Several key reports in recent years have made recommendations on improving working conditions for health professionals. However, little was known about how these reports were being considered and used. This article features findings from five knowledge utilization research projects, and discusses the role that reports can play in improving working conditions for nurses.

Engaging the Research Community

In 2002, a Department-wide consultation of senior officials led by Health Canada’s Health Policy Research Program (HPRP) identified research on the utilization of reports on quality workplaces for health professionals as a priority area that was not being addressed by other funders.

While a growing number of reports on quality workplaces in the health care field tabled recommendations for improving the working conditions and the health care system, evidence was needed on the uptake of these reports and their resulting impacts. To learn more about how or whether the information, report recommendations and strategies had been used to improve health care working conditions, HPRP released a Request for Applications in March 2003. The overall purpose of the research was to examine the impact the reports had in creating healthy workplaces for Canadian health professionals. Specifically, the research objectives were to:

- study the dissemination of key reports
- assess how or whether the reports were considered
- investigate whether report recommendations were implemented
- identify barriers and/or facilitators, both in implementing the recommendations and for creating healthy workplaces for health professionals

Five applications passed policy relevance and scientific peer review. The funded projects approached the research objectives from differing perspectives using a variety of methods, including surveys, focus groups and case studies.

While some researchers included other reports in their research, all five projects focused on four key health human resources reports:

- *Commitment and Care: The Benefits of a Healthy Workplace for Nurses, their Patients and the System* (2001)

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Research Highlights

Results of the five projects became available in the summer and fall of 2006. In keeping with the original intent of the Request for Applications, they focus on the knowledge transfer of reports and the implementation of recommendations for improving working conditions of all health professionals. The results of the projects also provide an understanding of nurses’ current working conditions, and of the barriers and facilitators for change. The findings presented below focus on the latter. More detailed information on the projects is available on the Health Canada website: <http://hc-sc.gc.ca/sr-sr/finance/hprp-prpms/results-resultats/proj015_e.html>.

Evidence from Policy Makers and Researchers

A project entitled The Supply, Distribution and Working Context of Health Professionals: Why Do Things (Almost) Never Change? was led by John N. Lavis of McMaster University. The findings showed some similar viewpoints among researchers and policy makers. For example, a high proportion of both groups agreed that research organizations/researchers and policy makers are jointly responsible for knowledge translation. However, their views differed over whether broad challenges in intergovernmental relations had hindered health human resources policy making, with the majority of researchers suggesting that they had and the majority of policy makers disagreeing. However, this was a unique example, as there was overall agreement on the influence of other factors on health human resources policy making.

Evidence from “the Field”

While Lavis’ work focused on knowledge translation and its influence on health human resources policy, the Nursing Environments: Knowledge to Action (NEKTA) project, led by Michael Leiter of Acadia University, examined knowledge uptake in the field in Atlantic Canada. Leiter’s results showed limited transfer of the reports. Few nurses on the front line knew of them—with the exception of the highly publicized Romanow Report. However, nursing stakeholders and health human resources planners in government, unions and professional associations, as well as administrators in health care organizations used these reports in various ways, including as information sources and lobbying tools. In analyzing transfer and use, NEKTA also identified several factors that act as facilitators or barriers for knowledge transfer and utilization, including: report length and readability; dissemination processes; roles and workload; influence of the disseminator; endorsement within nursing.

Health Human Resources Reports Studied: Recommendation Highlights

The four key reports included a number of recommendations:

- Promote workplaces that value employees, support leadership, recognize seniority, and reward efforts and achievements.
- Fund continuing education and professional development, and promote learning in the workplace.
- Promote workplace health and safety (i.e., provide appropriate supplies, implement policies to prevent violence and abuse).
- Address staffing issues (i.e., offer competitive pay, address the mix of full- and part-time status, develop an integrated health human resources strategy).
- Ensure manageable workloads (i.e., employ support staff to assist nurses, reduce non-nursing tasks).
- Conduct ongoing monitoring (i.e., forecasting HHR demands, the health of nurses, spending).
- Address quality of life issues (i.e., flexible scheduling, child care).

Case studies

Of the project’s four case studies, two related directly to nursing:

- the (initial lack of) attention to nurses’ working environment during a period of hospital restructuring and downsizing in Ontario, and the establishment of the Nursing Task Force
- the decision to provide public funding for nurse practitioners in Newfoundland and Labrador to address (at least in part) poor physician distribution

These studies demonstrated that increased knowledge translation helped to direct political attention towards issues in nursing work environments. It also made policy networks that had previously been limited to health care executives and government officials more accessible to a broader range of social actors. The heightened engagement enabled new policy choices.
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Signs of positive change
Despite the barriers to transfer and use—and limited evidence of familiarity with the reports—NEKTA showed that the issues in the reports studied were topics of discussion and action across the region. As such, it found some positive changes in nurses’ working environments in Atlantic Canada and gathering momentum as governments, schools and nursing leaders address issues of work force supply and quality of work life.

Researchers measured changes in nursing environments by grouping them in seven key theme areas:

1. **Work Force Supply** (health human resources strategies, education, number of nurses employed, recruitment and retention)
2. **Workload** (easing workload, nurse-to-patient ratio, support staff, equipment)
3. **Hours of Work** (employment status, scheduling, overtime)
4. **Work and Health** (healthy workplace culture, health of nurses)
5. **Nursing Leadership** (integrating nurses into governance, nurse managers’ span of control, succession planning, supports for managers)
6. **Scope of Practice** (maximizing scope of practice, reviews of scope of practice)
7. **Information Systems** (integrated human resource information systems, workload measurement, other workplace systems such as electronic health records)

Positive change was demonstrated in work force planning, leadership, scope of practice and information systems. Success was also evident in provincial nursing strategies, phased-in retirement, continuing education, increases in university nursing seats, conversion of casual positions to full time and healthy workplace agendas (see sidebar below).

Persisting challenges
There were fewer changes in other areas, especially quality of work life, and participants were discouraged about how slowly change occurred. Particularly at the institutional level, nurses, managers and administrators were all challenged by quality of work life issues such as workload, staff shortages and retention. For example, NEKTA highlights the issue of burnout for nurses. Figure 1 shows how nurses in Atlantic Canada scored on energy and efficacy, indicating exhaustion and low confidence in their work. They also scored in the negative range on five areas of work life that can contribute to burnout (see Figure 2); manageable workload (demands are manageable within available time, resources and energy), control (decision-making involvement and personal autonomy), reward (opportunities for recognition and enjoyable work), fairness (respect, equity and social justice) and value congruence (between individual and organizational values). The only area that scored in the positive range was community (the social world of work including social support and interpersonal conflict), but these results were not significant.

**Evidence on Barriers and Facilitators**

The work led by Marlene Smadu of the University of Saskatchewan, entitled Promoting High Quality Health Care Workplaces: Learning from Saskatchewan, focused on barriers and enablers to knowledge translation. Her report concluded that study participants were not aware of the specific policy documents identified. However,
Effective communication was seen as a critical factor in developing high quality health care workplaces, as well as in their sustainability. Other enablers included employee recognition, respect and trust, and teamwork. Budget constraints were considered to be a key barrier, with front-line workers noting that budget decisions came from above with little consultation. Also cited as barriers were employee morale, workload and the Health Information Protection Act, which was seen as having a negative impact on teamwork and communication.

The report recommended the use of leadership programs, and change management and communication strategies to create high quality health care workplaces. To improve knowledge transfer and evidence-based decision making, the recommendations focused on improved knowledge dissemination to target audiences, the use of deliberative processes that allowed for face-to-face interaction between different levels of decision maker, and knowledge utilization networks. They also encouraged the creation of mechanisms traditionally considered more personal or colloquial, such as blogs or web pages, meeting minutes or newsletters.

Evidence from a Regional Perspective

Ellen Rukholm of Laurentian University highlighted a specific Canadian region in her report, Knowledge Utilization: Creating Quality Northern Rural Workplaces. It showed that senior and middle managers had little or no knowledge of the reports and that they had not been disseminated effectively. She identified a number of barriers to implementation, including relevance, insufficient resources and competing priorities. Her project included suggestions for developing policies and procedures to support implementation, which would:

1) be transferable to northern settings;
2) improve access to opportunities currently limited by distance;
3) build capacity;
4) promote sharing of resources;
5) link with local networks;
6) support accreditation standards;
7) include an evaluative component; and
8) outline leaders’ expectations.

Evidence from Cancer Settings

Margaret Fitch of the Sunnybrook Health Sciences Centre addressed a specific field of nursing in Canada’s Experience Translating Workplace Knowledge in Cancer.
Cancer statistics have shown a steady increase in incidence and a shift toward treatment as a chronic disease. This has significant implications for workloads, suggesting that a substantial part of the future demand for nursing services will come from the field of oncology.

Awareness of the policy reports in cancer settings was lower than expected among senior decision makers, change champions, managers and staff nurses. Most who were aware used the information to validate their ideas or reinforce an initiative currently in place. The primary barrier to using the reports was seen as organizationally related (e.g., budgetary constraints and lack of organizational infrastructure).

Researchers observed many changes to improve the workplace conditions for nurses in cancer settings, such as initiatives to address recruitment and retention, augmentation of clinical support, professional development, and health and wellness recognition. However, the reports were seldom consulted directly to identify, plan or implement initiatives, and there were only limited systematic evaluations to assess workplace improvements for oncology nurses. Nevertheless, respondents did identify a number of success factors, including increased collaboration, commitment, clarity about expected outcomes, accountability for knowledge exchange and capacity for sustainability.

The Role of Reports

Overall, what do these research projects tell us about how reports on the working conditions of nurses can help? What roles can these reports play? How can they be more effective? What else is needed to improve nurses’ working conditions?

Emerging evidence of positive change

In the most concrete sense, the working conditions of nurses are determined by the immediate physical, institutional and social environments in which they work. Responsibility for these rests with front-line supervisors and local administrators. However, according to the research summarized above, these are the people least likely to be aware of reports aimed at improving nurses’ working conditions. Yet, as Leiter and Fitch show, there has been some improvement in areas identified by the reports. To what extent these reports were responsible for the change is difficult to assess. In some cases, they may have fostered discussion that brought new ideas and approaches to the attention of front-line supervisors and administrators, or changed the constraints under which they operated.

Raising the issue

One role that the reports certainly played was to raise the profile of nurses’ working conditions on the political agenda. Given governments’ responsibility for providing and funding health care, as well as their activities in health human resources planning and education, it is unlikely that nurses’ working conditions will improve unless they are given explicit consideration in government planning and policy-making processes.

Building collaboration

The reports also expanded the range of participants and interests involved in policy debates on the topic. They provided senior decision makers and other leaders with evidence to validate their own ideas, challenge others, assess change initiatives, or lobby for change. In this way, the reports supported a broader range of policy choices.

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| Poor communication: Information is not always made available to all levels of the work force. Expectations are unclear—i.e., who is responsible for implementing change? |
| Lack of buy-in: Change requires collaboration among many players, some of whom may be more accepting than others. Agreement on an appropriate course of action may be difficult. |
| Lack of resources: Implementing changes requires financial and human resources, both of which can be in short supply. |
Improving transfer and utilization

Evidence from the HPRP projects does not show whether these reports could have played other important roles in improving nurses’ working conditions if a significant number of nurses, front-line supervisors and local administrators had been aware of them. However, the potential for increased transfer and utilization appears to exist. Some of the challenges facing nurses (e.g., discouragement about the slowness of change, quality of work life, communication, employee recognition, teamwork) might have been mitigated had nurses, their supervisors or administrators been aware of the findings and given the opportunity to discuss them in relation to their own workplaces.

If these and similar reports can play a greater role in improving working conditions for nurses, how can they be made more effective? The projects summarized reinforce the importance of disseminating information by mechanisms and in formats suitable for the intended audiences. For example, Leiter noted that extensive media promotion of the Romanow Report was one reason that front-line stakeholders were aware of it. Several of the projects also identified length and readability of reports as a key factor. Research by Rukholm and Fitch showed that including issues specific to certain segments of the target audience could increase the reach and impact of such reports. Additionally, Lavis noted that both researchers and policy makers see themselves as jointly responsible for knowledge transfer. Thus, the institutional capacity to receive, digest and respond to such reports also influences their effectiveness.

Looking Ahead

This research provides abundant information on the barriers to implementing the reports’ recommendations, including budgets, workload, competing priorities and lack of organizational infrastructure. These factors, in turn, link to issues such as the level and distribution of resources in the health care system, the demand for various types of health care services, and the competing demands on the health care system and its organizational resources. While these broader issues ultimately place some limits on what is possible, this type of report can help focus attention on nurses’ working conditions when these broader issues are being considered.

As the interview on page 3 notes, and as the findings from the HPRP reports support, positive changes in nurses’ working conditions are underway. Building on this momentum, putting to use emerging knowledge on “facilitators” of knowledge transfer and utilization will assist efforts to improve working conditions for nurses. In turn, these efforts will contribute to achieving the goals of Canada’s national health human resources strategy. The next article explains the components of this strategy more fully.


Competing agendas: Political agendas may differ from health care organizations’ agendas and are subject to change.

Lack of context: Some of the recommendations may be vague, provide no direction for action, or not be applicable in all settings.

Time constraints: Immediate priorities (i.e., health crises, labour negotiations) take precedence over longer term goals. Nursing workloads limit time available for knowledge transfer.