursing hours in this study. The results of this study suggest that a higher proportion of professional nurses in the staff mix (RNs/RPNs) on medical and surgical units in Ontario teaching hospitals are associated with lower rates of medication errors and wound infections. Higher patient complexity was associated with greater patient use of nursing care resources.
Reference	**O'Brien-Pallas, L., Irvine Doran, D., Murray, M., Cockerill, R., Sidani, S., Laurie-Shaw, B., & Lochhaas-Gerlach, J. (2001). Evaluation of a client care delivery model, part 1: Variability in nursing utilization in community home nursing. *Nursing Economic$, 19*(6), 267-276.**
Online source	NA
Sector(s)	Community
Abstract	This research examines the influence of clinical provider characteristics, organizational variables, and environmental complexity (EC) on home care nursing utilization as defined by the number and length of visits. Clinical factors were predictive of visit time. Provider, organization, and EC variables also helped to explain a degree of variation in visit time, but were even more predictive of the total number of visits. Medical and nursing diagnoses explained some large variations in visit length. Specifically, mental health diagnoses contributed to longer, but not necessarily more visits. Visits performed by degree-- prepared nurses resulted in fewer total visits and improved RN perceptions of visit adequacy. Continuity of care by the primary nurse appeared to increase visit time, but reduced total visits. Managing home health care resources and achieving cost effective care delivery will be enabled by a better understanding of controllable variables influencing the length and number of home care visits.
Reference	**O'Brien-Pallas, L., Irvine Doran, D., Murray, M., Cockerill, R., Sidani, S., Laurie-Shaw, B., & Lochhaas-Gerlach, J. (2002). Evaluation of a client care delivery model, part 2: Variability in client outcomes in community home nursing. *Nursing Economic$, 20*(1), 13-21, 36.**
Online source	NA
Sector(s)	Community
Abstract	Using similar variables, Part 2 explores variation in client outcomes such as OMAHA knowledge, behavior, and SF36 scores. Medical and nursing diagnoses explained large variations in client outcomes. Clients cared for by degree prepared nurses improved knowledge and behavior scores. Unanticipated case complexity was negatively associated with client outcome even with nursing intervention. The study revealed that "for every unit increase in assignment of baccalaureate-prepared nurses, clients will on average demonstrate an 80% greater likelihood of improvement in knowledge scores and a 120% greater likelihood of improvement in behavior scores in relation to their health condition at discharge." This two-part study has offered insight into the controllable variables influencing the cost and quality of home care services.
Reference	**Canadian Nurses Advisory Committee. (2002).*Our health, our future: Creating quality workplaces for nurses.* Advisory Committee on Health Human Resources**.
Online source	NA
Sector(s)	All
Abstract	Overtime (p.13) Canadian Registered Nurses work almost *a quarter of a million hours ofovertime every week, the equivalent of 7,000 full-time jobs per year* (Canadian Labour and Business Centre [CLBC], 2002). If nurses work too many hours and work with the intensity that is now inevitable in the system, it takes a toll. All nurses, full-time and part-time, suffer startlingly high rates of strains

	and sprains and back injuries. When patients must be moved by too few nurses, with inadequate (or missing) equipment, and at a time when the nurse s may be tired or stressed or both, a high incidence of musculoskeletal injuries is hardly surprising. Recent research suggests an almost perfect correlation between overtime and sick time; furthermore, overtime is highly predictive of increased lost-day injury claim rates among nurses (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), 42-50.) Agency use (p. 72-80) Nurses say that relying on excessive overtime and on relief and agency staff to take up the slack is not a sustainable solution to staff shortages. They believe this policy is detrimental to patient safety and results in nurse burnout, which manifests itself in retention and recruitment problems.
Reference	**Baumann, A., Keatings, M., Blythe, J., Dziuba-Ellis, J., Johnson, G., Smith, T., White, K. & Pierson, S. (2005, June). *The Nursing Resource Team: An Innovative Approach to Staffing* . Hamilton, ON: Nursing Health Services Research Unit.**
Online source	http://www.nhsru.com/documents/Nursing%20Resource%20Team%20Report%20August%202005.pdf
Sector(s)	Hospitals
Abstract	Hamilton Health Sciences (HHS), one of the largest health care institutions in Canada, was a pioneer in the use of the nursing resource team (NRT). Prior to the establishment of the NRT, nursing human resources management had become problematic. Insufficient nursing capacity meant using agency nurses, sanctioning overtime, and leaving nursing teams short-staffed. Limited staffing capacity created stress for nursing staff who felt overworked and under-supported. In September 2002, HHS implemented the NRT to secure a supply of highly skilled registered nurses to augment clinical unit staff. Specific objectives for this study were: 1. To describe the structure, processes, and activities of the NRT. 2. To explore the impact the NRT has had on the nursing personnel of HHS. 3. To explore the impact the NRT has had on management and administration. 4. To explore the impact the NRT has had on the organization. The employment of a centralized resource team in a decentralized program management environment posed challenges. However, the study found that the NRT was an inventive human resources management strategy. It created full-time jobs that attracted nurses who would otherwise have remained in involuntary part-time positions. It also offered team members flexibility of scheduling and professional development opportunities that they might not have received as permanent unit staff. The NRT integrated nurses into the organization in a manner that recognized their unique abilities and employment needs, resulting in high staff satisfaction.
Reference	**McCutcheon, A., MacPhee, M., Davidson, J., Doyle-Waters, M., mason, S. & Winslow, W. (2005). *Staffing For Safety: A Synthesis of the Evidence on Nurse Staffing and Patient Safety.* Canadian Health Services Research Foundation.**
Online source	http://www.chsrf.ca/research_themes/pdf/staffing_for_safety_policy_synth_e.pdf
Sector(s)	All
Abstract	This report encourages evidence-informed decision-making around nurse staffing that will result in better patient outcomes. The available evidence on nurse staffing and patient outcomes focuses almost entirely on hospital and acute care settings. As of yet, there is little research on this topic in the community setting or in long-term care. Also, the research focuses mainly on registered nurses, with little focus on registered psychiatric nurses, licensed practical nurses, and advanced practice nurses such as nurse practitioners and clinical nurse specialists. To ensure inclusion of the spectrum of regulated nurses and sectors of public and community healthcare, this synthesis approach relied on evidence informed recommendations from decision makers with expertise on nurse staffing and patient safety. In addition to providing their expertise, decision makers helped identify specific areas for action, which are captured in this report's recommendations. This timely report is written for discussion and action.

Section D – Wages, Reasons for Turnover, Direct care and project work

Reference	**Ahlburg, D. & Mahoney, C. (1996). The Effect of Wages on the Retention of Nurses** ***The Canadian Journal of Economics / Revue canadienne d'Economique*****, Vol. 29, Special Issue: Part 1 (Apr., 1996), pp. S126-S129.**
Online source	NA
Sector(s)	All
Abstract	The authors investigated the interdependent decisions to work and to work as a nurse. Data were obtained from a survey questionnaire mailed in 1988 to a random sample of 8,000 RNs (approx. 20% of all RNs licensed in Minnesota) with a response rate of 75%. Results: why nurses leave the profession may have more to do with the conditions of employment than wages. Internal organizational changes in the healthcare industry may be needed in addition to (or perhaps instead of) more money for nurses' wages.
Reference	**Nursing Sector Study Corporation. (2006, May).** ***Building the Future: An integrated strategy for nursing human resources in Canada Phase II Final Report*****. Ottawa, ON: Author.**
Online source	http://www.buildingthefuture.ca/e/study/phase2/Phase%20II%20Final%20Report_ENG.pdf
Sector(s)	All
Abstract	The five year study consisted of two phases, and examined the nursing workforce for all three regulated nursing professions in Canada (Licensed Practical Nurses (LPN) Registered Nurses (RN), and Registered Psychiatric Nurses (RPN)). Phase I, which concluded in December 2004, examined the state of nursing human resources in Canada. A series of 15 technical research reports were completed which covered areas such as nursing mobility, the international labour market, nursing education in Canada, and many others. Phase II of the project got underway in the fall of 2005. The objective of Phase II was to develop a pan-Canadian nursing human resource (HR) strategy in consultation with government and non-government stakeholders that built on the findings and recommendations presented at the completion of Phase I. The technical research reports generated in Phase I were consolidated by province or territory and a series of jurisdictional consultations were held. Based on the feedback received from the jurisdictions, a summary report was created.
Reference	**Priest, A. (2006).** ***What is ailing our nurses? A Discussion of the Major Issues Affecting Nursing Human Resources in Canada*** **(March, 2006), Ottawa, ON: Canadian Health Services Research Foundation.**
Online source	http://www.chsrf.ca/research_themes/pdf/What_sailingourNurses-e.pdf
Sector(s)	All
Abstract	This report is intended to generate discussion and direct future initiatives aimed at improving the current nationwide shortage of nurses. It is a review, analysis, and discussion of six major research documents on Canadian nursing human resource issues produced during the last five years. The questions this report sets out to answer are: What are the fundamental issues behind nursing human resource challenges? What solutions and strategies have been put forward to address them? What areas are being addressed? What areas have not been addressed and why? Nursing health human resources cover a wide and complex range of topics. For practical purposes, the research divides issues into two main areas — workplace and workforce. Workplace issues include workload, leadership and professional development, scheduling, safety, and concerns about how best to balance professional and personal life. Workforce issues involve education and training, professional identity, scopes of practice, and health human resource planning.
Reference	**Cameron, S., Armstrong-Stassen, M., Bergeron, S. & Out, J. (2004). Recruitment and retention of nurses: Challenges facing hospital and community employers.** ***Nursing Leadership*****, 17 (3), 79-92.**
Online source	NA
Sector(s)	Hospitals and Community
Abstract	Understanding nurses' perceptions of their workplaces underpins successful recruitment and

	retention initiatives, particularly in this time of global nursing shortage. The American Nurses Association and the American Academy of Nursing have identified "magnet characteristics" - organizational factors that support excellent practice and working conditions in hospital settings. Using selected magnet characteristics, this exploratory study examined nurses' perceptions of their work experiences in both hospital and community settings. Mail surveys were completed by community and hospital nurses (n=1248) selected randomly from a provincial registry in Ontario. Scales measured organizational factors (organizational and immediate supervisor support, decentralized decision-making, nurse-physician relationships and work-group cohesiveness) and job-related factors (autonomy, job challenge, work demands, fair treatment, work-status congruence; satisfaction with career, salary, working conditions) of nurses' experiences in their work settings. Nurses in both sectors wanted more opportunities to participate in decision-making and recognition for their contributions to their organizations. In the hospital sector, nurses reported significantly lower levels of perceived organizational and supervisory support and autonomy, and were less satisfied with working conditions and scheduling. Nurses in the community sector were most dissatisfied with salary. No cross-sector differences were reported on nurse-physician relationships, degree of job challenge or career satisfaction. Successful recruitment and retention initiatives hinge on the ability (and willingness) of healthcare organizations to attend to the concerns expressed by nurses and create work settings that are attractive to both new recruits and nurses currently in their employ.
Reference	**Statistics Canada. (2006, December). *Findings from the 2005 National Survey of the Work and Health of Nurses.* Ottawa, ON: Minister of Industry.**
Online source	http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1588_E
Sector(s)	All
Abstract	The 2005 National Survey of the Work and Health of Nurses (NSWHN) represents a collaborative effort involving the Canadian Institute for Health Information, Health Canada and Statistics Canada. The NSWHN was designed to examine links between the work environment and the health of regulated nurses in Canada, and is the first nationally representative survey of its kind. The survey's high response rate.80%.reflects the enthusiasm with which nurses involved themselves in the survey. Nearly 19,000 regulated nurses registered nurses (RNs), licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs).across the country were interviewed on a variety of topics, including the conditions in which they practice, the challenges they face in doing their jobs, and their physical and mental wellbeing. They shared their perceptions of work organization, including staffing, shift work, overtime and employee support. Nurses were also asked about work stress, role overload, respect, and quality of patient care. Information about their health status, such as chronic conditions, pain, self-perceived general and mental health, medication use, and the impact of health on the performance of nursing duties, was also collected.

Section E – Orientation and education

Reference	**Lavoie-Tremblay, M., Viens, C.,Forcier, M., Labrosse, N., Lafrance, M., Laliberte, D., Lebeuf, M-L.(2002). How to Facilitate the Orientation of New Nurses Into the Workplace RN*Journal for Nurses in Staff Development.* 18(2), 80-85.**
Online source	NA
Sector(s)	Hospitals
Abstract	The orientation of new nursing graduates into the workplace is an impressive challenge. A research study was performed to identify the key elements of a program that would address the various issues regarding this orientation. A team of researchers from Laval University and the Centre Hospitalier Universitaire de Quebec (CHUQ) used a descriptive and participative research method and identified five key elements that must be considered in order for this orientation to succeed.
Reference	**Canadian Nurses Association & Canadian Federation of Nursing Unions. (2006). *Joint Position Statement - Practice Environments: Maximizing Client, Nurse and System Outcomes.* Authors.**
Online source	http://www.cna-nurses.ca/CNA/documents/pdf/publications/PS88-Practice-Environments-e.pdf

Sector(s)	All
Abstract	Overview of characteristics of a quality work environment include support for professional development i.e. adequate funding to allow nurses to access professional development opportunities to develop and maintain competence including continuing education, formal education, online learning and mentoring.
Reference	**Canadian Nurses Association. (2004). Achieving excellence in professional practice: A guide to preceptorship and mentoring. Ottawa, Canada: Author.**
Online source	http://www.cna-nurses.ca/CNA/documents/pdf/publications/Achieving_Excellence_2004_e.pdf
Sector(s)	All
Abstract	The purpose of this guide is to assist nurses and other health professionals to develop and revise programs that use preceptors and mentors to enhance the quality of nurses' work environments and the quality of nursing practice. This guide was written by the Canadian Nurses Association (CNA), whose mission is to advance the quality of nursing in the interest of the public. In advancing the quality of nursing, CNA is fully committed to shaping quality professional practice environments for nurses, so that they continue to provide safe, ethical and competent care for Canadians. Having programs that support teaching and learning through role modelling is a key part of a quality practice environment (CNA, 2001). This guide is intended for individual nurses, health and educational institutions and professional groups. This guide provides an overview of role modelling programs in nursing with a particular focus on preceptorship and mentoring. It outlines considerations for setting up role modeling programs, including costs, benefits, roles and responsibilities. In addition, Part V of this guide presents competencies1 for the roles of preceptor and mentor, which have recently been developed through CNA's Preceptorship and Mentoring Project and could form the basis of new programs. Some specific tools, guidelines, definitions and an extensive list of additional references with relevant website contacts are also included.
Reference	**Cruickshank, P. (1999). Nurse recruitment and retention strategy. *The Aboriginal Nurse.***
Online source	http://www.findarticles.com/p/articles/mi_qa3911/is_199912/ai_n8855423
Sector(s)	All
Abstract	Nursing services are essential to good community health care in Fist Nations. There needs to be support and encouragement to nurses presently working for either Medical Services Branch (MSB) of Health Canada or First Nations health authorities to develop and continue their careers in this specialized and challenging field. At the same time, the goal is to recruit nurses to live and work over the long term in First Nations communities, especially isolated ones. Unfortunately, both retention and recruitment of nurses have proven difficult for both MSB and First Nations health authorities, particularly in the past year, due to the national nursing shortage. The retention and recruitment problems are most acute in the isolated and remote northern communities where nurses work in expanded role functions and it is in these areas where the nursing vacancy rates are highest. In September, 1998, MSB established a working group with representatives from the Regional nurse managers, First Nations health authorities and the Professional Institute of the Public Service of Canada (PIPSC) union. This working group developed a Nurse Recruitment and Retention Strategy which was approved by senior MSB management in January 1999. Five key elements are, highlighted in the Strategy. They include: Promotion and Recruitment to attract a steady flow of interest and competent candidates appropriate to the work, lifestyle and individual community.
Reference	**Donner, G. & Wheeler, M. (in press). *A Guide to Coaching and Mentoring in Nursing*. Monograph: International Council of Nurses.**
Online source	http://www.icn.ch/
Sector(s)	All
Abstract	In press as of February 2007.

Section F – Manager Span of Control

Reference	**Doran, D., McCutcheon, A., Evans, M.,MacMillian, K., McGillis Hall, H., Pringle, D., Smith, S. & Valente, A. (2004, September). *Impact of the Manager's Span of Control Leadership and Performance*. Ottawa, ON: Canadian Health Services Research Foundation.**
Online source	http://www.chsrf.ca/final_research/ogc/pdf/doran2_e.pdf
Sector(s)	Hospitals
Abstract	The purpose and objectives of this study are to 1) examine the extent to which the manager's span of control influences nurse, patient, and unit outcomes; and 2) investigate which particular leadership style contributes to optimum nurse, patient, and unit outcomes under differing spans of control. The research was conducted at seven teaching and community-based hospitals, utilizing 51 units within these hospitals. The participants were 41 nurse managers, 680 patients, and 717 staff (registered nurses and registered practical nurses).
Reference	**McGillis Hall, L., Ed. (2005). *Quality Work Environments for Nurse and Patient Safety*. Sudbury, MA: Jones and Bartlett Publishers.**
Online source	See also: McGillis Hall, L., Ed. (2003, November). *Indicators of Nurse Staffing and Quality Nursing Work Environments: A Critical Synthesis of the Literature* http://www.health.gov.on.ca/english/providers/project/nursing/nursing_work_envir/execsummary_moh.pdf
Sector(s)	All
Abstract	This report outlines findings from a critical review and analysis of the literature on variables in work settings that can be considered indicators of the quality of nurse's work life in health care settings. The indicators include: nurse staffing; educational background of nursing staff; experience of nursing staff; team functioning; organizational climate and culture; span of control of unit manager; workload/productivity; level of autonomy and decision making experienced by nurses; professional development opportunities; scope of nursing leadership role; use of overtime hours and agency staff; absenteeism hours; and number of grievances. The goal of this analysis of the literature was to provide sound information related to measures that can be used for a feasibility study. Ultimately this research will inform decisions and recommendations regarding the complementary data required to link to the clinical outcome database being developed and tested in the Nursing and Health Outcomes Study.
Reference	**Morash, R., Brintnell, J. & Lemire Rodger, G. (2005) A Span of Control Tool for Clinical Managers. *Canadian Journal of Nursing Leadership*, 18(3), 83-93.**
Online source	NA
Sector(s)	Hospitals
Abstract	The Ottawa Hospital (TOH) and its partner organizations operate on five different campuses and have the largest grouping of nurses in Canada. The merger of all these campuses brought together different organizational structures, systems and cultures. As a part of a model design process, the various nursing roles in the corporation were reviewed and assessed. The Clinical Manager Work Group reviewed the position description and the various spans of control of clinical managers. The group identified the need to develop a tool to describe and measure the factors that affect clinical managerial roles, responsibilities and span of control. The purpose of introducing a tool was to determine whether the spans of control were appropriate. The basis for this decision was not only the number of staff and budget, but also complexity of the unit type. This paper describes the development and implementation of a span of control assessment tool, issues encountered, processes undertaken and suggestions for future tool development.
Reference	**Cathcart, D., Jeska, S., Karnas, J., Miller, S., Pechacek, J. & Rheault, L. (2004). Span of Control Matters. *Journal of Nursing Administration*, 34(9), 395-399.**
Online source	NA

Sector(s)	Hospitals
Abstract	Prompted by manager concerns about span of control, a large, integrated health system set out to determine if span of control really mattered. Was there something to it, or was it just an excuse for poor performance? A team of middle managers studied the problem and ultimately demonstrated a strong relationship between span of control and employee engagement. Consequently, it was decided to add 4 management positions to note the effect. One year later, positive changes were observed in employee engagement scores in all 4 areas. This study suggests careful review of manager spans of control to address the untoward effects of large spans of control on employee engagement.
Reference	**Baumann, A., Hunsberger, M., Blythe, J. & Crea, M. (2006, October). *The New Healthcare Worker: Implications of Changing Employment Patterns in Rural and Community Hospitals, Number 6.* Hamilton, ON: Nursing Health Services Research Unit.**
Online source	http://www.nhsru.com/documents/Series%206%20The%20New%20Healthcare%20Worker-Rural.pdf
Sector(s)	Hospitals – community and rural
Abstract	Rural health care is changing. Following restructuring in the 1990s some small hospitals remained independent, while others reorganized as amalgamations and alliances. In 2004, Ontario was divided into 14 Local Health Integration Networks (LHINs) to create accessible, quality health care at a local level. This study was designed to gain an understanding of the impact on nursing work and the workforce. It focused on 19 rural hospitals in Local Health Integration Network (LHIN) 2 in South West Ontario, and examined how employment patterns have evolved. The study provides critical information to assist policy makers in understanding the rural context of nursing practice and the effect of government policies on workforce sustainability.

Long Term Care

Reference	**McGillis Hall, L. & O'Brien-Pallas, L. (2000). Redesigning nursing work in long term care, *Nursing Economic$, 18* (2), 79-87.**
Online source	NA
Abstract	The work attitudes and activities among three groups of caregivers (RNs, RPNs and HCAs) working in long term care are examined. Work sampling, surveys and interviews with 46 caregivers in a large university-affiliated LTC facility in Toronto. While RNs stated their strong affinity for direct patient care activities, they perform the lowest percentage of direct care, chiefly due to their accountability for planning and coordinating the care provided by others. The HCAs who provided the bulk of direct patient care 'valued it the least' apparently finding little gratification with this aspect of their role. The study suggests that there is a need to examine and clarify work roles and perceptions for all caregivers as part of any work redesign process. A higher level of RN involvement in direct patient care activities, along with 'attention to enhancing the importance' of these activities for staff employed in the HCA role could be beneficial.
Reference	**Morgan, D., Semchuk, K., Stewart, N. & D'Arcy, C. (2002). Job strain among staff of rural nursing homes: A comparison of nurses, aides and activity workers. *Journal of Nursing Administration, 32* (3), 152-67.**
Online source	NA
Abstract	Caring for growing numbers of residents with Alzheimer's disease and related dementias increases the potential for stress among nursing home staff. To better understand occupational stress among caregivers in rural nursing homes, the authors studied differences in job strain among registered nurses, nursing aides, and activity workers. The authors discuss data from their survey questionnaires and focus group interviews with staff, providing insight into job strain and possible intervention strategies to improve the work environment.
Reference	**Stone, R. & Wiener, J. (2001, October). *Who will care for us? Addressing the long-term care workforce crisis.* The Urban Institute and the American Association of Homes and Services**

	for the Aging.
Online source	NA
Abstract	Home health aides, home care workers, and personal care attendants form the core of the formal home care system by providing assistance with activities of daily living and the personal interaction that is essential to quality of life and quality of care for their clients. High turnover and long vacancy periods are costly for providers, consumers, their families, and workers themselves. In 2002, 37 states identified worker recruitment and retention as major priority issues. Demographic and economic trends do not augur well for the future availability of quality home care workers. Policy makers in the areas of health, long-term care, labor, welfare, and immigration must partner with providers, worker organizations, and researchers to identify and implement the most successful interventions for developing and sustaining this workforce at both policy and practice levels. The future of home care will depend, in large part, on this third rail of long-term care policy.
Reference	**Ontario Ministry of Health and Long Term Care. (2004). *Booklet 4: Long-term Care Facility Recruitment and Retention.* Toronto, ON: Queens Printer for Ontario**
Online source	http://www.health.gov.on.ca/english/providers/program/ltc_redev/dev_tools/learn_ser/booklet_4.pdf
Abstract	The Learning Series has been developed as a series of tactical information booklets to help long-term care facility operators and administrators with a variety of marketing, recruitment and retention needs. The Learning Series is a generic guide to assist facility operators and administrators who are: • New or looking to augment their Human Resources (HR) marketing knowledge • Looking for new and unique ways to market to consumers and recruit and retain quality candidates to their facility Each of the booklets in the learning series contains tools, suggestions and practical solutions for various recruitment and retention challenges. **Booklet One HR Recruitment & Consumer Marketing Tools & Tactics** Booklet one focuses on tactics that can be applied to recruitment marketing of most staff positions in the long-term care facility sector. The booklet starts with a detailed step-by-step outline of how to develop a marketing plan which can help focus marketing activities. After marketing needs are determined, tactics can be identified; booklet one concentrates on how to market long-term care facilities through traditional advertising tactics such as job fairs, the Internet and local communities. **Booklet Two Building a Web Site from A to Z** Booklet two reviews all of the steps that are involved in building a simple web site. An introduction to the Internet, an outline of the elements that make up a web page and the approximate costs for a web site are provided. The main chapters review the steps to building a site from designing the layout, writing the content, building the web pages and finally launching and maintaining the site. **Booklet Three Targeted Recruiting by Long-Term Care Facilities** The third booklet in the learning series focuses on Targeted Recruiting. The booklet provides tips and strategies on how to target professionals for recruitment to rural communities, how to target graduating students for recruitment and how to tap into untapped labour pools such as mature workers, and workers who are new to Ontario. **Booklet Four Long-Term Care Facility Worker Retention** Keeping and developing quality employees is crucial to the continued existence of long-term care facilities. Booklet four focuses on best practices and employee retention strategies to assist facility operators in retaining and empowering current and future staff.

Community/Home Care

Reference	**Denton, M. (2003). *Organizational Change and the Health and Well-Being of Home Care Workers.* Workplace Safety and Insurance Board.**
Online source	http://socserv2.socsci.mcmaster.ca/~sedap/p/sedap110.pdf
Abstract	**Objective:** The objective of this research is to study the impact of health care restructuring and other organizational changes on the mental and physical health of home care workers. **Methods:** This study covers 11 agencies and 7 union locals. We interviewed 59 key decision makers, 171 workers in 29 focus groups, and surveyed 1,311 workers (70% response rate). Qualitative data are analyzed for themes and quantitative data analysis consists of descriptive statistics and associations between variables. **Results:** The restructuring of the health care sector and organizational change have increased stress levels and musculoskeletal disorders of home care workers. Physical health problems among this workforce are much higher than the comparable group in the Canadian population. Restructuring and organizational change are significant factors in decreasing job satisfaction, while increasing absenteeism rates, fear of job loss, and propensity to leave. **Conclusions:** Occupational health problems experienced by these workers are preventable. It is important to acknowledge that occupational stress can result from incremental changes in the work and external work environment, affecting physical health, job dissatisfaction, absenteeism, and propensity to leave. Sufficient government funding to provide services, avoiding continuous changes in the work environment, and creating supportive work environments can positively contribute to workers' health.
Reference	**Zeytinoglu, I. & Denton, M. (2005, December). *Satisfied Workers, Retained Workers: Effects of Work and Work Environment on Homecare Workers' Job Satisfaction, Stress, Physical Health, and Retention*. Ottawa, ON: Canadian Health Services Research Foundation.**
Online source	http://www.fcrss.ca/final_research/ogc/pdf/zeytinoglu_final.pdf
Abstract	The goal of this project was to assist health system managers and policy makers develop policies and strategies to recruit and retain human resources in the homecare sector and have a satisfied, healthy workforce. Researchers worked in partnership with the agencies and the unions representing workers in the agencies to examine the effects of work and work environments on homecare workers' emotional, mental, and physical health and intention to leave their workplaces. The overall research question was: *How do the work characteristics of homecare workers and the work environment in homecare contribute to job satisfaction, stress, physical health, and retention?* The factors we examined were job characteristics (non-standard work, flexible work, flexible pay, and flexible work schedules), physical and psychosocial work factors (physical work environment, heavy workload, work intensification, job insecurity, and social support), and factors related to organizational change (restructuring and perceived impact on clients). More specifically, we explored the impact of these factors on employee and organizational outcomes. The project had two phases. In the first phase of this study (reported elsewhere) we examined the impact of healthcare restructuring and other organizational changes on the mental and physical health of homecare workers. In the second phase, we focused on a set of factors affecting employee and organizational outcomes. Employee outcomes are represented as job satisfaction, stress, physical health problems, and musculoskeletal disorders. Retention is the organizational outcome and refers to the workers' intention to leave and, for those who have already left, their reasons for leaving and reasons for getting a different job.
Key findings	**Doran, D., Picard, J., Harris, J., Coyte, P. C., MacRae, A., Laschinger, H., Darlington, G., & Carryer, J. (2004). *Management and Delivery of Community Nursing Services in Ontario: Impact on the Quality of Care and the Quality of Worklife of Community-based Nurses.* Canadian Health Services Research Foundation.**
Online source	http://www.chsrf.ca/final_research/ogc/pdf/doran_final.pdf
Abstract	In 1995, the Ontario Ministry of Health and Long-Term Care created 43 community care access centres, which were charged with the responsibility of awarding service contracts to provider agencies using a competitive "request for proposals" process. Both for-profit and not-for-profit agencies submit proposals to the centres in response to requests for proposals, and in turn are

	awarded contracts for pre-determined periods of time. The Community Nursing Services Study described this model and examined its impact on nurse and client outcomes. The study was conducted in two phases. The report of the first phase was released in August 2002. It described how the competitive bidding process was being put into operation, including the volumes and costs of nursing visits for for-profit and not-for profit agencies during the first five years of competitive bidding. The report can be read at www.nursing.utoronto.ca/faculty/bios/CNSS_Phase_1_Reportb.pdf. **Objectives** The objectives of the second phase of the study were to examine the relationships between variables in the structure of the contracts and: quality of care; client outcomes; cost of care; and nurse outcomes. This report describes the second phase of the study. **Design** A longitudinal design was used to collect data on client outcomes twice: at admission to homecare or recruitment into the study; and at discharge or after six weeks, whichever came first. Nurses, agencies, and access centres were surveyed using written questionnaires and data abstraction from corporate databases. The setting consisted of 11 community care access centres and 11 nursing agencies. The sample included 740 clients and 700 nurses. **Findings** There were few differences in quality of care based on the contract length, contract volume, or whether the agency was for-profit or not-for-profit. Clients cared for by for profit agencies reported higher quality of care and higher satisfaction than clients cared for by not-for-profit agencies. There were significant differences in nurse quality outcomes among provider agencies. The more consistently the client was seen by the same nurse, the lower the nursing costs were. Consistency did not affect client health outcomes. Clients who were healthier when they were admitted to homecare were still healthier six weeks later or at discharge. More visits made by a registered nurse were related to better emotional and social functional outcomes. Older nurses and nurses who worked part-time enjoyed their work more than younger nurses and those who worked on a casual basis. Nurses who were compensated on an hourly basis reported higher satisfaction with time for care than nurses who were compensated on a per visit basis. Nurse turnover was not related to contract variables or ownership type.
Reference	**The Home Care Sector Study Corporation. (2003, October). *Canadian Home Care Human Resources Study: Synthesis Report.* Author.**
Online source	http://www.cacc-acssc.com/english/pdf/homecareresources/EngTechnic.pdf
Abstract	This document constitutes the final report of the Canadian Home Care Human Resources Study. The Study was carried out in three phases. Phase One: *Setting the Stage: What Shapes the Home Care Labour Market*, was designed to provide the context of the sector, to synthesize existing knowledge and information, and to provide input into the information gathered in Phase Two. Phase Two: *The Human Resources Environment in Home Care* focused on human resources in the home care sector. The objective of this phase was: to describe the human resource environment and management practices; to identify the trends and changes which may occur in the next three to five years and assess their implications for the sector; and, to assess current and future training and professional development needs and opportunities. Phase Three: *Analysis*, was designed to analyze the results of Phases One and Two, to identify both the capacity of the home care sector and shared views of the issues and challenges facing the sector, and, finally, to present a consensus on future courses of action to address the key challenges concerning human resources in the home care sector. This report is intended for a wide audience including policy makers, care providers, government officials, industry organizations and the public. Thus, it presents a summary of the findings of this project (for more detailed information, the reader is referred to the Phase One and Phase Two reports) and a set of coherent strategies which can be used to improve human resources in the home care sector.
Reference	**Victorian Order of Nurses. (2005, October). *Issues Related to Healthy Workplaces and Recruitment and Retention of Home and Community Care Nurses: A Synthesis Paper*. Ottawa,**

	ON: Author.
Online source	http://www.von.ca/pdf/special_projects/Healthy_Workplaces/Synthesis_paper_english.pdf
Abstract	In April 2005, VON Canada launched the "Healthy Workplaces Related to Home and Community Care Nursing and Impact on Recruitment and Retention" project with three year funding support from the Office of Nursing Policy, Health Canada. This project is intended to explore the impact of the work environment on recruitment and retention of nurses and how to address the current nursing shortage in this sector, including the identification of barriers in the home and community health care settings and strategies that lead to healthy work environments. This paper's purpose is to synthesize the information identified in the literature review to provide a brief overview of the unique challenges in recruiting and retaining nurses in home and community settings.

Public Health

Reference	**Underwood, J., Alameddine, J., Baumann, A., Deber, R. Laporte, A., & Eager, K. (2005, August). *Nurses in Public Health in Ontario*. Hamilton, ON: Nursing Health Services Research Unit.**
Online source	http://www.nhsru.com/factsheets/Public%20Health%20Fact%20Sheet%20Sept%2013.pdf
Abstract	The objective of this fact sheet is to provide a clearer understanding of selected demographic characteristics of nurses working in the Public Health sub-sector in Ontario. This fact sheet will analyze data held by the College of Nurses of Ontario (CNO) to clarify the supply trends as well as the age, education and registration profile of the nurses who work in this sub-sector.
Reference	**Armstrong-Stassen, M., & Cameron, S. (2005). Concerns, satisfaction and retention of Canadian community health nurses. *Journal of Community Health Nursing* , 22 (4), 181-194.**
Online source	NA
Abstract	This study of Canadian community health nurses (N = 1,044) compared the work-related concerns, job satisfaction, and factors influencing the retention of public health, home care, and community care access center (CCAC) nurses. Community health nurses identified similar work-related issues as being of greatest concern to them, but there were significant differences among the 3 groups of nurses in the magnitude of these concerns. There were also significant differences among the 3 groups for satisfaction with their jobs and their immediate supervisors, with CCAC nurses being the least satisfied except for the greater dissatisfaction of home care nurses with their pay and benefits. For the retention factors, the differences were primarily in the areas of job features and supportive work relationships. There are both similarities and differences among public health, home care, and CCAC nurses. Initiatives to address community health nurses' concerns, improve their job satisfaction, and increase their retention will require interventions tailored to the specific community health care setting.
Reference	**Registered Nurses Association of Ontario. (2005). Policy Statement: Vision for Nursing in Public Health.**
Online source	http://www.rnao.org/Storage/12/710_Policy_Statement_Nursing_public_health.pdf
Abstract	Policy statement provides background on current state of public health practice and includes three critical factors that must be addressed to maintain and sustain a vibrant public health nursing workforce: positions, education, and leadership.
Reference	**Best, M. & Thurston, N. (2006). Canadian Public Health Nurses' Job Satisfaction.** *Public Health Nursing, 23* (3), 250–255.
Online source	NA
Abstract	This study was undertaken to test the applicability of using a standardized questionnaire for measuring public health nurse (PHN) job satisfaction and to determine whether or not scores changed over 30 months. The importance of establishing a method for ongoing measurement of PHN job satisfaction was underscored by changing directions in practice and an emphasis on building public health capacity. A 30-month interval, repeated measures descriptive survey design was used. A randomly selected sample of 87 PHNs employed within 1 Canadian regional health authority participated. The survey questionnaire, the Index of Worklife Satisfaction, was designed to measure the importance of and satisfaction with 6 components of job satisfaction. Pay and omy

	were the most important components; the order of the 4 remaining components changed from first to second surveys. Professional status, autonomy, and interaction were the most satisfying components; PHN satisfaction with professional status and interaction improved significantly over 30 months. A majority of subjects reported that direct client care/client response/making a difference were worklife aspects providing them with most satisfaction. A valid, reliable questionnaire suitable for ongoing measurement was tested with PHNs, and baseline levels of their job satisfaction were established.

Rural Issues

Reference	**Bushy A, Leipert BD. Factors that influence students in choosing rural nursing practice: a pilot study. *Rural and Remote Health* 5 (online), 2005: 387.**
Online source	http://www.rrh.org.au/publishedarticles/article_print_387.pdf
Abstract	Nursing shortages continue globally and are especially critical in rural and remote communities. Attracting nurses to work in less populated regions presents challenges that differ from those in urban areas. This pilot study focused on self-identified factors of nursing students who expressed an interest in rural practice post-graduation. The sample included students from the USA and Canada, who were enrolled in graduate and under graduate programs of nursing, and were attending an international rural nursing conference. Findings from the pencil and paper short answer survey found those who have life experiences and connections in small communities are more likely to choose this setting. Post-graduation employment preference was reinforced by ongoing exposure to rural theory and practice settings in their programs of study. Nursing scholars may find this study useful to further examine students' employment preferences, and to develop targeted strategies to better prepare those having an interest in rural practice. Evidence based findings are critically needed to recruit and retain nurses to address critical nursing shortages in rural regions in North America and globally.
Reference	**Bushy, A. (2002). International perspectives on rural nursing: Canada, Australia and United States. *Australian Journal of Rural Health,10,* 104-111.**
Online source	NA
Abstract	This article compares and contrasts nursing practice in rural areas based on selected publications by nurse scholars from Australia, Canada and the USA. By no means is the analysis complete; rather this preliminary effort is designed to provoke interest about rural nursing in the global village. The information can be used to examine the rural phenomenon in greater depth from an international perspective and challenges nurses to collaborate, study, develop and refine the foundations of rural practice across nations and cultures. Content areas include: nursing practice, expanded roles, education, recruitment and retention.
Reference	**Stewart, N., D'Arcy, C., Pitblado, J., Morgan, D., Forbes, D., Remus, G., Smith, B., Andrews, M., Kosteniu,k, J., Kulig, J. & MacLeod, L. (2005). A Profile of Registered Nurses in Rural and Remote Canada. *Canadian Journal of Nursing Research, 37* (1), 122-145.**
Online source	NA
Abstract	Research on nursing practice issues in rural and remote areas of Canada is very limited.. This report describes the method and initial results of a comprehensive survey of registered nurses (RNs) practising outside the commuting zones of large urban centres, designed to determine: who practises nursing in rural and remote Canada; the nature and scope of their nursing practice; and their satisfaction with their work, community, and practice supports. Using a mailed questionnaire with persistent follow-up, the data-collection frame included a stratified random sample of rural RNs and the full population of RNs who worked in the northern territories and outpost ("remote") settings. The analyses focus on regional comparisons of demographics and primary work settings and on provincial comparisons of satisfaction levels related to work and community. The survey is part of a larger multi-method project intended to inform policy on rural nursing practice in Canada.

Location of Schools of Nursing in Ontario