TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development, Implementation Science, and Evaluation

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CHAPTER

3

CREATING HEALTHY WORKPLACES: ENABLING CLINICAL EXCELLENCE

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Outline the origins of RNAO's healthy work environment evidence-based guidelines for nurses and other healthcare providers
- Understand the elements of a healthy work environment and how their synergy contributes to the multifaceted and complex nature of healthcare work settings
- Discuss key aspects of a healthy work environment embedded in RNAO's set of Healthy Work Environment (HWE) BPGs
- Describe how a healthy work environment influences outcomes for nurses, patients, organizations, and systems

INTRODUCTION

This chapter describes the strong links between work environments and the uptake of clinical Best Practice Guidelines (BPG) and the establishment of evidence-based practice cultures. The rationale for the development of Healthy Work Environment (HWE) BPGs is provided, alongside the model of a healthy work environment that guided the development process. The chapter also outlines the collaborative processes used to select the initial foundational HWE BPGs and how their impacts were evaluated in workplaces across health sectors. It explores the development of HWE BPGs in foundational areas and other themes. The chapter concludes with a review of the outcomes of HWE BPG implementation, including enhanced provider satisfaction and sustained uptake of clinical practice guidelines, which together have led to better client outcomes.

INITIATION OF HEALTHY WORK ENVIRONMENTS (HWE) BPGS

In Ontario in the early 2000s, the Ministry of Health and Long-Term Care (MOHLTC) began to explore the impact of the work environment in healthcare on providers, organizations, and clients, and approached the Registered Nurses' Association of Ontario (RNAO) to expand its successful evidence-based clinical Best Practice Guidelines Program (Grinspun, Virani, & Bajnok, 2002) to focus also on work environments. In 2003, RNAO took up the challenge to develop HWE BPGs with funding support from MOHLTC and from the Canadian government.

At the time of the request from the Ontario government, RNAO had begun to identify emerging evidence of the link between uptake of clinical best practices and characteristics of the work environment. We had noticed enthusiastic uptake in what we called healthy work environments (HWE). HWEs were also being discussed by others (Izzo, 2001; Lowe, 2002; Rycroft-Malone et al., 2002). Through its policy work, RNAO was also acutely aware of serious workplace issues as expressed by nurses and documented by scholars (Baumann et al., 2001; Cohen, Stuenkel, & Nguyen, 2009; Griffin et al., 2003; O'Brien-Pallas et al., 2005; RNAO, 2000).

Seminal work by Rycroft-Malone et al. (2002) concluded that evidence uptake in clinical practice is closely linked to healthcare work environments that support evidence-based practice and decision-making. The authors noted that within healthy work environments, the following components are generally present and they positively impact successful guideline implementation processes (Rycroft-Malone et al., 2002):

- Transformational leadership
- Effective structures/teamwork
- Rewards and recognition for work and years of service
- A learning culture that:
    - Values staff and clients
    - Promotes democratic decision-making
    - Utilizes multiple sources of information methods to provide feedback to staff

Other important research by Izzo (2001) and by Lowe (2002) emphasized characteristics that contribute to a healthy workplace. These include relationships with supervisors and coworkers, the presence of rewards and recognition, and a culture that:

- Is built on trust
- Values people
- Supports learning
- Provides opportunities for participation
- Provides timely, complete information

With its groundbreaking work in developing HWE BPGs, RNAO brought to the forefront a greater understanding that HWEs are not only critical for a vibrant workforce and high-performing organizations, but also imperative for clinical excellence and positive health outcomes for patients (Griffin et al., 2003).

DEFINITION OF A HEALTHY WORK ENVIRONMENT

RNAO defines *healthy work environments* as "practice settings that maximize the health and well-being of nurses [and all health care workers], quality patient outcomes and organizational and system performance and societal outcomes" (RNAO, 2013b, p. 8).

This definition reinforces that the work environment is integral to workers and what they do, and the impact of their work, as well as organization and system outcomes. Each of these areas, and the synergy between and amongst them, will be discussed in this chapter. When RNAO commenced this leading-edge work, there were few guides to direct the process. A decision was made at the outset to develop a comprehensive conceptual model for HWEs that reflected the multidimensional and complex nature of the healthcare workplace (RNAO, 2006b, 2006c, 2007a, 2007b, 2007c, 2008). The HWE Conceptual Model is used by each HWE BPG Expert Panel in its development work, and it is included as part of the introduction to each HWE BPG. Additionally, RNAO's rigorous clinical BPG development and related processes for uptake and impact assessment were used to guide the development, implementation, and evaluation of evidence-based tools to enhance the work environment.

THE HWE CONCEPTUAL MODEL

The development of the HWE Conceptual Model preceded the development of the HWE BPGs and built on relevant existing models (Baumann et al., 2001; DeJoy & Southern, 1993; Griffin et al., 2003; O'Brien-Pallas & Baumann, 1992). The RNAO model served to better explain the multiple levels, diverse factors, complex relationships, and synergistic impacts associated with HWEs for healthcare providers, patients, organizations, and the system (RNAO, 2006b, 2006c).

Figure 3.1 illustrates the factors and components, and the interactions among the key elements, that influence an HWE.

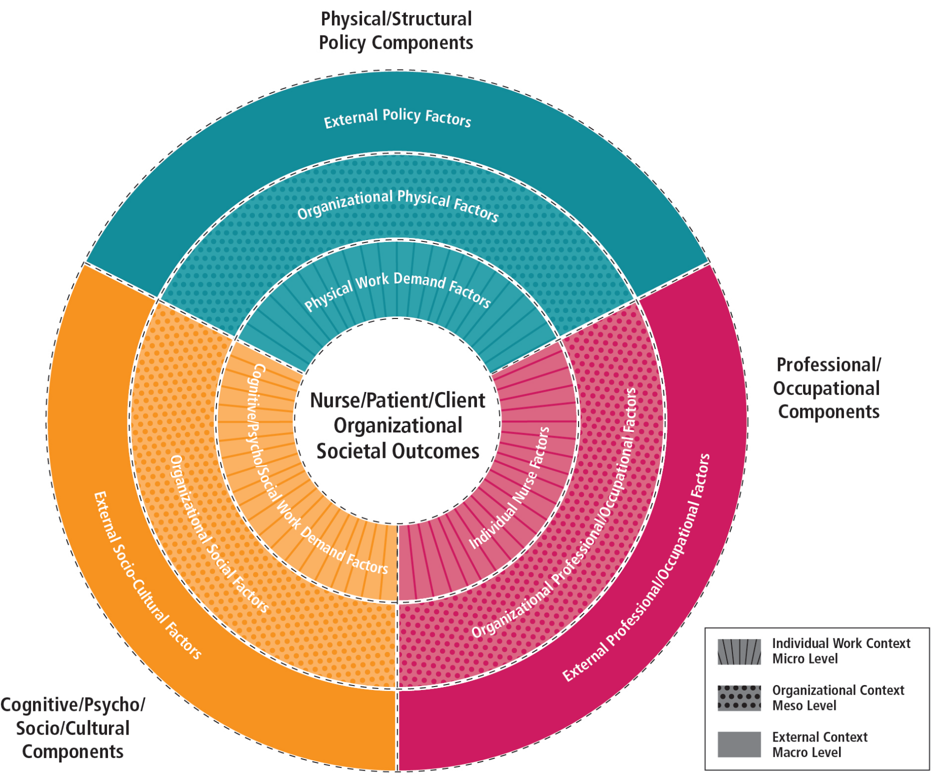

FIGURE 3.1 RNAO HWE Conceptual Model.
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When you look at this, you may ask, "What is this model trying to tell me?"

This model presents the healthy workplace as a product of the interdependence amongst individual, organizational, and external system factors, and three different types of components: physical/structural/policy, cognitive/psycho/socio/cultural, and professional/occupational components that are part of each of the factors. The factors are illustrated in three circles surrounding the central overall goal of HWEs—better outcomes for healthcare providers, patients, organizations, systems, and society as a whole, including healthier communities (Griffin et al., 2003). The components are illustrated in the three wedges that cut across each of the factors. The lines within the model are dotted to indicate the synergistic interactions amongst all levels and components of the model.

The model suggests that each individual practitioner's functioning is influenced by interactions between the individual and the individual's environment. Thus, interventions to promote HWEs must be aimed at multiple levels and components of the organization and the system. Similarly, interventions must influence not only the factors within the system and the interactions amongst these factors, but also the system itself (Green, Richard, & Potvin, 1996; Grinspun, 2000). The assumptions underlying the model are:

- Healthy work environments are essential for quality, safe patient care.
- The model is applicable to all practice settings and all domains of nursing.
- Individual, organizational, and external system-level factors are the determinants of healthy work environments for nurses.

- Factors at all three levels impact the health and well-being of nurses, quality patient outcomes, organizational and system performance, and societal outcomes, either individually or through synergistic interactions.
- At each level, there are physical/structural policy components, cognitive/psycho/social/cultural components, and professional/occupational components.
- The professional/occupational components are unique to each profession, while the remaining components are generic for all professions/occupations.

Figure 3.2 highlights the physical/structural policy components at each level that influence an HWE.

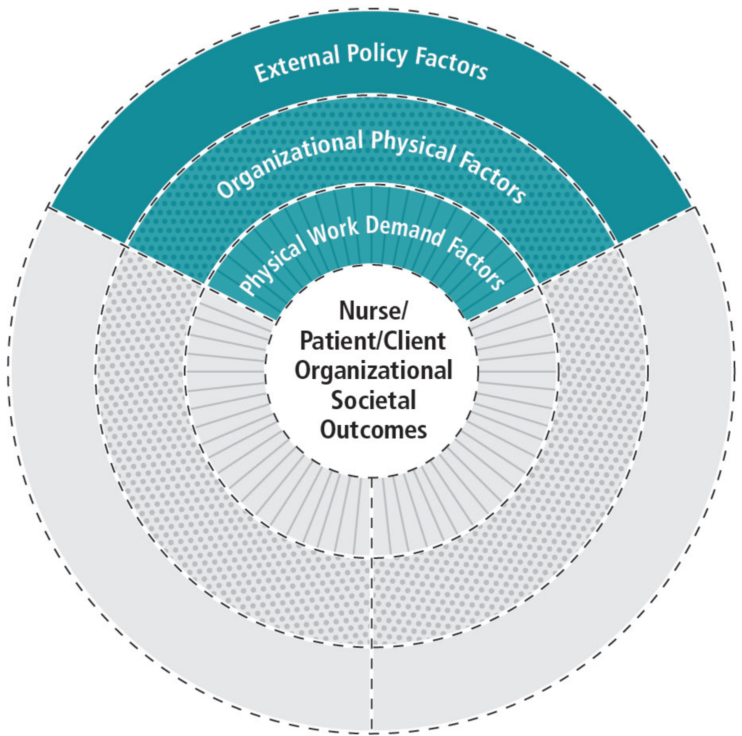

FIGURE 3.2 Physical/structural policy components.
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The physical/structural policy components identified above in the top wedge of the circles are the physical characteristics and environment of the organization developed to respond to the physical work characteristics and work demands. They include the following:

- Physical work demand factors (shown on the inner area of the wedge with striped lines) are those tasks that require effort and involve the physical capabilities of the nurse or care provider to deliver the care. An example of physical work demand factors could be the nature of the patient population that might require more physical lifting or rotating shifts.
- Organizational physical factors (shown on the dotted area of the wedge) are both the existing characteristics and the structures and processes that the organization creates to provide a

supportive work environment. An example of this might be the physical layout of the work setting and the design of multiple supply or equipment access points, such as computer terminals, to improve efficiency.

- External policy factors (shown on the solid outer area of the wedge) include factors such as immigration policies; healthcare funding policies; legislative, trade, economic, and political influences external to the organization; and other agreements that have the potential to affect healthcare.

Figure 3.3 highlights the cognitive/psycho/socio/cultural components at each level that influence an HWE.

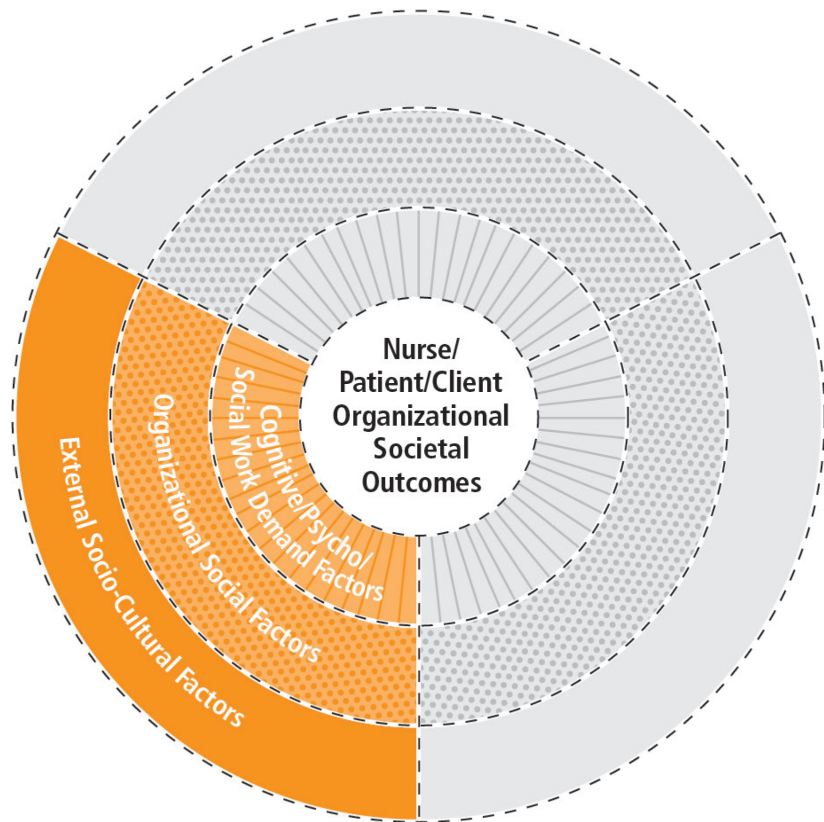

FIGURE 3.3 Cognitive/psycho/socio/cultural factors.
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The cognitive/psycho/social/cultural components identified on the left lower wedge of the circles are the factors represented by the individual working in healthcare and as a member of society. They include the following:

- Individual cognitive/psycho/social work demand factors (shown on the inner area of the wedge with striped lines) refer to those situations that require effective problem solving, coping, and communication by the individual. This kind of work demand requires cognitive, psychological, and social capabilities and effort (Grinspun, 2010). This applies to most nursing roles but could be more complex with specific patient populations.

- Organizational social factors refer to factors such as the climate, culture, and values of the organization.
- External socio-cultural factors: These are consumer trends, care preferences, family roles, diversity of the population and providers, and changing demographics. As an example, in the early 2000s we saw a relaxation of visiting policies with the trend to more patient-centeredness and inclusivity of families in care (Farmanova, Judd, Maika, & Wilkes, 2015). However, in 2004 with the advent of SARS (severe acute respiratory syndrome), there was an enormous move back to less open visiting policies (Rogers, 2004).

When exploring these organizational factors in your own work setting, ask yourself the following questions: Does the organization value nursing? Are there visible supports for staff who work shift and opportunities for professional development?

Figure 3.4 highlights the professional/occupational components at each level that influence an HWE.

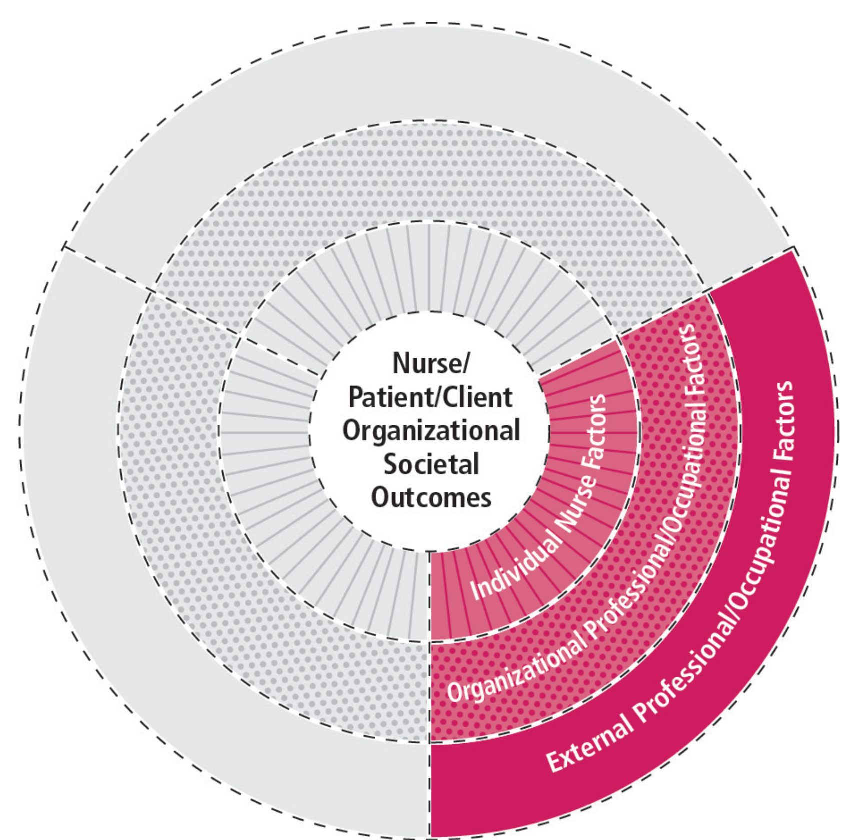

FIGURE 3.4 Professional/occupational components.
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The details of this section of the model, shown on the right lower wedge of the circles, have been outlined here to be specific to nurses (and could be altered depending on the type of healthcare worker), whereas the other components of the model are applicable to all healthcare workers. They include the following:

- Individual nurse factors are the knowledge, skill, and personal attributes (such as age, education, and physical health and well-being) of the individual that determine response to the work demands.
- Organizational professional/occupation factors refer to the nature of the professional's role and supports within organization (e.g., level of autonomy, scope of practice).
- External professional/occupational factors refer to those factors outside of the organization that come as a result of policies and regulations, such as standards of practice and the regulated scope of practice from the regulatory body for nursing (e.g., standards of practice, certification, and ethical recruitment).

Consider the following questions to assess this component in your organization: What level of autonomy for practice is supported? Is there a nursing committee that determines scope of practice for nurses in your organization?

HWE BPG DEVELOPMENT METHODOLOGY

To meet our commitment to ensuring that every HWE BPG is based on the best available evidence, it was a given that RNAO would utilize the same rigorous Guideline Development process as for the clinical BPGs, and monitor and revise each guideline on a regular basis. The HWE BPG development process remains consistent with the clinical BPG process, and as the clinical BPG development methodology is refined and enhanced, the development processes for the HWE BPGs are modified to reflect the increased rigor. The HWE BPG development methodology includes the following steps:

- The topic is selected based on key issues/trends in healthcare, data from RNAO's Best Practice Spotlight Organizations (BPSO), input from nurse and other healthcare professionals, or recommendations from government and/or other healthcare task forces.
- A panel of nurses and inter-professionals is convened from a range of specialties, roles, and practices settings. Increasingly, the panels have national and international representation. We recruit nurses and inter-professionals who possess expertise in practice, research, policy, education, and administration related to the topic area. These individuals form the Expert Panel.
- The scope of the guideline is identified and defined through a process of discussion and consensus with internal RNAO partners and external subject-matter experts.
- The Expert Panel identifies key themes and concepts in the subject matter that direct the research questions for the systematic literature review search and provide an organizing framework for the guideline.
- Following retrieval of relevant literature by a qualified health sciences librarian, a systematic literature review is conducted by a team of qualified nurse researchers (part of RNAO's BPG development team). The findings are used to inform the development of recommendations from individual and team, organizational, and policy perspectives.

- Drafts of the guideline are developed through a consultative process with RNAO and the Expert Panel members. The drafts are reviewed and revised by the Expert Panel and members of RNAO's Guideline Development Team.
- The guideline is distributed for review, first to panel members and then to external stakeholders.
- All feedback from panel members and stakeholders is considered and changes are made as necessary by consensus and evidence.
- The recommendations and evidence are then finalized through an internal process and editorial review at RNAO.
- The Guideline Development Team reaches consensus on the final document.
- The HWE BPG is published and widely disseminated for use.

DEVELOPING HWE BPGS: WHERE TO START

As indicated, the initial goal of the Program was the development of foundational guidelines that would assist nurses and other clinicians with day-to-day workplace challenges, to facilitate their focus on clinical excellence. These foundational HWE BPGs were based on key topic areas identified using a grounded research approach in which, through a series of focus groups, nurses from across sectors and geographic areas in Canada were asked about key workplace issues they felt were critical to quality patient care. There was a high consistency in the results, which included six discrete topic areas that would become the foundational HWE BPGs.

These first six HWE BPGs were developed in partnership with the Joanna Briggs Institute (JBI), which carried out the systematic literature reviews related to each of the topic areas identified (Pearson et al., 2006a, 2006b, 2006c, 2007a, 2007b). At the time, JBI had just released its quality-appraisal and data-extraction tools for qualitative research, which were most appropriate in defining the evidence base for the HWE BPGs. Six foundational guidelines were published between 2006 and 2008, addressing: leadership; collaborative practice; workload and staffing; professionalism; diversity; and workplace health, safety, and well-being.

Recognizing the importance of leadership, collaboration, and capacity-building related to workplace issues, their impact, and resolution, the HWE BPGs were targeted to all levels of staff within organizations as well as a number of external stakeholders such as regulatory bodies, governments, and unions, thus supporting a team responsibility for workplace health. In keeping with this intent, the HWE BPGs included evidence-based individual- and team-oriented recommendations to support direct care clinicians in learning about HWEs and contributing to a healthy work environment. Also, evidence-based organizational and policy recommendations were designed to support health care organizations in creating and sustaining positive work environments. In addition, system-oriented recommendations were developed to garner the engagement of governments, unions, and regulatory and standard-setting bodies in addressing workplace issues. Figure 3.5 graphically displays and explains the types of recommendations included in RNAO's System and Healthy Work Environment BPGs.

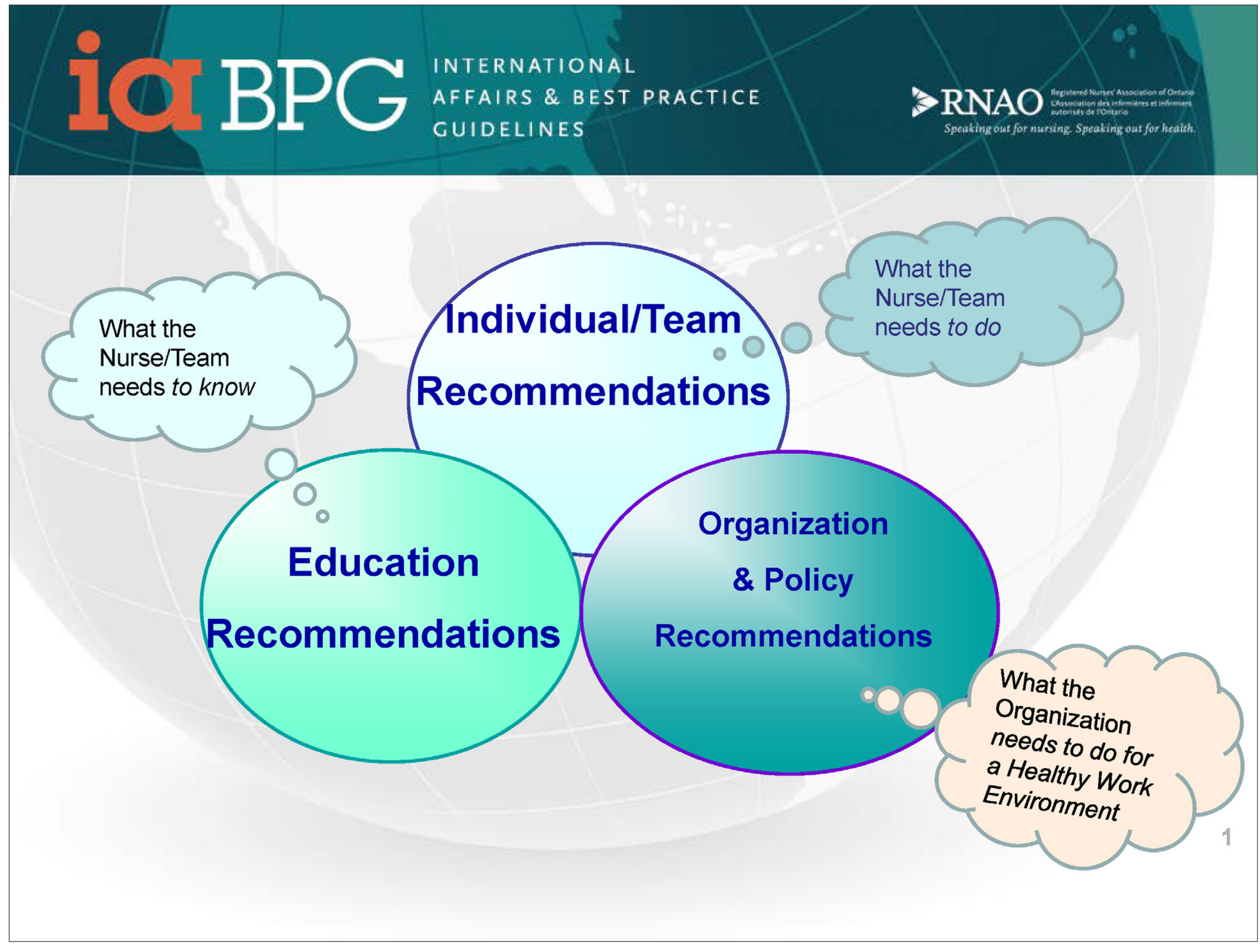

FIGURE 3.5 Types of recommendations included in RNAO's System and Healthy Work Environment BPGs.
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THE FOUNDATIONAL HWE BPGS

The six foundational guidelines are:

- *Collaborative Practice Among Nursing Teams* (RNAO, 2006b)
- *Developing and Sustaining Effective Staffing and Workload Practices* (RNAO, 2007a)
- *Developing and Sustaining Nursing Leadership* (RNAO, 2006c)
- *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* (RNAO, 2007b)
- *Professionalism in Nursing* (RNAO, 2007c)
- *Workplace Health, Safety and Well-Being of the Nurse* (RNAO, 2008)

The intent was to use these six guidelines as the initial focus for creating an HWE and then develop additional guidelines that stemmed from these foundational themes to enable further enhancement of the work environment. A short description of each foundational HWE BPG is provided in the following sections.

EFFECTIVE NURSING LEADERSHIP

Effective leadership is a pivotal aspect in all nursing roles whether the nurse practices directly with patients, in the field of education developing future leaders, as a researcher who mentors new researchers, or as an administrator or executive leader who provides support and guidance to staff (Cummings et al., 2010; Pearson et al., 2007a; RNAO, 2006c).

COLLABORATIVE PRACTICE

Strengthening team practice amongst all categories of nurses supports the practice setting for nurses. This guideline explores what fosters healthy work environments and effective teamwork amongst all categories of nurses in Ontario, Canada—the registered nurse, the registered practical nurse, and the nurse practitioner (Pearson et al., 2006c; RNAO, 2006c)

STAFFING, WORKLOAD, AND STRUCTURE

Staff mix for a specific practice setting is composed of various categories of nurses working intra-professionally and inter-professionally. Education, experience, skill mix, and leadership qualities have an enormous impact on the quality of nurse staffing. Nurse staffing is a complex process. An effective and formalized staffing plan requires an understanding of the complexity involved in patient care and in matching human resources (scope of practice, skills, number of staff, education, and experience) to patient needs (Pearson et al., 2006c; RNAO, 2007a).

PROFESSIONALISM

This guideline recognizes eight qualities of a professional staff and, in addition, outlines how organizations and leaders support professional behaviours in nursing and other staff. Some questions in determining the degree of professionalism are (Pearson et al., 2006b; RNAO, 2007c): Does the staff have the necessary knowledge and skills? Does the nursing staff have a positive and professional attitude to support evidence-based practice? Does the organization have a positive view of the nursing profession? Have nurses been effectively supported through practice change in the past?

As you read these short descriptions of each HWE BPG, consider how decisions are made in your organizations, the workload patterns, and the physical facilities and resources available to support you in your role. What are the decision-making processes? Is there enough staff to support the complexity of patients and their care?

WORKPLACE CULTURE AND DIVERSITY

The degree to which the workplace culture supports and builds on diversity is a critical factor in HWEs, as well as in effective individual and team functioning.

This can be assessed by asking the following questions: What is the overall nature of the organization, in terms of how we think things should be done? What is seen as important? To what degree does the culture support change and evidence-based practice? Are the organizational values clear and evident

in how and what decisions are made? Is there a culture of respect for all? Are all key stakeholder perspectives considered and incorporated? Are processes in place to evaluate decisions? (Pearson et al., 2007b; RNAO, 2007b)

WORKPLACE HEALTH, SAFETY, AND WELL-BEING OF THE NURSE

The health of nurses involves various complex components. These components are discussed in the guideline. They include the physical design of the organization, the work nurses do, working conditions, occupational hazards, injury and illness prevention, health promotion, organizational culture, and system supports (RNAO, 2008).

PILOT IMPLEMENTATION AND EVALUATION

Shortly after their release, the foundational HWE BPGs were evaluated through a 4-year, multisite study involving nine health care settings (acute care, mental health, and home care) in Ontario. A pre- and 3- and 6-month post- research study design was used. Units/teams in each setting were randomly assigned specific HWE BPGs to implement (RNAO, 2010). The results were extremely encouraging and demonstrated extensive engagement of nurses and other healthcare professionals in the HWE BPG implementation work. The findings also revealed the high value that was placed on this work and the perceived positive outcomes as expressed by staff in relation to: the effectiveness of teamwork, staff satisfaction, the quality of care, and patient outcomes (RNAO, 2010). In addition, it became clear that the HWE BPGs were useful across settings and sectors, and with a variety of nursing and other health professionals and staff.

These results fuelled widespread implementation, and the success of the foundational guidelines led to the development of other related HWE BPGs consistent with longstanding and emerging issues in healthcare work settings. The following list of HWE BPGs represents either a second edition of the foundational BPG or new themes:

- *Preventing and Managing Violence in the Workplace* (RNAO, 2009)
- *Preventing and Mitigating Nurse Fatigue in Health Care* (RNAO, 2011)
- *Managing and Mitigating Conflict in Health-Care Teams* (RNAO, 2012a)
- *Developing and Sustaining Interprofessional Health Care: Optimizing Patients/Clients, Organizational, and System Outcomes* (RNAO, 2013a)
- *Developing and Sustaining Nursing Leadership*, Second Edition (RNAO, 2013b)
- *Intra-Professional Collaborative Practice Among Nurses*, Second Edition (RNAO, 2016a)
- *Developing and Sustaining Safe, Effective Staffing and Workload Practices*, Second Edition (RNAO, 2017b)

As the Program has matured, the HWE BPG Program has expanded to focus on the health system, and the guidelines are now termed System and Healthy Work Environment BPGs. Examples of guidelines that reflect the health system include *Practice Education in Nursing* (RNAO, 2016c), and *Adopting eHealth Solutions: Implementation Strategies* (RNAO, 2017a).

A variety of resources has been developed, reflecting best practices in implementation science (RNAO, 2012c), that facilitate dissemination and uptake of the HWE BPGs. For example, *The Healthy Work Environments Quick Reference Guide* (RNAO, 2013c) includes summaries of all the HWE BPGs and was developed for managers to enable ease of use in the workplace. This resource was so popular that it was made available to all staff for online access. In addition, for a number of the BPGs, a summary of key guideline recommendations and assessment resources, called Tips and Tools, was developed and targeted to point-of-care nurses. The following Tips and Tools were developed for the following associated guidelines.

GUIDELINE	TIPS AND TOOLS RESOURCE
Preventing and Managing Violence in the Workplace (2009)	*Preventing and Managing Violence: Tips and Tools for Nurses* (2014e)
Preventing and Mitigating Nurse Fatigue in Health Care (2011)	*Managing and Mitigating Fatigue: Tips and Tools for Nurses* (2014c)
Managing and Mitigating Conflict in Health-Care Teams (2012a)	*Managing and Mitigating Conflict: Tips and Tools for Nurses* (2012b)
Developing and Sustaining Interprofessional Health Care: Optimizing Patients/Clients, Organizational, and System Outcomes (2013a)	*Developing and Sustaining Interprofessional Health Care: Tips and Tools for Health-Care Teams* (2014a)
Developing and Sustaining Nursing Leadership (2013b)	*Developing and Sustaining Nursing Leadership: Tips and Tools* (2014b) *Point-of-Care Leadership Tips and Tools for Nurses* (2014d)

For some of the BPGs—*Practice Education in Nursing* (2016c) and *Adopting eHealth Solutions: Implementation Strategies* (2017a)—a synopsis of the guideline was developed, incorporating evidence highlights and recommendations.

As noted earlier, the work environment needs to be healthy in order to support positive patient outcomes. By identifying and developing the foundational HWE BPGs, an awareness of the importance of the work environment was raised and has been sustained. In addition, it became clear that environmental readiness (reflecting issues in the workplace) was a critical factor in implementation science and incorporated in RNAO's clinical implementation resources (RNAO, 2012c).

CREATING HEALTHY WORKPLACES

Achieving HWEs for nurses requires that organizational leaders and individual practitioners commit to transformational change using interventions specific to the underlying workplace context and organizational factors (Lowe, 2004; RNAO, 2008). The HWE BPGs support this type of transformational change through the use of evidence-based recommendations that address unique nursing professional practice as well as common workplace issues. Evidence-based recommendations that address the individual provider, care teams, education for HWEs, and organizational and system policy incorporate a focus on the nurses' health and morale and ensuing ability to provide care, patient outcomes, and organizational and system performance (RNAO, 2006b, 2006c, 2007a, 2007b, 2007c, 2008).

Evidence about HWEs in healthcare settings and their broad impacts continues to mount. In a systematic review conducted by Lindberg and Vingard (2012), results strongly link the work environment and the ability to provide safe, quality care. In the review, the following nine (9) elements were identified as necessary to achieve a healthy workplace:

- Collaboration/teamwork
- Development of the individual
- Recognition
- Employee involvement
  - Positive, accessible, and fair leaders
  - Autonomy and empowerment
- Appropriate staffing
- Skilled communication
- Safe physical environment

REFLECTION

Do you remember your first job? Maybe your first job was in nursing, or maybe another field. Chances are the first thing you will remember are the people. Staff relations and teamwork are critical aspects of the work environment.

All these areas are addressed in RNAO's 12 System and Healthy Work Environment BPGs.

HEALTHY WORK ENVIRONMENTS AND THE IMPACT ON HEALTHCARE SETTINGS

Organizations with HWEs recognize that people and their relationships are at the heart of their ability to achieve the mission within the context of the overall vision and strategic plan (Burgess & Purkis, 2010; RNAO, 2016a). The work environment and the multiple influences within the workplace (as delineated in the HWE Conceptual Model) have an impact on the mental and physical well-being of employees, including the cultural, social, and professional roles performed by nurses and other members of the inter-professional team.

WORK ENVIRONMENT AND NURSE OUTCOMES

It is important to examine the work environment as part of quality improvement to enhance nurse outcomes, and by extension patient outcomes (Baernholdt & Mark, 2009). Better support services, a

smooth workflow, and a work environment that enables autonomous nursing practice and committed nurses contribute to strong nursing outcomes (Baernholdt & Mark, 2009).

Other factors from the work environment that impact nurse and ultimately patient outcomes are (Grinspun, 2002, 2003, 2007; Grinspun & Anyinam, 2014; O'Brien-Pallas & Hayes, 2010; Pearson, et al., 2007a; 2007b; RNAO, 2008):

1. Nursing workload
2. Casualization (or increasing numbers of temporary part-time staff) of the nursing workforce
3. The age demographic in many jurisdictions
4. Nursing leadership
5. Financial support
6. Respect

Chachula, Myrick, and Yonge (2015) examined the factors and basic psychosocial processes involved in the decision of newly graduated RNs in Western Canada to leave the profession on a permanent basis. The results of the study (Chachula et al., 2015) indicated that participants withdrew from their nursing identities in the absence of intrinsic and extrinsic rewards (e.g., support, validation, and legitimization of their roles).

Four interconnected categories were also reflected in the findings (Chachula et al., 2015):

1. Navigating the constraints of the healthcare system and workplace (e.g., strained, rigid, nonresponsive, bureaucratic, high patient loads, cutbacks, poor working conditions)
2. Negotiating social relationships, hierarchies, and troublesome behaviours (e.g., hierarchies, horizontal and lateral violence, bullying)
3. Facing fears, traumas, and challenges (e.g., sensitivity, patient deaths, critical feedback)
4. Weighing competing rewards and tensions (e.g., losing joy of nursing, weighing positives and negatives)

These findings relate directly to the work environment, and it has been suggested that the factors fuelling the ongoing shortage of nurses are the result of unhealthy work environments (Dunleavy, Shamian, & Thomson, 2003; Grinspun, 2010; RNAO, 2008, 2017b). This is compounded by funding models that make it challenging for workplaces to hire the most qualified staff to deliver and oversee the complex care required in today's health system. This has a definite impact on quality of care, as several studies have shown a link between positive patient outcomes and sufficient Registered Nurse staffing (Drach-Zahavy, 2004; Mattila et al., 2014; RNAO, 2016b).

Havaei, MacPhee, and Dahinten (2016) looked at skill mix in acute care settings and two nurse outcomes, namely emotional exhaustion and intention to leave. The findings identified that those with a higher level of emotional exhaustion, high workload, and exposure to lack of respect, and those seeking a change in their career were more likely to leave the profession altogether. Within the home care sector there were similar findings. That is, home care nurses who reported having an intention to leave desired to have: higher nurse-evaluated quality of care, greater variety of patients, more

satisfaction with salary and benefits, greater income stability, greater continuity of patient care, greater meaningfulness in work, more positive relationships with supervisors, and higher work-life balance (Tourangeau, Patterson, Saari, Thomson, & Cranley, 2017).

WORK ENVIRONMENT AND PATIENT OUTCOMES

Patient outcomes associated with HWEs that reflect best practices related to staffing, staff mix, teamwork, and leadership include:

- Decreased patient mortality and a higher value of care (Silber et al., 2016)
- Decreased adverse outcomes (McHugh et al., 2016)
- Better nurse staffing and work environments associated with increased survival of in-hospital cardiac arrest patients (McHugh et al., 2016)

Furthermore, many research studies and reviews have examined the positive patient outcomes that occur as a result of full-time nurse staffing (a critical component of a healthy work environment), many of which have cost-saving implications from a systems and organization-level perspective:

- Decreases in missed care (Zhu et al., 2012)
- Decreased unassisted falls (Staggs & Dunton, 2014)
- Decreased failures to rescue (Harless & Mark, 2010; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007)
- Decreased cardiac arrest (Kane et al., 2007)
- Decreased hospital acquired pneumonia (Kane et al., 2007)
- Increased patient safety in ICU and surgical care (Kane et al., 2007)

WORK ENVIRONMENT AND ORGANIZATIONAL OUTCOMES

The nurses' work environment impacts the organizational outcomes; for example in the case of absenteeism, the cost to the organization and sector can be substantial (Aldana, 2001), and unless the root cause is addressed (e.g., leadership, workload, team dynamics, safety, not enough equipment and other resources), absenteeism due to illness, stress, and injury will continue to add costs to the bottom line, and by extension add risks to quality care (Aldana, 2001; Duffield et al., 2011; O'Brien-Pallas & Hayes, 2010; O'Brien-Pallas, Tomblin Murphy, & Shamian, 2008; RNAO, 2008, 2017b).

Organizations that adopt HWE principles and values—and take a comprehensive and collaborative approach to ensure workers can function in a safe and respectful atmosphere—are the most successful in BPG uptake, leading to better outcomes (Davies et al., 2006; Shamian & El-Jardali, 2007). Shamian and El-Jardali (2007) also acknowledged RNAO's HWE Program as having potential to create professional practice environments and ease the nursing recruitment and retention issues plaguing healthcare. HWEs promote nurse and employee well-being, engagement, retention, productivity, and patient safety, all of which affect the health system's costs (Cohen et al., 2009; O'Brien-Pallas et al., 2008). We need healthy nurses and other healthcare workers who are consistently present to affect good clinical

outcomes for patients. Healthcare workers are one of the highest-risk groups for work-related injuries and illness in Ontario and across Canada. Statistics reveal that:

- The average number of days of work lost due to illness or disability was at least 1.5 times greater for workers in healthcare than the average for all workers (Canadian Institute for Health Information, 2005).
- The lost time injury rate in the healthcare sector in Ontario was 1.27 per 100 workers in 2015. Of this lost time, 12% was directly related to workplace violence (Ontario Ministry of Labour, 2017).
- Fifty-four percent (54%) of Ontario nurses have experienced physical abuse; 85% have experienced verbal abuse, and 19% have experienced sexual violence or abuse (Ontario Nurses Association, 2015).

Unhealthy work environments impact the ability to retain and recruit healthcare workers. Illnesses and injuries resulting from these unhealthy environments place additional pressure on coworkers, reduce providers' ability to meet their patients' needs, and, as discussed previously, may in some cases even cause people to consider leaving their profession (Chachula et al., 2015; Havaei et al., 2016; Public Services Health and Safety Association, 2011; Tourangeau et al., 2017).

Therefore, attention to work environments is critical to ensuring strong organizational outcomes, and managers and nurse administrators have a critical role in influencing the work environment through increasing nurse retention and preventing staff turnover, to ultimately improve patient care (Sellgren, Kajermo, Ekvall, & Tomson, 2009). Some factors that may help increase retention and decrease turnover include acknowledging the challenges faced by nurses (Sellgren et al., 2009); shared clinical decision-making and full-time employment (Grinspun, 2007); models of care delivery that promote continuity of caregiver (Grinspun, 2010; Meyer, Wang, Li, Thomson, & O'Brien-Pallas, 2009; RNAO, 2006a); promoting self-scheduling (Butler et al., 2011); work support programs (Luo, Lin, & Castle, 2013); appropriate working conditions (Nakamura et al., 2010); and staffing within budgeted levels (North et al., 2013). In 2015, the total days of work lost in healthcare occupations was reported to be 13.8 per worker (Statistics Canada, 2014). The financial benefits yielded from improvements in the work environment that lead to reduced absenteeism, improved productivity, and reduced healthcare costs for employees have been clearly documented (Aldana, 2001; RNAO, 2017b).

REFLECTION

Reflecting on that first job again, do you recall if you worked alone or if other employees were an important part of your day-to-day experience? Did you feel supported? Did you feel part of a team? These are important considerations that influence the work environment and have a link to clinical outcomes for patients. Reflect on them also in relation to your current work position.

WORK ENVIRONMENT AND HEALTH SYSTEM OUTCOMES

HWEs are also closely tied to the recruitment and retention of nurses who are critical in ensuring access to health services and sustaining the healthcare system (Laschinger, Wong, & Grau, 2012). An adequate supply of appropriately qualified registered nurses is central to a healthy work environment and to the provision of quality, evidence-based care (Frith, Anderson, Fan, & Fong, 2012; Trinkoff et al., 2011). In a spiralling down cycle, staff shortages impact retention, as nurses who are dissatisfied

with the quality of care they can provide leave the workplace and may also leave the profession. Nursing shortages may in turn impact recruitment success at the organizational level (Berry & Curry, 2012; MacPhee, 2014; RNAO, 2000) because nurses do not want to work in unhealthy workplaces, and at the professional level, because potential nurses are looking for satisfying, meaningful work.

In Canada, data from the Canadian Institute for Health Information (CIHI) indicates there was a decline in the number of RNs, the first in almost two decades (CIHI, 2015). This emerging trend, at a time when patients and health issues across all sectors are becoming more complex (Lipsitz, 2012), does not bode well for healthy work environments or quality care. It behooves governments, professional bodies, unions, regulatory bodies, healthcare organizations, and individual managers and direct care nurses to work together to use the plethora of strong evidence available to shape healthy work environments.

IMPLEMENTING HWE BPGS

Implementing HWEs (see Chapter 4, *Forging the Way with Implementation Science*) and building a culture of safety for healthcare workers opens the door to developing a culture of evidence-based clinical practice. If the work environment issues are addressed, nurses and other clinicians and managers are freed to focus on delivering the highest-quality evidence-based care possible. Implementing HWE BPGs is not *instead of* implementing clinical BPGs, but in *support of* implementing clinical BPGs. The principles and practices of implementation science are as critical in implementing HWE BPGs as they are with clinical BPGs. The RNAO Implementation Toolkit (2012c) addresses principles of implementation science as they pertain to uptake of both clinical and System and Healthy Work Environment guidelines, and includes relevant exemplars specifically related to HWE BPGs to aid users. The case study on page 87 is one of many examples that demonstrate how attention to work environment issues enhanced the ability to advance evidence-based clinical practice.

HWE BPGS: EVALUATING IMPLEMENTATION PROCESSES AND OUTCOMES

Evaluation of approaches to creating healthy work environments using HWE BPGs is imperative and must be a factor at the outset of any initiatives to plan changes to improve the workplace. There are numerous tools for assessing and evaluating various components of the work environment, and within each of the RNAO HWE BPGs, there are evaluation guides and specific structure, process, and outcome indicators that can be used to measure the impact of implementing the BPG. The structural indicators refer to the supports needed to be available in the organization (e.g., people, physical entities, policies, accessible computers) that allow nurses and others to provide quality care in a workplace that supports staff health and well-being. The process indicators (e.g., education, team meetings, safety reviews) include the methods or the systems implemented and developed to achieve the outcomes. The outcomes measured examine the desired states for patients and providers resulting from the adoption of healthy work processes (Donabedian, 2005). Staff satisfaction and of course clinical excellence are also key indicators of the health of the work environment.

When you are in a workplace, what are the indicators you usually use to determine the health of the work environment?

CASE STUDY

HWE BPGS AND CLINICAL EXCELLENCE: SCARBOROUGH AND ROUGE HOSPITAL'S EXPERIENCE

Representing the Birchmount and General sites of the Scarborough and Rouge Hospital (SRH) in Toronto, Canada, we began a focus on a healthy workplace as part of our Best Practice Spotlight Organization (BPSO) predesignation work. This decision followed a strong interest identified through focus groups, a review of incident reports, and leadership engagement. We knew that it was important for our work environment to be as healthy as possible, as we embarked on building trusting relationships amongst each other and working as a cohesive team to create clinical changes necessitated by clinical BPG implementation. This focus on a healthy workplace showed us that there were areas that required improvement.

We chose to implement the *Preventing and Managing Violence in the Workplace* (RNAO, 2009) HWE BPG, because workplace bullying was a worrisome factor that had preoccupied a number of our staff and leadership teams. We formed a working group, which included representatives from the inter-professional team, occupational health department, security, and the formal leadership. Using the individual, team, and organizational recommendations in the BPG, we identified and worked on a number of the evidence-based strategies presented. These strategies involved all staff and included: a hospital wide presurvey, a policy review, anti-bullying education, an improved response plan for incidents, as well as other training related to wellness and violence reduction. We also conducted regular monitoring of incident reports for trends and emerging issues, which were followed up by leaders within the organization to ensure a timely response and contribute information to our committee for ongoing attention.

While all staff participated in the anti-bullying training and were impacted by the new policies and procedures, specific teams in identified areas carried out more targeted strategies such as creating anti-bullying charters for their units.

We conducted a post survey and as might be anticipated with more knowledge about what constituted bullying, greater attention to a respectful workplace, and clarity of the reporting processes, the post-implementation survey yielded a higher number of individuals reporting they had experienced violence in the workplace. These results helped us all to be more aware of the extent of the issue and work together to meet the higher expectations we were now setting.

The focus on this aspect of an HWE enabled staff to appreciate that their well being was important, and impacted staff morale and engagement. Our work on implementation of clinical Best Practice Guidelines was facilitated through this initial attention to a critical issue in the workplace and aided the staff to focus on evidence-based care for their patients knowing that the organization was supporting them. The successes of the clinical Best Practice Guidelines were in part due to the implementation of the HWE guidelines.

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Within NQuIRE (Nursing Quality Indicators for Reporting and Evaluation), RNAO's comprehensive international data system used to measure the impact of clinical BPG implementation, there are general human resource structural indicators, and process and outcome indicators related to each clinical BPG. The structural indicators are those factors and components that make up the work environment. To date in the NQuIRE data dictionaries, the structural indicators are reflective of the *Developing and Sustaining Safe, Effective Staffing and Workload Practices*, Second Edition (RNAO, 2017b), and the *Intra-professional Collaborative Practice Among Nurses*, Second Edition (RNAO, 2016a) HWE BPGs;

however, over time these indicators will expand to include aspects of other HWE BPGs. The value of measuring these indicators in relation to the process indicators (what the nurse does for the patient) and the outcome indicators (the patient's health status) is that it helps us better understand the impact of the healthcare work environment on practice (process indicators) and subsequently on patient outcomes. In a fiscally conscious environment, such knowledge is crucial to help us learn the best ways to maximize results and minimize costs.

INTO THE FUTURE

As we look forward to how the HWE BPGs can continue to support positive clinical outcomes for patients, as well as better provider and organizational outcomes, RNAO's focus is the ongoing updating of all HWE BPGs to reflect current evidence, incorporating the latest research in this area. In addition, RNAO will continue to take a lead role in promoting and supporting studies that explore the relationships between and amongst workplace structures and processes, and clinical, provider, and organizational outcomes.

RNAO's clinical BPGs will continue to include within the recommendations for organizations and health systems the top aspects of HWEs that enable sustained clinical practice change leading to better patient outcomes. In addition, as RNAO's NQuIRE matures, more of the HWE BPGs will be captured in the structural indictors, empowering a better understanding of the interconnection between evidence-based nursing practice and work environments. As pointed out in Chapter 1, quality patient care is both an individual and a collective responsibility.

CONCLUSION

This chapter showcases healthy work environments and their importance for clinical excellence and patient well-being through enhancing provider, organizational, and system outcomes. It highlights the urgent need for attention to work environments and why it is critical especially in healthcare. The chapter outlines the many resources developed by RNAO, including System and HWE BPGs, and how their use by practitioners and other stakeholders within and outside organizations can make a difference to the broad spectrum of outcomes they influence.

The work environment cannot be forgotten in any setting, as it is clear that those expected to carry out their roles need to have the right preparation and resources to do their work, as well as feel valued, respected, engaged, and acknowledged. This is vital in healthcare where the targets of care and service, our patients and families, are often the most vulnerable amongst us. What is good for nurses and other health workers—in terms of the work environment—is also good for patients.

KEY MESSAGES

- Clinical excellence is fuelled by a number of factors, including the health of the work environment.
- Uptake of evidence-based clinical guidelines is enhanced by attention to elements of the work environment that influence staff satisfaction, such as access to resources, trust, teamwork, rewards, and recognition.
- Leadership in all roles and sectors is a critical work environment factor that impacts the ability of clinicians to uptake evidence and be able to deliver evidence-based practice every day and over time.
- Measurement of clinical outcomes must go hand-in-hand with structural measurement of work environment indicators that help us determine the context for clinical excellence.
- The RNAO System and HWE BPGs outline recommendations that help care providers (individuals and teams), organizations, and the system create healthy work environments for all, ultimately making a difference for patients.

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