POSITIVE WORKLIFE – QUALITY CARE

A Report of the
Residential Care Policy Committee

November 2009
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I. INTRODUCTION

In 2006, the Ministry of Health Services entered into policy discussions with the Facilities’ Bargaining Association, the Nurses’ Bargaining Association and the Health Employers Association of BC. One of the outcomes of the Facilities’ Bargaining Association policy discussions was the formation of a Residential Care Policy Committee (RCPC) whose purpose was to create the opportunity for constructive dialogue on issues related to quality care and staffing in long term/complex care and assisted living.

The RCPC was chaired by the Ministry of Health Services and composed of members of the Facilities’ Bargaining Association, the Nurses’ Bargaining Association, the Health Employers Association of BC, health care employers, educators and a geriatrician. A list of the membership of the RCPC is contained in Appendix A. The RCPC began meeting in November 2006 with the goal of providing two reports; one on training requirements, standards and delivery methods for Residential Care Aides and the second to contain a synthesis of information gathered on quality care and staffing with recommendations for next steps. This report relates to quality care and staffing.

The RCPC received and reviewed a number of presentations and articles over the course of its two year term. It recognized that there were a number of different groups, both inside and outside of government and policy tables, which were researching, examining and acting on the myriad of objectives and challenges that exist in long term care. After considerable discussion, the RCPC decided to focus its efforts on examining some elements of the residential long term care setting that contribute to a positive working environment and safety culture. Due to the extensive activity in this field, the RCPC also chose to rely on the material that was presented and reviewed, rather than engage in any additional or original research.

The RCPC commissioned a working group from within its ranks to examine and develop the themes that arose through the presentations and in the articles. Names of the members of the working group are contained in Appendix B to this report. This report was developed by the RCPC Working Group and finalized after discussion with the RCPC.

The RCPC is appreciative of the funding and support which was received from the BC Ministry of Health Services and would like to extend our gratitude to all the people who presented and discussed the matters which form the basis of this report.
II. OVERVIEW OF REPORT AND RECOMMENDATIONS

This synthesis outlines themes, as identified in the presentations and articles, that contribute to a positive working environment for people who work in residential long-term care and makes recommendations on some next steps that will promote such environments. While other key indicators exist which focus more directly on resident outcomes, this report focuses on the role of a positive work environment and a safety culture in creating healthy and caring communities. The long term care literature suggests that factors supporting positive outcomes for employees also contribute to positive patient/resident outcomes. Many of the presentations and articles that the RCPC examined commented on this connection.

Various themes that promote a positive work environment and quality care were identified in the presentations and articles. These themes include: teamwork; employee engagement and empowerment; concrete policies and practices that are fair and transparent; leadership; safety culture; and education and learning.

Within the context of these themes, the RCPC recommends that:

1. Continued efforts be encouraged to establish a “central capacity centre for collaborative practice” and that within such a centre a dedicated area be established that focuses on residential care and supports implementation of collaborative practice/change management initiatives and interventions that will promote a positive work environment.

   Such initiatives should include:
   i. support for both large projects (e.g. transformation at a facility level) and smaller ones (e.g. communication tools such as S-Bar and safety huddles);
   ii. a funded research component where appropriate; and
   iii. be inclusive of all staff who contribute to resident care (e.g. RCAs, rehab/activity staff, nurses, physicians, etc).

2. A system be developed for sharing tools, educational materials, survey tools, policy documents, guidelines, and links to key resources and support related to enhancing positive work environments. Such a resource is particularly important for small, rural and/or isolated worksites and should be easily accessible and user friendly. The potential for such a system may reside within a shared regional or provincial organization.

3. Employee leadership in areas of patient/staff safety be encouraged and developed to include peer mentoring and involvement such as was done in the Vancouver Health Ceiling Lift Coaching Program and the Fraser Health front-line worker initiative.

4. Front-line supervisor and management leadership training provide skill development and education in relation to quality worklife factors (including
employee engagement) and their relationship to patient/resident/client care and safety.

Additionally, the RCPC was invited by the Home and Community Care Council to provide comment and/or make recommendations on the Provincial Performance Management Framework for Residential Care Facilities. The RCPC makes the following comments and recommendations with respect to the framework.

1. The RCPC supports the importance of provincial consistency in the definitions and reporting of measures and indicators in the Provincial Performance Management Framework.

2. The Quality Worklife-Quality Healthcare Collaborative that has been endorsed by all of the Health Authorities offers a number of quality worklife indicators such as turnover rate, vacancy rate, training and professional development opportunities, overtime, absenteeism, workers compensation lost time incidents, patient/client satisfaction and patient/client safety. The RCPC is aware that the Home and Community Care Council considered a number of these or similar indicators in the development of the Provincial Performance Management Framework in 2007-08 and the RCPC encourages further examination of quality worklife indicators as the Provincial Performance Management Framework evolves.

3. The RCPC is pleased that a validated staff work life performance measure will be incorporated into the Provincial Performance Management Framework and notes that the Quality Worklife - Quality Healthcare Collaborative Standard QWL Indicators include “Health Provider Satisfaction” along with other suggested indicators. The RCPC is aware that a variety of questionnaires and tools are currently used to assess “health provider satisfaction” and, while we do not recommend any specific questionnaire or tool be mandated, we do recommend that any such assessment tool include standard questions such as identified in the JQWC report which contains the CCHSA-OHA Pulse Survey Questions as follows:

**CCHSA-OHA Pulse Survey Questions**

a. I am satisfied with communications in this organization.

b. I am satisfied with communications in my work area.

c. I am satisfied with my supervisor.

OR

I believe that my supervisor...

i. Is competent and knowledgeable.

ii. Communicates honestly with employees.
iii. Cares about the best interests of employees.
iv. Does not withhold important information from employees.
v. Can help solve important problems faced by our organization.
d. I am satisfied with the amount of control I have over my job activities.
e. I am clear about what is expected of me to do my job.
f. I am satisfied with my involvement in decision making processes in this organization.
g. I have enough time to do my job adequately.
h. I feel that I can trust this organization.
i. This organization supports my learning and development.
j. My work environment is safe.
k. My job allows me to balance my work and family/personal life.
l. In the past 12 months, would you say that most days at work were (choose one) not at all stressful, not very stressful, a bit stressful, quite a bit stressful, extremely stressful.
m. In general, would you say your health is ...excellent, very good, good, fair, poor.
n. In general would you say your mental health is ...excellent, very good, good, fair, poor.
o. In general would you say your physical health is ...excellent, very good, good, fair, poor.
p. How satisfied are you with your job? Very satisfied, somewhat satisfied, not too satisfied, not at all satisfied.
q. In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day).
r. During the past 12 months, how many days did you work despite an illness or injury because you felt you had to? (counting each full or partial day as 1 day).
s. How often do you feel you can do your best quality work in your job? (Never, rarely, sometimes, often, always).
t. Overall, I am satisfied with this organization.
u. Working conditions in my area contribute to patient safety.
III. DISCUSSION

(i) Background

While the focus of this report is on identifying strategies that support a more positive work environment for staff, it is important to remember that these strategies also contribute to better resident care.

There have been a number of journal articles and reports regarding the development of staffing frameworks that are evidence-based and consider all the important variables, including the complexity involved in matching human resources to resident needs. As the complexity of care needs has risen, so has the need for adequate and appropriate staffing. The literature also indicates that staffing levels and mix are not the sole factors that impact a positive work environment, including resident outcomes and job satisfaction. Many other factors, including organizational characteristics, management practices, work culture, education and experience of staff, clinical leadership, and resident needs and complexity all have an impact.

Boothman’s research found that access to structural empowerment had a statistically significant positive effect on the reported provision of individualized care to residents and, if care providers have access to such empowerment they are more apt to contribute constructively and effectively to the achievement of the organizational goal of the provision of high quality, individualized care. Clements et al note that the evidence for inter-professional coordination and teamwork continues to grow and it appears that teamwork and team composition could have positive effects, particularly in quality and safety, including reducing medical errors, improving quality of care, addressing workload issues, building cohesion and reducing burnout of health care professionals.

Shamian et al report that the evidence shows that healthy workplaces improve recruitment and retention, workers’ health and well-being, quality of care and patient safety, organizational performance and societal outcomes. Lowe comments that the 2004 Canadian Adverse Event Study suggested “the greatest gains in improving patient safety will come from modifying the work environment of healthcare professionals, creating better defences for averting [adverse events] and mitigating their effects” and the US Agency for Healthcare Research and Quality has concluded that working conditions affect patient outcomes, including safety.

Murphy reported that the research shows there is a positive relationship between nurse and personal care staffing and quality of care in residential care, as well as a relationship between managerial and organizational factors and quality of care and staffing and job satisfaction and identified key factors associated with residents’ quality of care outcomes. Incidents of aggressive behaviour, restraint use, immobility complications and incidences of pressure
ulcers were found to be associated with such managerial and organizational factors.

Additionally, the Quality Worklife Quality Healthcare Collaborative Report\textsuperscript{xii} notes that “the health and well-being of the health workforce and the quality of the healthcare work environment has a profound impact on the effectiveness and efficiency of healthcare services.”

(ii) Presentations and Articles

\textit{Care Provider Access to Structural Empowerment and Individualized Care}

In November 2007, Sienna Boothman made a presentation to RCPC regarding her Master’s thesis research\textsuperscript{xiii} which showed that access to structural empowerment (i.e. informal power, formal power, information, support, resources and opportunity structures) had a statistically significant positive effect on reported provision of individualized care for residents. Therefore, if care providers have access to informal power, formal power, information, support, resources and opportunity structures in a LTC facility, they are more empowered to contribute constructively and effectively to the achievement of the organizational goal of the provision of high quality, individualized care. Support, especially in the form of enabling access to educational opportunities and the provision of rewards and recognition for a job well done seem to be particularly significant empowerment factors for formal care providers. “Support” refers to guidance and feedback received from subordinates, peers and supervisors to enhance effectiveness. “Informal power” contributed directly to the measurement of empowerment among care aides. “Informal power” refers to power derived from the quality of alliances and relationships with people in the organization. This finding suggests that the quality of work relationships may have a direct and meaningful influence on care aides’ ability to provide individualized care.

Interestingly, there was no statistically significant relationship between the care providers’ reported levels of access to structural empowerment and the specific model of care (e.g. Eden Alternative, Gentle Care, Person-Centred Care) that management had implemented. Boothman found that only 35% of care staff (both RN/LPN and care aides) agreed with management as to which model of care had been implemented within their facility. This result indicates that there is a gap between the perceptions of managers and formal care providers regarding models of care within their respective LTC Facilities. Finally, staff who concurred with managers regarding the implemented model of care reported moderately higher levels of access to informal power than those who didn’t, slightly higher levels of access to information than those who didn’t and marginally higher levels of access to opportunity than those who didn’t. These results reveal the importance of ensuring that staff are aware of what model of care has been
implemented in the facility and may also represent the significance of open and effective communication between managers and staff.

Czorny Alzheimer Centre

In January 2008 the RCPC received a presentation on the Czorny Alzheimer Centre. This provided the RCPC with a concrete example of how an organization had structured and organized a positive living environment for people living with Dementia and their families including:

- helping community members (elders, families, and staff) to clearly understand the vision and direction of the organization and the responsibility of each group in creating that vision;
- hiring the right people for the work;
- involving community members (elders, staff, families) in decision making;
- nurturing and caring for staff needs;
- grouping of staff into smaller teams where work is focused on improving team functioning;
- outstanding leadership providing practical, consistent, visible support to staff; and
- creating a substantive learning environment.

Study on Low Injury Rate Factors

In March 2008 the RCPC was provided with a presentation about “Reducing Injuries in Intermediate Care” (2003 study which explored contributing factors to the high injury rate among care aides and LPNs in long term care, identified factors that mitigate high injury rates and made recommendations for successful intervention strategies to lower injury rates. The study was guided by an Advisory Committee comprised of WCB, MoHS, HBT, HEABC, HEU, and BCNU. In this study, 8 long term care facilities were compared: 4 identified as relatively low injury risk (LIRFs) and 4 identified as relatively high injury risk (HIRFs). The study identified that workers in LIRFs have better access to information; clearer understanding of policies; more involvement in care planning; better support from managers; and more positive beliefs about their facilities' quality of care.

The study offered the conclusion that a successful (i.e. low injury rate) facility would operate with the following elements:

- An engaged environment:
  - multidisciplinary teamwork is cultivated;
  - feedback and initiative are encouraged by participatory meetings and by manager responsiveness;
flexibility with residents is supported by RNs and personnel in other departments; and
follow-up to problems is visible.

- A substantive philosophy of care:
  - clear and realistic expectations about the model of care backed up by training/education that does not idealize working conditions, but rather works with them; and
  - values are modeled by managers in dealings with staff, in a climate of mutual respect, trust and fairness.

- Concrete policies and practices:
  - policies are clear and visible, e.g. no manual lifting;
  - policies are consistently monitored and enforced by peers, RNs and managers;
  - staffing levels are appropriate;
  - mechanical lifts are accessible;
  - programming and services for residents are comprehensive; and
  - training and staff development are ongoing and inclusive.

**Effective Teamwork in Healthcare**

In “Effective Teamwork in Healthcare: Research and Reality” the authors review the evidence for effective teamwork, primarily that gathered by a research team funded by the Canadian Health Services Research Foundation (CHRSF) and through expert opinion provided by a group of 25 researchers and decision makers convened by the CHRSF in late 2005 at a forum for discussion about issues related to effective teamwork.

The authors conclude that the empirical evidence from high-risk work environments tells us that collaboration and teamwork is a way to produce high-quality results. In the health workplace, they note that the evidence for inter-professional coordination and effective teamwork continues to grow and they opine that while the link is not definitive, it appears that teamwork and team composition could have positive effects, particularly in quality and safety, including reducing medical errors, improving quality of care, addressing workload issues, building cohesion and reducing burnout of healthcare professionals. The CHRSF synthesis references a range of potential benefits from effective teamwork gleaned from selected teamwork initiatives including improved communication and partnership among health providers and patients; clarity on the role of all health providers; better response processes in addressing the
determinants of health; improved coordination of healthcare services; high levels of satisfaction on the delivery of services and effective use of health resources.

One major focus of the CHSRF discussions was to identify why previous or existing efforts to implement collaborative practice in healthcare organizations had succeeded or failed to meet expectations. Factors that were signals to likely failure in implementing collaborative practice included a lack of time to bring people together to reflect and change; insufficient inter-professional education, including continuing education and the persistence of professional silos; systems of payment that do not reward collaboration; few links between collaborative practice and individual goals; and the absence of efforts to capture evidence for success and communicate this to key stakeholders, including the public.

The key factors underpinning success for collaborative practice initiatives were identified as:

- leadership and having champions who can drive change management processes;
- clarity regarding roles on the part of all team members; and
- trust, respect, value and being valued within the team work setting and cultural readiness within the workplace or significant efforts to create a culture of acceptance.

**Healthy Workplaces**

The authors of "Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice" note that over the past few years healthy workplace issues in Canada have been on the agenda of many governments and employers and evidence shows that healthy workplaces improve recruitment and retention, workers’ health and well-being, quality of care and patient safety, organizational performance and societal outcomes. The purpose of this paper was to provide a progress update on knowledge transfer and uptake of research evidence in policy and practice. The authors note that there is not yet a standardized and comprehensive definition of "healthy workplaces" so they define "healthy workplaces" as "mechanisms, programs, policies, initiatives, actions and practices that are in place to provides the health workforce with physical, mental, psychosocial and organizational conditions that, in return, contribute to improved workers’ health and wellbeing, quality of care and patient safety, organizational performance and societal outcomes”.

The Shamian paper is divided into two sections: a review of the progress that had been made on healthy workplace issues in terms of research, policy and practice and an outline of “next steps” in these areas for moving forward with the healthy workplace agenda. In “next steps” for practice they identify the following:

- healthy workplace targets developed by the Health Council of Canada need to be implemented for 2008;
the notion of “professional development to lifelong learning” should be broadened to make it more inclusive with professional development a regular part of budget planning and time provided for staff to enhance their training;

- exploration of collective agreement barriers or facilitators to creating quality practice environments;

- improvements to management and leadership, such as more on-the-job leadership training to help supervisors and middle managers do a better job of managing the tension between productivity and workers’ health and safety;

- people expect healthcare organizations to act with social responsibility and serve as good stewards of resources to make every effort to provide good working conditions for health workers, which translate into greater quality of care;

- different styles of management and leadership are recommended;

- reduce absenteeism and turnover and improve performance through compensation adjustment, work incentives and safe working conditions;

- healthcare organizations should develop a statement of clear vision and values that reflects the importance of supporting healthy workplaces;

- employers need to monitor and evaluate the implementation and impact of health workplace initiatives on front-line healthcare workers; and

- Healthy Work Environment Best Practice Guidelines established by the RNAO should be used as tools for the development and sustainability of a healthy work environment.

**Violence Against Personal Support Workers**

In “Out of Control: Violence against Personal Support Workers in Long-Term Care” Banerjee et al drew on an international study comparing long-term facility-based care across three Canadian provinces (Manitoba, Nova Scotia and Ontario) and four Nordic European countries (Denmark, Finland, Norway and Sweden) that showed the Canadian personal support workers were almost seven times more likely to experience violence on a daily basis with nearly half (43%) of the workers being subjected to violence every day. The authors provided the following recommendations:

- Governments must recognize chronic short-staffing as a key contributor to workplace violence. Governments need to address short-staffing by legislating adequate care standards and by providing the funding to meet these standards.

- An empowering work environment needs to be fostered; one that gives personal support workers a true voice in how their work is designed, organized and scheduled.
 ➢ Documentation of violence is necessary and this will not be successful until the culture of blame is addressed.

 ➢ Appropriate training that recognizes the complete medical, mental, emotional and social needs of residents is essential. Workers must be supported so that they have the time and resources to attend training sessions. Training must be accessible (on paid time, with absent staff replaced), designed with worker input, credentialed, and comprehensive.

 ➢ Long-term care must be recognized as an essential health service and become a national priority.

**Shaping a Safety Culture**

In *The Role of Healthcare Work Environments in Shaping a Safety Culture* the author discusses the importance that workplace environment factors such as work features and occupational or organizational practices play in creating a culture of safety. In the introduction the author notes that patient safety is a basic goal of all Canadian healthcare organizations; yet there is still much to learn about the determinants of safety and one of the biggest knowledge gaps is how workplace factors influence safety outcomes. The background comments note that the 2004 Canadian Adverse Events Study suggested “the greatest gains in improving patient safety will come from modifying the work environment of healthcare professionals, creating better defenses for averting [adverse events] and mitigating their effects” and the US Agency for Healthcare Research and Quality has concluded that working conditions affect patient outcomes, including safety. The study is based on a 2006 Health Sciences Association of Alberta survey of allied health professional and technical workers in Alberta which provided an opportunity to examine specific employee characteristics and workplace factors associated with a strong or weak safety culture. In this study the author found that specific work environment factors were consistently and significantly associated with safety culture. The five core concepts that were identified as the key work environment underpinnings of a safety culture (and obvious levers that can be used to develop safety-focused work-place cultures) are fair processes in workplace, team or unit; teamwork; learning environment; supportive immediate supervisor and “people leadership” by senior management. Overall, the importance of work environment factors, especially teamwork and fair processes, overshadowed that of any other influences on safety culture that were measured.

In discussion of the study and its findings, the author notes that given the serious recruitment and retention challenges faced by health care employers, it is useful to consider how a safety culture contributes to key employee outcomes that, increasingly, align with their strategic goals. A comprehensive perspective on safety culture is presented in the following logic model.
In conclusion, the author notes that the key findings of this study were a high-quality environment is a cornerstone of a healthcare safety culture; teamwork, fair workplace practices, supportive and people-centred supervision and leadership and a learning environment contribute to a culture that values safety; this safety culture itself is associated with positive quality of work-life outcomes for employees – they experience their work environments as healthy and safe, are more satisfied and have pride in what they do; employers also benefit from safety cultures because of the links to commitment and engagement; and the findings also highlight the importance of teamwork – now often described as collaborative, inter-professional patient centered care – as a pathway for health system renewal.

Residential Care Literature

In 2006, the Murphy Report, funded by the BC Nursing Directorate and guided by a multi-stakeholder Advisory Committee, reviewed the literature on nurse and personal care staffing and quality of care in residential care. Murphy examined literature related to two areas specifically: (i) the relationship between nurse and personal care staffing and resident quality of care; and (ii) organizational and managerial characteristics and their impact on nurse and personal care staffing and quality of care. The literature review points to a positive relationship between nurse and personal care staffing and quality of care in residential care. In addition, the relationship between managerial and organizational factors and quality of care, staffing and job satisfaction in residential care is examined. In this regard, the research shows that there are key managerial factors associated with residents’ quality of care outcomes. Incidents of aggressive behaviour, restraint use, immobility complications and incidences of pressure ulcers have been found to be associated with the following managerial and organizational factors:

➢ Managerial Factors
  ❖ Open communication
  ❖ Opportunities for input and participation in care decisions
  ❖ Relationship oriented leadership
Clearly defined work processes
Fair supervision
Opportunities for training and career mobility for care aides

Organizational Factors
- Use of full time versus part time and contract staff
- Director of Nurses’ tenure and experience
- RN, LPN, and Care Aide turnover and retention

Because turnover and retention of nursing staff have been found to be associated with quality of care, this review included an examination of organizational and managerial factors impacting turnover and job satisfaction which were similar to those listed above. Factors also included clear organizational goals; emphasis on employee welfare and relationships; involvement in care planning decisions; supportive management and staff relationships; considerate listening; respect and trust; and opportunities for personal growth and development. The Murphy Report concluded with suggestions for further discussion and research on quality of care, staffing and managerial factors, and organizational factors.

Patient Safety Agenda and Long Term Care

"Broadening the Patient Safety Agenda to Include Safety in Long-Term Care" discusses findings from key informant interviews that were conducted in May 2007 by the Canadian Patient Safety Institute, Capital Health (Edmonton) and CapitalCare (Edmonton). The purpose of the interviews was to identify safety issues in LTC. The following twelve themes were identified as factors, priorities and gaps in resident safety in long term care:

1. **Balance between Safety and Quality of Life** – It is important to examine both the effects of safety interventions on the incidence of adverse events and the impact of those interventions on residents’ quality of life.

2. **Staff Knowledge, Skills and Training** – Barriers include the availability of adequate training programs for best practices and the ability to cover staff when they are off the floor. Priority areas for education include techniques around redirecting and re-focusing frustrated and aggressive residents, dementia care, identifying and recognizing risks, use of equipment and infection control.

3. **Increasing Clinical Complexity of Residents** – Staffing levels and staff knowledge and abilities have not increased to meet the rise in need. Recruiting and retraining staff to work with the increasingly complex LTC client has become more difficult.
4. **Equipment and Technology** – Due to resource limitations, it is not always possible to purchase appropriate equipment. Risk is increased if staff members are not trained in the proper use of the equipment, proper protocols are not in place regarding the use of the equipment, equipment is not in good working order and the equipment is not appropriate for the resident.

5. **Physical Environment** – Respondents discussed challenges with older buildings resulting from small or shared bathrooms, insufficient storage space, too much clutter, poor lighting and insufficient access to sinks. Renovations and upgrades to older buildings can have a positive impact on safety when the changes are made with safety in mind.

6. **Communication between Management, Staff, Residents and Families** – Accurate and complete documentation is essential to prevent errors and ensure consistent and adequate care. Communication with family about the progression of residents’ diseases is important so that family members do not put residents in unsafe situations.

7. **Medication Management** – There is a need to ensure that the drugs prescribed are appropriate for the residents, medication reviews are effective, instructions regarding medications are communicated accurately and the right drugs are administered to the right people, in the right dose, at the right time.

8. **Aggressive Resident Behaviours** – Managing the behavioural challenges posed by residents with dementia, brain injury and mental health issues can be difficult, especially when one is attempting to minimize the use of restraints.

9. **Falls** – Falls are a key safety issue in LTC because of the frailty of the population. Medications, physical environment, social environment, equipment and facility policies can impact residents’ risk of falling.

10. **Infection Control** – Hand-washing, glove use and influenza vaccinations reduce risks. Ensuring buy-in on infection-control procedures from staff on the front-lines is essential.

11. **Restraints** – There is still some resistance to the policy of least-restraint from family and staff. Funding for alternatives to restraints is sometimes an issue.

12. **Staffing** – There is insufficient funding to ensure adequate staff-to-resident ratios and adequate numbers of support people such as educators and infection-control practitioners. It has become more difficult to recruit and retain staff.

The authors’ conclusion is that little research has focused on LTC and other areas outside of the acute care setting. Progress in resident safety in Canadian LTC settings is imperative to improve the safety of frail elders in this setting.
Research on safety in LTC is necessary to guide policy and to improve the quality of care.

**Ceiling Lift Coaching Program**

In July 2007 Vancouver Coastal Health issued a final report on the Health and Safety Initiative Funding for Ceiling Lift Coaches which was presented to the RCPC in April 2009. Based on an analysis and review of all injuries coded as musculoskeletal, VCH estimated that 40% of all musculoskeletal injuries could be prevented by use of ceiling lifts. To achieve that reduction it was important not only to provide ceiling lifts in areas where patients or residents require assistance with lifting or transferring but also to insure that the lifts were used by health care providers for all appropriate activities. In the belief that there was potential to increase the utilization of ceiling lifts for patient care areas, VCH and WorkSafeBC piloted the development of Ceiling Lift Coaches on selected units.

Three residential facilities and one sub-acute rehab facility agreed to participate and 10 front line staff coaches (9 care aides and 1 LPN) volunteered to participate in the program. In collaboration with the Vancouver Coastal Health Musculoskeletal Injury Prevention advisors (MSIP team) facilitators developed a 5 day program for the coaches incorporating training in body mechanics, ergonomics, patient handling, ceiling lift techniques both basic and advanced, as well as communications, coaching and facilitation skills. Throughout the program the coaches, assisted by their respective MSIP advisors provided 1:1 and small group coaching and facilitation with respect to safe patient handling techniques and ceiling lift use. They worked with managers and staff to identify and problem solve specific barriers to ceiling lift use and for other staff safety issues and worked – both on their coaching shift and regular duty shifts – to model safe work behaviour.

The program ended May 30, 2007 and evaluation of the project was undertaken with the assistance of the Occupational Health and Safety Agency for Healthcare (OHSAAH). The evaluation provided as follows:

- The program received overwhelmingly positive feedback from management and staff. In addition to encouraging full utilization of ceiling lift technology, coaches were instrumental in devising sling management systems, problem solving maintenance issues and tackling other issues impacting staff safety, e.g. the need for adaptive clothing for residents.

- In comparing the incidence of accepted MSI time loss injury claims at the three VCH pilot sites the median incidence dropped 42% for the quarters following implementation from 12 per quarter to 7 per quarter.

- In addition, there appeared to be significant benefits in terms of heightened safety awareness in general as a result of the program as the incidence of all time loss injury claims dropped 45% from a median of 16.5 per quarter to 9 per quarter.
Most encouraging was the drop in injury rates - when measured for all three VCH pilot sites for the three quarters prior to the introduction of the program as compared with the two quarters following the implementation of coaches with a 30% drop in the rate of all injuries and an 18% drop in the MSI injury rate.

The conclusion of the Report was that the Ceiling Lift Coaching Program was an effective mechanism, in conjunction with education and training programs, for creating behaviour changes in the workplace and the peer mentoring approach showed great promise in terms of creating a true safety culture within healthcare. The model was so successful that VCH funded another round of Coaching through internal resources with the three VCH pilot sites continuing to participate. Further expansion of this peer mentoring approach has included all aspects of patient/resident handling, including transfers and repositioning. The GF Strong program expanded to cover the whole facility and two other departments included (Evergreen House, a residential care facility on the North Shore and two critical care units at Vancouver General Hospital). VCH also planned to utilize this approach to other large scale change management initiatives.

**Enabling Care Aide Leadership**

In May 2009, author Catherine Fast published her Master's thesis “Not Just a Care Aide: Enabling Leadership in the Forgotten Front Line, the Role of Peer Coaching” and in it she notes that Vancouver Coastal Health and OHSAAH are currently collaborating on a comprehensive evaluation of the Ceiling Lift Coaching Program, which will examine in more detail the impact of a peer coaching model on injury rates at intervention and control site, as well as include a cost-benefit analysis. Fast's thesis examined the Ceiling Lift Coaching Program from the perspective of the development of RCA leadership skills which were an unintended consequence of the ceiling lift coaching program. Fast concluded, among other things, that the organizational benefits to VCH of developing RCA leadership capacity are the development of employee engagement, the creation of frontline leaders to serve as change agents and conduits for knowledge transfer and translation and the establishment of a framework for a learning organization based on a model of shared leadership.

**Safety Culture and Front-Line Involvement**

Another example of front-line worker involvement strengthening the safety culture was presented in a Research Release from Fraser Health. In that project the objective was to determine ways in which the elements of positive work culture in a “best performer” environment could be replicated in other worksites. A facility with consistently lower rates of injury compared to other care units despite frequent changes in management, constant organizational restructuring and receiving the same type of and numbers of equipment to reduce risk of injury to care staff was identified as a “best performer”. Team members from a facility
where improvements were to be made observed a number of work shifts at the best performer site, including job shadowing and informal interviewing with the purpose of identifying the key elements that help that work group achieve a safe working culture. Their findings served to develop a survey tool to identify key gaps between sites with the information serving as a starting point in the development of action plans for their own work environment. Three interventions were delivered involving relocating the ADL sheet for easier access, improvements in communication, and a comprehensive education and training program was developed with regularly scheduled biweekly sessions delivered by front-line staff.

Quality Worklife – Quality Healthcare Collaborative

In June 2005, ten national healthcare organizations\(^{xxv}\) partnered to form the Quality Worklife – Quality Healthcare Collaborative (QWQHC). The QWQHC mandate is to develop a pan Canadian Quality Worklife – Quality Healthcare Framework and Action Strategy which was released in April 2007 in Within our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada’s Healthcare System 2007”\(^{xxvi}\). This action strategy identifies three focused areas of immediate action (i) quality worklife measurement and reporting (ii) implementation of improvement strategies and (iii) knowledge exchange.

The QWQHC operates from a shared belief that it is unacceptable to fund, govern, manage, work in or receive care in an unhealthy healthcare workplace. The QWQHC has developed a “Healthy Healthcare Leadership Charter” to assist health leaders in signaling their commitment to action. That Charter, which has been signed by all six BC health authorities, provides as follows:

This Charter is intended to support the continuous improvement of the health of all Canadian Healthcare workplaces and providers. It is founded on the principle that a fundamental way to better healthcare is through healthier workplaces, and that it is unacceptable to work in, receive care in, govern, manage and fund unhealthy healthcare workplaces.

A healthy healthcare workplace is a work setting that takes a strategic and comprehensive approach to providing the physical, cultural, psychosocial and work/job design conditions that maximize health and well-being of healthcare providers, quality of patient outcomes and organizational performance.

Health human resources should be viewed and treated as core assets of the health system. A high quality of worklife is required for the retention of our finite number of resources. Quality of worklife is important for the delivery of effective, efficient and safe patient/client care.

Our vision is for Canadian health providers to achieve optimal health and work in healthcare settings that demonstrate healthy workplace leadership, management
and accountability practices. Canada’s health system needs a comprehensive and collaborative approach to workplace and workforce renewal that does not pit one organization against another in a zero-sum quest for recruitment. By working together to build, implement, evaluate and share healthy workplace leading practices, we will achieve this vision.

We agree with these principles and will act now to...

- Make quality of worklife a strategic priority.
- Assess monitor and report on quality of worklife (QWL) indicators including the Standard QWL indicators identified by the QWQHC.
- Identify one or more priority action strategies that we will implement and evaluate.
- Identify and build knowledge on leading practices related to healthy workplaces.
- Exchange knowledge and network with other health leaders on healthy workplace practices.

The Quality Worklife - Quality Healthcare Collaborative has identified standard Quality Worklife Indicators (QWL) that they advocate all health organizations build into their management information systems, performance agreements and accountability reports with a goal of having a national benchmarking report of these QWL indicators to assist organizations in identifying areas for focused improvement, setting annual targets and identifying potential leading practices to develop, share and translate to other organizations across the country. The standard QWL indicators include turnover rate, vacancy rate, training and professional development opportunities, overtime, absenteeism, workers compensation lost time incidents, health provider satisfaction, patient/client satisfaction and patient/client safety. The JQWC report contains the CCHSA (now Accreditation Canada)-OHA Pulse Survey Questions as a list of recommended standard questions for assessing health provider satisfaction.

The QWQHC sets out several organizational and system actions to help the health community work together to build healthy workplaces and link improvement to patient/client care outcomes. The QWQHC has identified the four “Priority Actions\textsuperscript{xxxviii} and, for each of these, provides evidence-informed “menus” of leading practices.

The QWQHC believes success can be achieved in the short term if health leaders and their organizations commit to:

1. Making QWL a strategic priority and putting in place appropriate performance expectations and accountability practices.

All publicly funded health organizational leaders and system leaders are challenged to take up the call to action and to signal their
commitment by adopting and signing the Healthy Healthcare Leadership Charter.

2. Measuring QWL - Organizations and systems are challenged to measure and report on the QWQHC’s Standard QWL Indicators with common definitions to facilitate Pan-Canadian benchmarking and monitoring.

3. Implementing one or more strategies to improve QWL and evaluating these initiatives.

Four priority actions for health organizations and four priority actions for health system leaders are provided along with menus of leading practices and an overall recommended change process to aid in the focused implementation of QWL initiatives.

4. Building good internal and external knowledge exchange to continue to share, learn and improve.

The QWQHC Knowledge Network aims to actively connect explicit (formal) knowledge (e.g. research findings) and tacit (informal) knowledge (e.g. frontline experiences); and plans to provide a one-stop shopping approach to frontline QWL champions/change agents, organizations, policy makers and researchers to connect on QWL issues in healthcare.

The QWQHC report notes that across the country, many initiatives are underway which improve the quality of worklife for health providers; however, they are often isolated due to lack of coordination, integration and shared learning. Collaborative efforts are required to ensure an increase in the pace and effectiveness of these efforts. The Report further notes that national and provincial human resource initiatives have focused mainly on managing the dynamics of the supply and demand of health providers and that a broader focus and coordinated effort is needed so that health providers are viewed – and treated- as core long term assets of the health system.

**Accreditation Canada**

The RCPC received a presentation about the relatively new methodology which Accreditation Canada is utilizing to evaluate the quality of health care services. Accreditation Canada is a national, non-profit organization with the mandate to help organizations across Canada to examine and improve the quality of services they provide. A new program called QMentum was implemented in 2007 to emphasize the continuous cycles of quality improvement and the role of frontline staff in quality improvement and resident safety. For example, care aides along with all other colleagues rate their residential setting using national long term care standards. As well, all staff participate in a worklife and safety culture survey. Staff teams review their questionnaire results and prioritize which areas to target action plans and hold themselves accountable to. Surveyors trace
clinical and administrative processes through dialogue with front-line providers during the survey portion of the three year quality improvement cycle. The role of care aides is recognized in the new program through greater involvement of all staff who contribute to quality and safety.

**Collaborative Practice Initiative**

In January 2009, at the point when the RCPC began to explore potential viable recommendations, it received a presentation about a report on a business case for collaborative practice that was being developed within the Ministry of Health Services which proposes a “capacity centre” for collaboration be established in the province which would:

- Connect and solidify interprofessional education, practice and research expertise to enhance collaboration in healthcare
- Actively engage in collaborative interprofessional activities or programs designed to facilitate change by serving as a catalyst for enhanced professional practice. These collaborations would facilitate best practices in interprofessional education and service.
- Work in close partnership with those already seen as leaders in interprofessional education in BC such as the College of Health Disciplines, the Rural Co-ordinating Centre of BC, the BC Academic Health Council, as well as existing interprofessional models throughout BC health authorities and post secondary education system.

The goals of such a capacity centre would be to:

- Enable inter-professional education and inter-professional collaborative practice in key service delivery settings such as primary health care, chronic disease management, patient safety, rural and aboriginal health.
- Embed inter-professional education in all BC health professional training programs across academic and clinical settings.
- Improve health outcomes for British Columbians.
- Facilitate system change in both post secondary education and health service delivery in support of inter-professional education for collaborative patient-centred care.
- Promote knowledge exchange across BC health and education sectors, and provider groups.
- Serve as the definitive provincial resource on all facets of inter-professional education and inter-professional collaborative practice.
- Create an organization that embraces the values of operational excellence, customer/stakeholder service, flexibility, and responsiveness.
A number of examples were provided on how inter-professional education and practice make a difference, such as improved access and shorter wait times for patients/clients; improved safety and better patient outcomes; greater public confidence in the system; decreased morbidity; lower costs of care; greater emphasis on prevention and social determinants of health; greater provider satisfaction and enhanced recruitment and retention.

Inter-professional collaboration is important in the residential care sector because complex care of the older adult requires multiple areas of expertise; inter-professional teams have been studied more in the geriatric setting than in any other; and residential care provides a unique context that leads itself to inter-professional collaboration focused on resident and family needs. There was an acknowledgment in the presentation that there is a significant amount of inter-professional and collaborative practice occurring in British Columbia and that some of the strongest evidence for such activity comes from the residential care sector where, on a practical basis, there is a great deal of collaborative practice occurring.

In November 2009 an update was provided to the RCPC. There is still commitment to the concept of a “capacity centre for collaboration” although funding priorities do not allow for immediate realization of the work as previously contemplated. The project lead is currently working with the College of Health Disciplines at UBC and the work to date resides with the Interprofessional Rural Program of BC.

(iii) Provincial Performance Management Framework for Residential Care Facilities

In April 2008 the RCPC received a presentation and handout on the Ministry of Health Home and Community Care services and the Provincial Performance Management Framework for Residential Care Facilities, April 1, 2008. It was noted that the document had been in development for over a year and was still a “work in progress”. The purposes of the Provincial Performance Management Framework for Residential Care Facilities are to:

1. support the provision of quality services and care to residents of home and community care residential facilities;
2. improve the health outcomes of facility residents; and
3. support a consistent approach to performance management in facilities across the province.

The framework was jointly developed by a task group comprised of representatives from the five regional health authorities, BC Care Providers Association, Denominational Health Association and Ministry of Health Services. Once the framework is completed and put into effect it will be the first time there
will be a provincial requirement to report using the same measures and indicators.

Performance management includes the following components:

- Performance standards – establish the level of performance expected to improve the health outcomes of facility residents.
- Performance measures – the specific quantitative representation of a capacity, process or outcome deemed relevant to the assessment of performance.
- Reporting of progress – documentation and reporting of progress in meeting standards and sharing of information through feedback.
- Quality improvement – a program or process to manage change and achieve quality improvement in facilities based on performance standards, measures, and reports.

Residential Care Performance Standards are to be consistent with the Ministry of Health Services Model Standards for Continuing Care and Extended Care Services (Model Standards).

Performance Measures are organized according to four of the eight dimensions of quality (efficiency, effectiveness, safety and client-centered services). As InterRAI is implemented more fully, many of the clinical quality performance indicators will be captured by that instrument. A staff work life performance measure will be developed in the future based on the national research and development work currently underway by the CCHSA and other standard setting bodies. Many of the Health Authorities are using the Gallop 12 instrument and have asked the CCHSA to incorporate that instrument into the CCHSA dimensions of quality.

RCPC members acknowledged that there has been some progress in consistency in reporting various indicators across the province and were pleased that one of outcomes of this new framework would be a provincial requirement to report using the same measures and indicators. There were concerns expressed about the “physical health” nature of many of the ten performance measures, e.g. falls resulting in injury; new fractures; pressure ulcers; weight loss; and medication administration errors and a suggestion made that there be a measure related to quality of life that was completed or contributed to by the resident.

The RCPC was invited by the Home and Community Care Council to provide comments and/or recommendations regarding the framework to the Home and Community Care Council. The RCPC wishes to thank the Home and Community Care Council for this opportunity and provides the following comments and recommendations:
1. The RCPC supports the importance of provincial consistency in the definitions and reporting of measures and indicators in the Provincial Performance Management Framework.

2. The Quality Worklife-Quality Healthcare Collaborative that has been endorsed by all of the Health Authorities offers a number of quality worklife indicators such as turnover rate, vacancy rate, training and professional development opportunities, overtime, absenteeism, workers compensation lost time incidents, patient/client satisfaction and patient/client safety. The RCPC is aware that the Home and Community Care Council considered a number of these or similar indicators in the development of the Provincial Performance Management Framework in 2007-08 and the RCPC encourages further examination of quality worklife indicators as the Provincial Performance Management Framework evolves.

3. The RCPC is pleased that a validated staff work life performance measure will be incorporated into the Provincial Performance Management Framework and notes that the Quality Worklife - Quality Healthcare Collaborative Standard QWL Indicators include “Health Provider Satisfaction” along with other suggested indicators. The RCPC is aware that a variety of questionnaires and tools are currently used to assess “health provider satisfaction” and, while we do not recommend any specific questionnaire or tool be mandated, we do recommend that any such assessment tool include standard questions such as identified in the JQWC report\textsuperscript{xxiv} which contains the CCHSA-OHA Pulse Survey Questions as follows\textsuperscript{xxxv}.

**CCHSA-OHA Pulse Survey Questions**

a. I am satisfied with communications in this organization.
b. I am satisfied with communications in my work area.
c. I am satisfied with my supervisor.

OR

i. I believe that my supervisor...

ii. Is competent and knowledgeable.

iii. Communicates honestly with employees.

iv. Cares about the best interests of employees.

v. Does not withhold important information from employees.

vi. Can help solve important problems faced by our organization.

d. I am satisfied with the amount of control I have over my job activities.
e. I am clear about what is expected of me to do my job.
f. I am satisfied with my involvement in decision making processes in this organization.
g. I have enough time to do my job adequately.
h. I feel that I can trust this organization.
i. This organization supports my learning and development.
j. My work environment is safe.
k. My job allows me to balance my work and family/personal life.
l. In the past 12 months, would you say that most days at work were (choose one) not at all stressful, not very stressful, a bit stressful, quite a bit stressful, extremely stressful.
m. In general, would you say your health is …excellent, very good, good, fair, poor.
n. In general would you say your mental health is …excellent, very good, good, fair, poor.
o. In general would you say your physical health is …excellent, very good, good, fair, poor.
p. How satisfied are you with your job? Very satisfied, somewhat satisfied, not too satisfied, not at all satisfied.
q. In the past 12 months, how many days were you away from work because of your own illness or injury? (counting each full or partial day as 1 day).
r. During the past 12 months, how many days did you work despite an illness or injury because you felt you had to? (counting each full or partial day as 1 day).
s. How often do you feel you can do your best quality work in your job? (Never, rarely, sometimes, often, always).
t. Overall, I am satisfied with this organization.
u. Working conditions in my area contribute to patient safety.

(iv) Positive Work Environment Themes
Various themes were identified in the presentations and articles which promote a positive work environment. Those themes include teamwork; employee engagement and empowerment; fair, transparent and concrete policies and practices; leadership; safety culture; and education and learning.
1. Teamwork

Teamwork as an important theme arises in the WCB Study, the Clements and Lowe articles and in the Czorny presentation.

In the WCB Study, one of the conclusions reached was that a low injury rate facility was one that operated with an “engaged” environment in which multi-disciplinary teamwork was cultivated.

Clements notes that the CHRSF synthesis references a range of potential benefits from effective teamwork, including improved communication and partnership among health providers and patients; clarity on the role of all health providers; better response processes in addressing the determinants of health; improved coordination of healthcare services; high levels of satisfaction on the delivery of services and effective use of health resources. Factors that were signals to likely failure in implementing collaborative practice included:

- a lack of time to bring people together to reflect and change;
- insufficient inter-professional education, including continuing education and the persistence of professional silos;
- systems of payment that do not reward collaboration;
- few links between collaborative practice and individual goals; and
- the absence of efforts to capture evidence for success and communicate this to key stakeholders, including the public.

The key factors underpinning success for collaborative practice initiatives were identified as:

- leadership and having champions who can drive change management processes;
- clarity regarding roles on the part of all team members; and
- trust, respect, value and being valued within the team work setting and cultural readiness within the workplace or significant efforts to create a culture of acceptance.

Teamwork was one of the five core concepts that were identified by Lowe as the key work environment underpinnings of a safety culture. The measures that were utilized in the work environment study to assess teamwork were:
**Teamwork**

My co-workers are friendly and helpful.
My co-workers treat me with respect.
Communication is good among the people I work with (in workplace, team or unit).
There is a high level of interdisciplinary collaboration (in workplace, team or unit).
There is adequate opportunity to discuss professional practice issues (in workplace, team or unit).

One of the factors identified in the success of the Czorny Centre was the grouping of staff into smaller teams where work is focused on improving team functioning.

2. **Employee Engagement and Empowerment**

Employee engagement and empowerment as contributing themes to a positive work environment and improved resident care are highlighted in the Boothman and WCB studies; in the Czorny Centre presentation and in the “Out of Control: Violence in Long Term Care” article.

Boothman notes that “support”, especially in the form of enabling access to educational opportunities and the provision of rewards and recognition for a job well done seem to be particularly significant in the engagement of formal care providers. “Support” refers to guidance and feedback received from subordinates, peers and supervisors to enhance effectiveness. “Informal power” contributed directly to the measurement of empowerment among care aides. “Informal power” refers to power derived from the quality of alliances and relationships with people in the organization. This finding suggests that the quality of work relationships may have a direct and meaningful influence on care aides’ ability to provide individualized care. Boothman’s study indicates that if care providers have access to information, support, resources an opportunity structures in a long-term care facility, then they are more empowered to contribute constructively and effectively to the achievement of the organizational goal of the provision of high quality, individualized care.

The WCB Study offered the conclusion that a low injury rate facility operates with an “engaged” environment where multidisciplinary teamwork is cultivated; feedback and initiative are recognized and encouraged by participatory meetings; manager responsiveness and flexibility with residents is supported by RNs and personnel in other departments and follow-up to problems is visible.
In the Czorny Centre presentation one of the success factors noted was the involvement of community members (elders, staff, families) in decision making. One of the recommendations in the “Out of Control: Violence in Long Term Care” article was than an empowering work environment – one that gives personal support workers a true voice in how their work is designed, organized and scheduled needs to be fostered to reduce the incidence of violence.

3. Concrete Policies and Practices that are fair and transparent
   The WCB Study identified that workers in low injury facilities had a clearer understanding of policies. It also offered the conclusion that a low injury rate facility operates with concrete policies and practices which are clear and visible, e.g. no manual lifting; policies that are consistently monitored and enforced by peers, RNs and managers; staffing levels that are appropriate; mechanical lifts that are accessible; programming and services for residents that are comprehensive and training and staff development that are ongoing and inclusive. The Lowe study identified fair processes in the workplace as one of the five core concepts of key work environment underpinnings of a safety culture. Lowe’s scale in this regard has the following measures:

   **Fair Processes in Workplace, Team or Unit**
   Rules and policies are fairly applied.
   Rules and policies are consistently applied.
   The hiring and competition process is fair.
   Rules and policies make sense.
   Work is assigned fairly and equitably.

   Murphy reported that the research showed key managerial factors were associated with residents’ quality of care outcomes. Clearly defined work processes were one such factor.

4. Leadership
   As noted previously, Clements identified that one of the key factors underpinning success for collaborative practice initiatives is leadership and having champions who can drive change management processes. Shamian et al proposed improvements to management and leadership, such as more on-the-job training to help supervisor and middle managers do a better job of managing the tension between productivity and workers'
health and safety as one of the next steps to move the health workplace agenda forward. Different styles of management and leadership were also recommended.

Lowe identifies supportive immediate supervisors and people leadership by senior management as two of the core concepts that are key work environment underpinnings of a safety culture. The measures that he utilized for these concepts are:

**Supportive Immediate Supervisor**
- My supervisor listens to and acts upon my suggestions and ideas.
- My supervisor encourages teamwork.
- My supervisor encourages me to be innovative in how I do my job.
- My supervisor supports my career development.
- My supervisor provides timely and constructive feedback on my job performance.
- My supervisor helps me achieve a work-life balance.
- My supervisor shares information.
- My supervisor creates a work environment free of harassment and discrimination.

**People Leadership by Senior Management**
- Those in senior management actively seek employees' ideas about how to do things better.
- Those in senior management take employees' interests into account when planning changes.
- Those in senior management make employees feel valued for the contributions they make to patients and clients.
- Those in senior management effectively communicate to employees about changes that will affect them.
- Those in senior management set realistic performance goals for my area.

Murphy notes that one of the key managerial factors that affect quality care, staffing and job satisfaction is “relationship oriented leadership” and that supportive management and staff relationships impact turnover and job satisfaction which are in turn linked to care outcome. Murphy also recommended the development of positive, respectful, effective resident care teams that include RN/RPNs and LPNs in leadership roles and that recognize the central role played by care aides in the provision of direct resident care.
One of the success factors noted in the Czorny Centre presentation was the outstanding leadership which provided practical, consistent, visible support to staff.

Priority Action 2 in the QWQHC report xxxvi involves the implementation of a comprehensive and integrated human resources, workplace health and organizational development strategy. The report notes that front and mid-level managers play an important role in implementing system change, encouraging front-line workers to adopt and change and facilitating change at upper management or leadership levels. Managers with positive leadership styles (i.e. who develop, stimulate, and inspire followers to exceed their own self-interests for a higher purpose), had more satisfied staff, lower levels of employee turnover, and higher patient/client satisfaction. The menu of leading practices identifies the provision of mentoring for new managers and providing skill development and education for all managers in relation to quality worklife factors and their relation to patient/client care.

5. Safety Culture

The QWQHC Report notes that the health and well-being of the health workforce and the quality of the healthcare work environment both have a profound impact on the effectiveness and efficiency of health service delivery. With staffing shortages affecting more health professions every year there is broad consensus that more must be done to support and retain current employees. The QWQHC reports that across the country, many initiatives are underway which improve the quality of worklife for health providers; however, they are often isolated due to lack of coordination, integration and shared learning. Collaborative efforts are required to ensure an increase in the pace and effectiveness of these efforts. The Report further notes that national and provincial human resource initiatives have focused mainly on managing the dynamics of the supply and demand of health providers and that a broader focus and coordinated effort is needed so that health providers are viewed – and treated – as core long term assets of the health system.

Shamian identifies one of the next steps in moving forward with the healthy workplace agenda is for healthcare organizations to develop a statement of clear vision and values that reflect the importance of supporting healthy workplaces. Additionally, employers should demonstrate that employee health and well-being are an integral part of their strategic plans and healthy workplace indicators and numerical targets should be included.

Rust notes that little research has focused on long term care and other areas outside of the acute care setting. Progress in resident safety in Canadian long term care settings is imperative to improve the safety of
frail elders in this setting and research is necessary to guide policy and to improve the quality of care.

Lowe’s Study identified the five core concepts that are key work environment underpinnings of a safety culture as fair processes in workplace, team or unit; teamwork; learning environment; supportive immediate supervisor; and people leadership by senior management. One of the recommendations in Murphy’s report was that discussion should occur about the support needed to promote a residential care environment that is elder friendly and supports safe work places. In “Out of Control: Violence Against Long Term Care Workers” one of the recommendations is that documentation of violence is necessary and this will not be successful until the culture of blame is addressed.

The Health and Safety Initiative Funding for Ceiling Lift Coaches project found that the use of LPN and care aide coaches was an effective mechanism, in conjunction with education and training programs, for creating behaviour changes in the workplace and this peer mentoring approach showed great promise in terms of creating a true safety culture within healthcare.

6. Education and Learning

Another theme that arose in the presentations and articles that described positive work environments was the benefit of education and learning in a number of different ways.

Boothman’s Study noted that enabling access to educational opportunities was a particularly significant empowerment structure to formal care providers. In the Czorny presentation it was noted that one of the structural processes to their success was creating a substantive learning environment.

One of the conclusions in the WCB study was that low injury rate facilities operate with a number of elements including clear and realistic expectations about the model of care backed up by training/education that does not idealize working conditions, but rather works with them. Another important element was that training and staff development was ongoing and inclusive. One of the signals for likely failure in implementing collaborative practice noted in the Clements article was insufficient interprofessional education, including continuing education.

The “next steps” for practice recommended by Shamian to move forward with the healthy workplace agenda include:

- The notion of “professional development to lifelong learning” should be broadened to make it more inclusive with professional
development a regular part of budget planning and time provided for staff to enhance their training.

- Improvements to management and leadership, such as more on-the-job leadership training to help supervisors and middle managers do a better job of managing the tension between productivity and workers’ health and safety.

One of the five core concepts that Lowe identifies as the key work environment underpinnings to a safety culture is a learning environment. In his study, this was measured with the following:

<table>
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<tr>
<th>Learning Environment</th>
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<tr>
<td>I take initiative in my job.</td>
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<tr>
<td>I learn new ways to do my job better.</td>
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<tr>
<td>I feel that I fully contribute my skills, knowledge and abilities.</td>
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In Murphy’s report it is noted that the research shows that there are key managerial factors associated with residents’ quality of care outcomes. One of the managerial factors identified was opportunities for training and career mobility for care aides. An examination of organizational and managerial factors that impacted turnover and job satisfaction included opportunities for personal growth and development for staff.

Murphy’s recommendations included:

- Development of residential care leadership that has a working knowledge of gerontology, is well versed in licensing and health care policies and demonstrates positive relationship and team building skills.

- Development of clinical team leaders who have knowledge and experience working with older persons and people with disabilities (and where appropriate have certification in Gerontology) and who demonstrate leadership skills.

- Discussion of support required for development of a learning environment and for the provision of accessible continuing education programs for all categories of staff.

Staff knowledge, skills and training was one of the twelve themes identified in the Rust article regarding safety issues in long term care. Key informants identified barriers, including the availability of adequate training programs for best practices and the ability to cover staff when they are off the floor. Priority areas for education included techniques around redirecting and re-focusing frustrated and aggressive residents, dementia
care, identifying and recognizing risks, use of equipment and infection control.

One of the recommendations in "Out of Control: Violence Against Long Term Care Workers" is that appropriate training that recognizes the complete medical, mental, emotional and social needs of residents is essential. Workers must be supported so that they have the time and resources to attend training sessions. Training must be accessible (on paid time, with absent staff replaced), designed with worker input, credentialized and comprehensive.

The above noted theme areas were utilized by the RCPC in developing the recommendations that follow.

(v) Recommendations on Theme Areas

Within the context of the theme areas, the RCPC recommends that:

1. Continued efforts be encouraged to establish a “central capacity centre for collaborative practice” and that within such a centre a dedicated area be established that focuses on residential care and supports implementation of collaborative practice/change management initiatives and interventions that will promote a positive work environment.

   Such initiatives should include:

   i. support for both large projects (e.g. transformation at a facility level) and smaller ones (e.g. communication tools such as S-Bar and safety huddles);

   ii. a funded research component where appropriate; and

   iii. be inclusive of all staff who contribute to resident care (e.g. RCAs, rehab/activity staff, nurses, physicians, etc).

2. A system be developed for sharing tools, educational materials, survey tools, policy documents, guidelines, and links to key resources and support related to enhancing positive work environments. Such a resource is particularly important for small, rural and/or isolated worksites and should be easily accessible and user friendly. The potential for such a system may reside within a shared regional or provincial organization.

3. Employee leadership in areas of patient/staff safety be encouraged and developed to include peer mentoring and involvement such as was done in the Vancouver Health Ceiling Lift Coaching Program and the Fraser Health front-line worker initiative.
4. Front-line supervisor and management leadership training provide skill development and education in relation to quality worklife factors (including employee engagement) and their relationship to patient/resident/client care and safety.
Appendix A – Residential Care Policy Committee Membership

- Valerie St. John, Assistant Deputy Minister, Health Human Resources Planning, Ministry of Health Services (Chair)
- Marcy Cohen, Director Policy and Research, Hospital Employees’ Union
- Elisabeth Drance, Medical Co-Director, Older Adult Program, Vancouver Community Mental Health Services
- Karen Jewell, Advocate/General Counsel, Health Employers Association of BC
- Sandi McGladdery, Coordinator, HCA program, University of the Fraser Valley
- Marnie Mander, RCA, Ridge Meadows Hospital, HEU
- Georgina Mosely, RCA, Glacier View Lodge, HEU
- Chris Norman, Executive Director, St. Jude’s Anglican Home
- Bobbi Pettett, LPN, Northern Health, BCGEU
- Linda Pipe, Chair, Fraser Valley Region, BCNU
- Linda Rose, Director, Vancouver Community, Vancouver Coastal Health
- Val Waymark, Operations Manager, Simon Fraser Lodge
- Patricia Wejr, Senior Policy Analyst, BC Nurses’ Union
- Jacqueline Zilkie, LPN, Victorian Community Health Centre of Kaslo

Support for the Residential Care Policy Committee was provided through the Nursing Policy Section by Donna Smart and Gwen Dowell.

Appendix B – RCPC Working Group Membership

- Marcy Cohen, Director Policy and Research, Hospital Employees’ Union
- Elizabeth Drance, Medical Co-Director, Older Adult Program, Vancouver Community Mental Health Services
- Karen Jewell, Advocate/General Counsel, Health Employers Association of BC
- Linda Rose, Director, Vancouver Community, Vancouver Coastal Health
- Patricia Wejr, Senior Policy Analyst, BC Nurses’ Union

Note that scales for questions a-k and t and u are a 5-point likert scale (Strongly agree to strongly disagree).


Boothman, op cit. This research involved 588 participants (care aides, LPNs, RNs and managers) from 61 facilities in FHA, VCHA and VIHA who were surveyed with the results then processed to explore the relationship between the factors associated with structural empowerment and individualized care.

Joint Project of WCB, HEU, OHSAH, Institute of Health Promotion Research, Canadian Institute of Health Research, UBC; “Reducing Injuries in Intermediate Care: Risk factors for musculoskeletal and violence-related injuries among care aides and
licensed practical nurses in Intermediate Care facilities; February 2003, Vancouver, British Columbia; available on December 23, 2008 at http://www2.worksafebc.com/Portals/HealthCare/Musculoskeletal.asp.

xv Clements et al, op cite.

xvi Shamian et al, op cite


xviii Lowe, op cite.

xix Murphy, op cite.

xx Discussion and review of what clinical practices, skill mixes, staffing, training and education contribute to and promote best practices and the collection of meaningful measurements of care and staffing standards that will result in better outcomes for residents and consistency of client care.

Review, refine and/or develop quality indicators for residents including physical health and well-being indicators as well as quality of life indicators (i.e. indicators that measure social and spiritual aspects of care and that promote resident dignity and respect.

Discussion and review of the communication pathways and processes needed to coordinate the groups that collect and utilize indicators to promote standardized measurement of quality care as well as standardized methodology for collecting and analyzing indicators.

Discussion of clinical research activities that may be undertaken to inform best practices and staffing policies, including but not limited to, research on quality measurements, work loads, and cost-analysis of staffing levels required for optimal care.

xxi Development of residential care leadership that has a working knowledge of gerontology, is well versed in licensing and health care policies and demonstrates positive relationship and team building skills.

Development of clinical team leaders who have knowledge and experience working with older persons and people with disabilities (and where appropriate have certification in Gerontology) and who demonstrate leadership skills.

Development of positive, respectful, effective resident care teams that include RNs/RPNs and LPNs in leadership roles and that recognize the central role played by care aides in the provision of direct resident care.

Support for and development of managerial practices that promote the meaningful inclusion of members of the patient care and nursing team in the planning and delivery of care.

Discussion of support required for development of a learning environment and for the provision of accessible continuing education programs for all categories of staff.

Development of team environments that encourage support and debriefing following episodes of agitation and excessive behaviours.

xxii Discussion of the support needed to promote a residential care environment that is elder friendly and supports safe work places.

Discussion of appropriate staffing and other resources (e.g. lifts, bladder scanners, blanket warmers, etc. needed to maintain best practices.

Discussion and review of the provision of allied health professionals and support services sufficient to provide physical activities as well as social engagement opportunities to make life meaningful.

Discussion of the support needed to ensure that documentation occurs to advance consistent care that is individualized to the client.

xxiii Rust, T.B., Wagner, L., Hoffman C., Rowe, M., Neumann, I.; Healthcare Quarterly Vol. 11 Special Issue 2008.; pp. 31-34.

xxiv Fast, Catherine; “Not just a Care Aide: Enabling Leadership in the Forgotten Front Line, the Role of Peer Coaching”; Masters Thesis; Royal Roads University; May 2009.

xxv "Evidence-based Implementation & Evaluation of a "Safety Culture" in Residential Care Through Involvement of Front-Line Workers", Research Release, Fraser Health Intranet.

xxvi Canadian Council on Health Services Accreditation, Academy of Canadian Executive Nurses, Association of Canadian Academic Healthcare Organizations, Canadian College of Health Service Executives, Canadian Federation of Nurses Unions, Canadian Healthcare Association, Canadian Health Services Research Foundation, Canadian Medical Association, Canadian Nurses Association and National Quality Institute were the original ten organizations.


xxviii The four Priority Actions are as follows:
Create strategic Leadership and management system for QWL.
Implement a comprehensive and integrated human resources, workplace health and organizational development strategy.
Link QWL and workplace health to performance management systems.
Develop internal and external knowledge exchange Capacity.

XXX The organizational-level priority actions are the creation/implementation of (i) a strategic management system for QWL; (ii) a comprehensive and integrated HR, Health & Safety and Organizational Development strategy (leading practices relating to this activity have been themed into 8 key areas); (iii) Measurement of QWL and linking it to other organizational performance management systems; (iv) enhanced internal and external knowledge exchange capacity regarding QWL.

XXX The four system-level priority actions are the creation/implementation of (i) a national QWL database and support for reporting of standard QWL indicators; (ii) enhanced performance/accountability agreements and accreditation standards; (iii) a pan-Canadian QWQHC knowledge network to recognize and share leading practices; and (iv) a national workplace health promotion program for healthcare.


XXXII www.chd.ubc.ca

XXXIII www.irbpc.com


XXXV Note that scales for questions a-k and t and u are a 5-point likert scale (Strongly agree to strongly disagree).