PROVINCIAL NURSING WORKLOAD PROJECT

FINAL REPORT

March 31st, 2010

THE PROJECT STEERING GROUP & ACKNOWLEDGEMENTS

A steering group comprised of representatives from the Chief Nursing Officers (CNOs), the Health Employers Association of British Columbia (HEABC), the Nurses' Bargaining Association (NBA), the Nursing Policy Secretariat (NPS), and the University of British Columbia (UBC) provided oversight and direction for the Provincial Nursing Workload Project (PNWP). This project steering group is also responsible for the composition of this final report. The members of the steering group are:

Cheryl Campbell, (Nurse Consultant)
Karen Jewell (Advocate/General Counsel), HEABC
Suzanne Johnston (Vice President, Academic & Chief Nursing Officer), Northern Health
Dr. Maura MacPhee, (Academic Lead), UBC
Andrea Wardrop (Project Manager), NPS
Patricia Wejr, (Senior Policy Analyst, BCNU), NBA

We would like to acknowledge Barb Mildon, former CNO for the Fraser Health Authority, for her significant contributions to the project and service on the Steering Committee. We would also like to acknowledge all those involved at the 8 demonstration sites for their hard work and dedication to the project.

ACRONYMS

The following acronyms have been used in this report:

CNOs	Chief Nursing Officers
EOI	Expression of Interest
HEABC	Health Employers Association of British Columbia
LPN	Licensed Practical Nurse
MoHS	Ministry of Health Services
NBA	Nurses' Bargaining Association
NPS	Nursing Policy Secretariat
PNWP	Provincial Nursing Workload Project
RN	Registered Nurse
RCA/PCA	Resident Care Attendant/Patient Care Attendant
RPN	Registered Psychiatric Nurse
UBC	University of British Columbia
WMS	Workload Measurement System

PROVINCIAL NURSING WORKLOAD PROJECT

EXECUTIVE SUMMARY

Introduction

As part of a Memorandum of Agreement contained in the 2006-2010 Provincial Collective Agreement between the Health Employers Association of BC (HEABC) and the Nurses' Bargaining Association (NBA), representatives of the Ministry of Health Services, the NBA, the Health Authorities and the HEABC joined together to implement nurse workload/staffing plan process projects at two acute care settings, two residential care settings, two community health care settings and two community mental health care settings within BC.

Background

The design of this project was based on the magnet/healthy work environment literature and the empowerment literature. Effective workload management, including staffing/skill mix and care delivery model design, is one of the major work environment factors that contributes to magnet-like work environments. Magnet-like environments or healthy work environments are associated with improved nurse and patient/resident/client outcomes. Nurse job strain, burnout, and job dissatisfaction are associated with heavy nursing workloads. Shared decision-making and participatory management approaches have been successfully used to create healthy work environments.

Demonstration Site Work

The following 8 demonstration sites were chosen:

1. Richmond Hospital (acute care; Vancouver Coastal Health)
2. Cowichan District Hospital (acute care; Vancouver Island Health Authority)
3. Brock Fahrni Pavilion (residential care; Providence Health Care)
4. Yucalta Lodge (residential care; Vancouver Island Health Authority)
5. Seven Sisters, Birchwood Place & Terrace Community Mental Health (community mental health; Northern Health Authority)
6. Abbotsford Mental Health (community mental health; Fraser Health Authority)
7. Tri-Cities Home Health (community health; Fraser Health Authority)
8. Chilliwack Public Health (community health; Fraser Health Authority)

There were 3 phases in the project work, which occurred over the course of one year with each demonstration site:

1. Introduction of the project, evaluation of the work environment and planned change initiatives
2. Staffing plan processes
3. Evaluation and creation of project toolkit

Recommendations

- **Point of care team involvement**: Provision of paid time and facilitation services for teams of point of care staff was beneficial in identifying some workload concerns, in generating solutions, and engaging in the change process. We recommend health authorities consider the use of such teams in decision-making.

- **Synergy model:** Given the potential uses for the synergy model noted at all sites, further evaluation of its uses is recommended. Furthermore, rigorous evaluation of the

model's use, including evaluation of the effects on patient/resident/client outcomes, should be done at those sites that have committed to using it past the term of the PNWP demonstration projects.

- **Specific recommendations for the structure of similar projects:** the following recommendations arise from our lessons learned from having worked on the project.

    - **Project orientation:** We recommend comprehensive orientation to the project including an education session for project team lead and site manager before beginning project work to clarify roles and responsibilities, project scope and structure, communications structures, and financial reporting. We also suggest engaging in a robust project orientation with the project team, as well as with the full staff.

    - **Communications:** We recommend ongoing, site-wide communication throughout the course of the project, including periodic evaluation of the effectiveness of the project communications structure in place.

    - **Facilitation:** We recommend having consistent facilitation at all site meetings for the course of the project and it is beneficial to have facilitators with backgrounds in group work and nursing.

    - **Structure of project work:** We recommend providing structure to how release time is used, ensuring teams commit to project work, use their time efficiently, and are action-focused.

    - **Use of tools:** It is important that tools used for this type of work include specific examples to help teams envision how to use them. Furthermore, tools should be inter-related, and facilitators should refer back to tools used earlier in the process.

    - **Financial:** We recommend providing teams with a structured financial reporting template at the beginning of their work, and checking in early in the process to ensure there is no confusion about the reporting structure. Furthermore, future project should consider recording hours actually spent on the project including the number of hours backfilled, as well as management and administrative hours.

TABLE OF CONTENTS

INTRODUCTION & BACKGROUND

Introduction

As part of a Memorandum of Agreement contained in the 2006-2010 Provincial Collective Agreement between the Health Employers Association of BC (HEABC) and the Nurses' Bargaining Association (NBA), representatives of the Ministry of Health Services, the NBA, the Health Authorities and the HEABC joined together to implement nurse workload/staffing plan process projects at two acute care settings, two residential care settings, two community health care settings and two community mental health care settings within BC.

Although health care managers and NBA members led this project, it was recognized that staffing plans cannot be developed in isolation. Therefore, at each of the project sites, all members of the care team were involved at some level. The purpose of this project was to engage nurses (RNs, RPNs and LPNs) and other care providers in discussions and decisions related to safe and effective staffing plan processes within their specific practice sites. What we learned from these pilot projects helped to develop a Nursing Workload and Staffing Plan Process Toolkit (attached).

Background

The design of this project was based on the magnet/healthy work environment literature[1] and the empowerment literature. Effective workload management, including staffing/skill mix and care delivery model design, is one of the major work environment factors that contributes to magnet-like work environments. Magnet-like environments or healthy work environments are associated with improved nurse and patient/resident/client outcomes[2]. Nurse job strain, burnout, and job dissatisfaction are associated with heavy nursing workloads[3].

One way to address nursing workloads is to consider the context of nurses' work—the work environment[4]. Phase 1 was designed to provide the project teams with the "bigger picture." The teams were given tools and supports that enabled them to better understand and evaluate the context of their work. During Phase 1, the project teams were also taught how to engage in shared decision-making and participatory change management: project team-management processes that resulted in constructive solutions to workload issues. Shared decision-making/participatory change management are empowerment strategies that result in greater nurse satisfaction, organizational commitment, and

---

[1] Laschinger, H., Almost, J., & Tuer-Hodes, D. (2003). Workplace empowerment and magnet hospital characteristics: Making the link. *Journal of Nursing Administration, 33*(7/8), 410-422.; Parsons, M. (2004). Capacity building for magnetism at multiple levels: A healthy workplace intervention, Part 1. *Topics in Emergency Medicine, 26*(4), 287-295.; Parsons, M., Cornett, P., & Wilson, R. (2004). Capacity building for magnetism at multiple levels: A healthy workplace intervention, part II—an emergency department's healthy workplace process and outcomes. *Topics in Emergency Medicine, 26* (4), 296-304.

[2] Aiken, L., Clarke, S., Sloane., D., et al. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association,* 288 *(16)*, 1987-1993.; Havens, D. S., & Aiken, L. H. (1999). Shaping systems to promote desired outcomes: The magnet hospital model. *J Nurs Adm, 29*(2)*,* 14-20.; Tourangeau, A., Cranley, L., & Jeffs, L. (2006). Impact of nursing on hospital patient mortality: a focused review and related policy implications. *Quality and Safety in Health Care, 15,* 4-8.; O'Brien-Pallas, L., Thomson, D., Alksnis, C., Luba, M., Pagniello, A., et al. (2003). *Stepping to Success and Sustainability: An Analysis of Ontario's Workforce.* NHSRU, University of Toronto.

[3] Baumann, A., O'Brien-Pallas, L., Armstrong-Stasser, M., Blythe, J., Bourbonnais, R., Cameron, S., et al. (2001). *Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system.* Ottawa: Canadian Health Services Research Foundation. Available at www.chsrf.ca

[4] Page, A. (2004). *Keeping Patients Safe: Transforming the Work Environment for Nurses.* Washington, D.C: National Academies Press.

nurses' perceptions of improved quality care[5]. Shared decision-making and participatory management approaches have been successfully used to create healthy work environments[6].

Once project teams were able to critically examine workload issues, we initiated Phase 2 with more in-depth evaluations of workload issues related to staffing. During Phase 2, project teams used a rating scale adapted from the synergy model[7] to identify workload associated with their patient/resident/client care needs. Based on staff characteristics, such as experience and scopes of practice, the project teams developed staffing plan processes with staffing decision rules to more systematically, objectively make staffing assignments. The premise of the synergy model is that a better fit between staff characteristics and patient/resident/client care needs will result in improved nurse and patient/resident/client outcomes.

Staffing plan processes in place in the United States have proven to be a successful way for nurses and nurse managers to identify the client/patient/resident needs of specific healthcare sectors and settings[8]. The research evidence shows that those who provide care are vital to staffing discussions. Nurses are knowledgeable about their own practice environment, and they know what is necessary to safely and effectively respond to their patients' care needs[9]. Staffing plan processes, developed by staff and management, provide a means for nurses to contextualize what they do for their clients/residents/patients in specific settings[10].

This project was not intended to develop a nursing workload measurement system (WMS). Although progress has been made in refining WMSs currently in existence, these systems usually reflect only part of the actual work done[11]. Instead, this project was designed to enable front-line staff and management to address evidence-based factors that influence workload by: (Phase 1) participating in a broader examination of workload issues within their work environments, and (Phase 2) focusing specifically on workload issues related to staffing plan processes.

Since a primary objective of the project was to facilitate nurses' capacity to systematically examine factors that influence their workloads, we used an Action Research model to structure our work with the demonstration site teams. In Action Research, people who know their environment collaborate together to find the best ways of working and living together within that environment. They use tools, such as the Plan-Do-Study-Act (PDSA) cycle to systematically analyze their situation. In Action Research, the people within the environment are the experts. Facilitators, such as outside researchers, guide the experts through the process of figuring out what works well - and what needs some fine-tuning.

---

[5] Erickson, J., Hamilton, G., Jones, D., & Ditomassi, M. (2003). The value of collaborative governance/staff empowerment. *The Journal of Nursing Administration, 33*(2), 96-104.; Laschinger, H. (2008). Effect of empowerment on professional practice environment, work satisfaction, and patient care quality: Further testing the Nursing Worklife Model. *Journal of Nursing Care Quality, 23*, 322-330.

[6] McGillis-Hall, L., Doran, D., & Pink, L. (2008). Outcomes of interventions to improve hospital nursing work environments. *Journal of Nursing Administration, 38*(1), 40-46.; Parsons, 2004; Parsons et al., 2004

[7] Curley, M. A. Q. (2007). *Synergy: The unique relationship between nurses and patients.* Sigma Theta Tau International: Indianapolis.

[8] DeVandry, S. N. & Cooper, J. (2009). Mandating nurse staffing in Pennsylvania: more than a numbers game. *J Nurs Adm, 39*(11), 470-478.

[9] Canadian Health Services Research Foundation. (2006). Implement nurse staffing plans for better quality of care. www.**chsrf**.ca/mythbusters/pdf/**boost**7_e.pdf.; Canadian Nurses Association. (2003). *Measuring Nurses' Workload.*

[10] DeVandry & Cooper, 2009

[11] McGillis-Hall, L., Pink, P., Lalonde, M., et al. (2006). Decision making for nurse staffing: Canadian perspectives. *Policy, Politics & Nursing Practice, 7*(4), 261-269.

The Synergy Model

We used the synergy model, developed for the American Association of Critical Care Nurses[12], as a starting point to address staffing with the teams. The teams adapted the tools to reflect their specific patient/resident/client populations and used the adapted tools to classify patients/residents/clients and develop guidelines for safe staffing. The synergy model is based on 8 universal characteristics (stability, complexity, predictability, resiliency, vulnerability, participation in decision making, participation in care, and resource availability). It provides a means for nurses to articulate their patient/resident/clients' characteristics, to consider the impact those characteristics have on workload, and to determine the caregiver best suited to meet their needs.

The PNWP demonstration teams agree that the synergy model captures the patient/resident/client characteristics which impact nurse workload and their ability to provide safe and effective care. The characteristics reflect the critical decision-making components of professional nursing care, not just the tasks. Pilot work with the synergy model in the U.S. has indicated that it is useful in a variety of healthcare sectors: acute care, critical care, and specialty areas, such as pediatrics.

There are many workload measurement systems (WMSs) and patient assessment/classification systems already in existence. The synergy model, a professional practice model, was chosen because it focuses on patient/resident/client characteristics and their impact on caregiver workload, which is a departure from traditional WMSs which focus on caregiver tasks.

Although progress has been made in refining WMSs currently in existence, these systems usually reflect only part of the actual work done[13]. There is a lack of objective tools to guide staffing decisions. Staffing decisions are often based on history and habit, or workload measurement systems that fail to contextualize nurse competencies, patient needs, and the practice environment[14]. Health care providers require staffing decision tools that they can use to make real-time staffing decisions. Traditional WMSs predominantly provide averages or trends data that are used at operational levels for budgetary purposes. Alternatively, this project was designed to enable front-line care staff to address evidence-based factors that influence workload by participating in staffing plan processes.

Demonstration Site Selection & Work

The project was publicized via the partners, and in summer 2007, interested sites were asked to complete an Expression of Interest (EOI) packet that included endorsement letters from each site's Regional Nursing Workload Committee, Chief Nursing Officer, Human Resource Vice President, Clinical Nurse Leader/Clinical Nurse Educator/Team Leader, and an NBA representative. The submitted EOI needed to provide evidence of nursing staff enthusiasm and support, such as up to six staff willing to serve as project team members. The project work began with the acute and residential care sites, and those four sites were chosen based on variability in staff experience, a high full-time to part-time staff ratio (in interests of stability), low vacancy rates, availability of 2-5 point of care staff and a front-line leader to form the project team, strength of letters of support, quality of their stated reasons for wanting the project at their site, evidence of innovation at the site, and evidence of the availability of additional resources that the project team might require. Furthermore, we sought to have representation from both rural and urban settings. In spring 2008, we requested EOIs from the community health and community mental health care sectors. Based on our

---

[12] Curley, 2007

[13] Bauman et al., 2001; CNA, 2003

[14] Devandry & Cooper, 2009; McGillis-Hall, et al., 2006.

experience working with the acute and residential care sites, we added a lack of competing initiatives to the selection criteria listed above in the selection of the final four sites.

We found that it was difficult to attract EOI submissions for the project. We were surprised by this, since we had expected a good response from interested sites. However, we heard about a number of factors that might have influenced this, including "change fatigue" at both at a unit and system level, timing issues (we requested EOI submissions during the summer), and confusion over what participation as a demonstration site for the project entailed.

At each site, the teams represented their typical staff composition, including registered nurses (RNs), registered psychiatric nurses (RPNs) licensed practical nurses (LPNs), patient/resident care aides (PCAs/RCAs), social workers and counsellors. Although some teams included non-nurses, the majority of each team was composed of NBA members.

An original goal of the project was to assess nurse-sensitive patient/resident/client outcomes. However, this was determined to be beyond the resources of the project. The demonstration site work was on a limited timeline of one year per site, and the foundational team building and change management skills that were necessary to develop with the teams before moving on to other work required more time than anticipated. Furthermore, we determined that we would not be able to make clear causal connections between the project teams' work and the outcome indicators. Therefore, outcome indicators would not be an accurate reflection of the work done.

The Project Manager, Nurse Consultant and/or Academic Lead met with each demonstration site monthly for one year. At these meetings the teams planned their project work, using tools provided by the project steering group. The teams often met in smaller groups between these monthly meetings to work on project initiatives.

There were 3 phases in the project work:

1) **Introduction of the project, evaluation of the work environment and planned change initiatives**
   Involving point of care staff in workload decisions is necessary for a healthy work environment[15]. Where appropriate,[16] the teams distributed surveys about the work environment which they used, in combination with brainstorming, to identify areas of opportunity. Through discussion of those issues, they decided which ones would be most beneficial to address, developed action plans, implemented a change and evaluated the success of the change. We focused on shared decision-making, communications, teamwork, the practice environment, and action-planning.

2) **Staffing plan processes**
   We led the demonstration site teams through a process to classify their patients/residents/clients, based on the synergy model developed by Dr. Martha Curley (as described above). The teams created guidelines for safe and effective staffing.

[15] College of Registered Nurses of British Columbia (2005). *Guidelines for a quality practice environment in British Columbia.* Vancouver, BC: College of Registered Nurses of British Columbia.
[16] Where data existed from previous relevant surveys, this step was omitted.

3) Evaluation and creation of project toolkit

Upon concluding our work with the teams, our goal was to conduct focus groups first with the project team members, and then with other staff members. We obtained ethics approval from UBC and each participating Health Authority to conduct the focus groups, and each focus group participant completed a consent form. We also requested feedback from the leadership associated with each site through an online survey.

We used a variety of tools with the project teams throughout the course of the project. We revised the tools as the project progressed, based on feedback from project team members and our observations of how well the tools met the various sites' needs. We then compiled the tools that proved useful for the teams' work into a toolkit, which is attached.

THE TOOLKIT

The toolkit is a compilation of the resources that proved useful to the demonstration project teams in their work, along with templates and illustrative examples. Not all of the tools were used with each of the 8 demonstration sites, but each was useful in working with at least one site. Tools were added to the toolkit as specific needs were identified through the demonstration teams' work. These resources focused on the process of teamwork, change management and action planning. Although using the tools piecemeal to tackle an issue was helpful, it was working through each step of the process which promoted team growth and development and a greater understanding of how to get things done.

SECTION 1: ASSESSMENT OF THE PRACTICE ENVIRONMENT

- Quality practice environment survey
- Strengths and challenges of your site brainstorming exercise

SECTION 2: TEAM BUILDING

- Teamwork
- Project team roles and responsibilities
- Group guidelines
- Developing a communication plan
- Conflict management
- How to run an effective meeting
- Example meeting agenda
- Meeting minutes template

SECTION 3: CREATING EFFECTIVE CHANGE

- Action research
- Empowerment
- Change management
- Innovation
- The Plan, Do, Study, Act Cycle
- Action planning worksheet

- How to create a survey
- Celebrating successes

SECTION 4: DEVELOPING A STAFFING PLAN

- The synergy model
- The synergy model's eight patient/resident/client characteristics
- Adapting the synergy model for use with your population
- Clarifying terms and creating markers
- Refining your adaptation of the synergy model
- Determining inter-rater agreement
- Creating guidelines for a safe staffing assignment
- Creating a safe staffing assignment
- Other suggested uses of the adapted synergy model

THE EIGHT DEMONSTRATION SITES - INTRODUCTION

We have listed below the staffing and patient/resident/client population as they were at the beginning of the demonstration projects. The staff composition and/or patient/resident/client population at some sites has changed since, and this information is therefore not necessarily reflective of the sites' current makeup.

RICHMOND HOSPITAL

Richmond Hospital 6 North (RH 6N) is an acute care unit in the Vancouver Coastal Health Authority, with 24 general surgery beds and 4 pediatrics beds, and an RN/LPN staff mix. The project team consisted of 4 RNs and 2 LPNs.

COWICHAN DISTRICT HOSPITAL

Cowichan District Hospital 2 South (CDH 2S) is an acute care unit in Duncan, in the Vancouver Island Health Authority, with 38 medical beds and an RN/LPN/RCA staff mix. The project team consisted of 4 RNs, 1 LPN and 1 RCA.

BROCK FAHRNI

Brock Fahrni Pavilion is a residential care facility in Vancouver, under Providence Health Care, with 75 beds and an RN/RCA staff mix. The project team consisted of 4 RNs and 2 RCAs.

YUCALTA LODGE

Yucalta Lodge is a 100 bed residential care facility in Campbell River, in the Vancouver Island Health Authority, with an RN/LPN/RCA staff mix. The project team consisted of 4 RNs, 1 LPN and 1 RCA.

TERRACE MENTAL HEALTH

The Terrace Mental Health team consisted of representatives from Birchwood Place, Seven Sisters, and the Terrace Community Mental Health Team, all in the Northern Health Authority. Birchwood Place is an 8-bed residential and recovery care site. Seven Sisters is a 20-bed residential and recovery care site. The Terrace Community Mental Health Team provides crisis response, counselling, case management, recreation therapy and life skills support. The project team consisted of 3 RPNs and 2 LPNs. Partway through the project term, one of the LPNs resigned her position, and a Social Worker Case Manager joined the project team in her stead.

ABBOTSFORD MENTAL HEALTH

Abbotsford Mental Health is a community mental health office with an RN/RPN/Social Program Officer/Program Assistant staff mix, under the Fraser Health Authority. The project team consisted of 2 RNs, 2 RPNs, and 1 Master level counsellor.

TRI-CITIES HOME HEALTH

Tri-Cities Home Health is a community health unit in Coquitlam under the Fraser Health Authority with an RN-only staffing model. The project team consisted of 6 RNs.

CHILLIWACK PUBLIC HEALTH

Chilliwack Public Health is a public health unit with an RN-only staffing model, under the Fraser Health Authority. The project team consisted of 5 RNs.

We have highlighted the strengths identified at the sites, the ongoing workload issues that remain at the demonstration sites, and the challenges that the project teams addressed. This is an evaluation/discussion of the workload issues at the sites that arose from surveys of the staff, working with the project teams, and the focus groups. An evaluation of the Provincial Nursing Workload Project will follow later in the report.

Strengths

Throughout the year long project, themes have arisen that are consistent through all or most of the sites in relation to work environment strengths. These themes arose through surveying staff, brainstorming with the project teams, discussions with management, and during the evaluation of the project. It is important to note that these strengths were not reported at all sites.

Demonstration Site Work Environment Strengths	
Staff cohesiveness	This was the strength that was identified most frequently by staff at the demonstration sites. Staff members are highly supportive of each other. Strong working relationships (with nurses, with the interdisciplinary team and with the administrative staff) were identified as being an important factor in retention and work satisfaction. Staff expressed respect for each other's practice, skills and knowledge and for the caring attitudes they brought to the workplace.
Dedication to quality care	The staff demonstrated dedication to providing quality care and following best practice guidelines. They also demonstrated genuine caring towards their patients/residents/clients, resulting in rewarding relationships and a strong sense of work satisfaction.
New graduates	Having new graduates as part of the team was often identified as providing a positive influence. New graduates brought a shift in culture, fresh ideas, and positivity, as well as enabling senior staff to serve as mentors which many identified as being very rewarding.
Online documentation	Online documentation was identified as providing consistency, clarity in charting and accessibility to historical data.
Leadership support	Staff often asserted that they felt supported by leaders and management. This support was especially apparent during and after a critical incident, times of overwhelming workload, and during times of large organizational change. Educators, Clinical Nurse Leaders and Team Leaders were identified as being valuable sources of information and providing important support, particularly around practice issues. Leaders who encouraged staff input were highly appreciated by staff.
Education	Educational programs existed at all sites. Staff identified ongoing education and professional development as an important factor in quality care and staff satisfaction.

Other	Staff identified free and accessible parking, high quality food on site, and staff appreciation events as improving morale and important for retention.

COMMON WORKLOAD THEMES ACROSS SITES

Throughout the year long project, themes have arisen that are consistent through all or most of the sites in relation to workload. These themes arose through surveying staff, brainstorming with the project teams, discussions with management, and during the evaluation of the project. Many of the workload issues identified were not tackled by the project teams due to the scope of the project and the available resources. However, at all of the sites, these issues did emerge as ongoing significant workload issues and were identified as needing further evaluation and action.

Workload Themes Across Sites	
Rising acuity	This theme came up consistently at every participating site and was identified by staff, by team members and by management. Staff and management agreed that acuity is rising, but this has not been formally documented. Sites who used the synergy model to classify their patients/residents/clients expressed that the model captured this phenomenon.
Heavy caseloads/assignments	Related to rising acuity, nurses report sometimes having the same number of patient/residents/clients in an assignment as previously, while the workload is increased.
Documentation	Many of the sites identified increasing documentation demands negatively impacted workload and required more nursing time away from direct care. Most sites did not address this issue specifically since many of the documentation procedures are mandated by the Ministry of Health Services and/or Health Authorities.
Control over admissions, discharges and transfers	Many group members identified increased pressures on their specific workplaces due to increased pressures on the healthcare system as a whole. There was a general attitude that all healthcare sectors are being asked to "hurry" patients/residents/clients through the system. Some group members asserted that historically they were able to delay or refuse a new admission based on unit workload, but that this is becoming less acceptable.
High level and speed of change	Staff identified change as a constant in their work environments. Some change initiatives were perceived as being positive, such as best practice, and some were perceived as being negative, such as budgetary constraints. However, positive or negative, change caused stress and a period of adjustment among staff, which was exacerbated by a perceived lack of control and opportunity for input.

Staff morale	The staff and teams at many sites indicated that employee morale was often a significant issue. Low morale was often attributed to demanding workloads and/or lack of staff appreciation and/or lack of social activities and events.
Shifting of roles and responsibilities	Many teams are having staff with new designations join the staff, such as a historically RN-only staff having the addition of LPNs. Also, in teams where there is more diverse staff mix, less trained staff members are being asked to take on greater responsibilities. Team members at all levels expressed discomfort with this shifting of responsibilities and have identified the need for more training, educational support and policies.
Accountability	Many teams and staff members expressed what they referred to as a "lack of accountability" as an issue. They felt they were not able to consistently rely on others to perform their duties and responsibilities.
Leadership support	Effective leadership is an issue that arose at several sites. Staff and project teams expressed that although many problems are solvable, this cannot be done without collaboration between staff and leadership. The teams recognized that the heavy workload of their leadership impacted their effectiveness as leaders.
Administrative support services and/or time	Many teams and staff members expressed that they have inadequate clerk and/or administrative support time to properly support them in providing care.
Resources for education & staff development	Many teams and staff members asserted that there are not adequate resources for staff education and development, particularly in areas of specialized skills.

CHALLENGES ADDRESSED BY THE SITE PROJECT TEAMS

The project work was process-oriented in that we focused on developing effective, action-oriented teams to tackle workload issues. We did this by providing education and guidance around team building and conflict management, change management, communications and action planning. At all of the sites, building an effective team was integral to successful project work. Therefore much of our work as facilitators was focused on building effective teams before we could adequately address workload issues. We initially focused on high-value, low-effort and visible initiatives with the teams to establish solid team identity and buy-in from staff and management. We then moved on to longer-term initiatives, which often needed more time and resources.

Richmond Hospital – 6 North

Work Environment Concern	Intervention carried out by 6N PNWP team
Call lights	Call lights provide a communication 'lifeline' for patients, but frequent interruptions from call lights disrupt continuity of care. The team conducted a study tracking call light frequency & reasons, before & after the introduction of structured hourly rounds, based on nursing literature. They found benefits & challenges of such rounds. The hourly rounds reduced call light frequency by 23% overall, but were often difficult for the nurses to complete due to workload. The team is continuing to share what they learned about hourly rounds with other RH staff and have included it in new staff orientation.
Inadequate supplies	Emergency supplies were not well managed. Supplies were often inaccessible & unused supplies were being thrown out. The team made supply bins that keep supplies clean and organized, saving time & money. The team recommended the purchase of new dynamaps, which subsequently occurred.
High staff turnover (difficulty keeping newly graduated nurses & loss of senior staff)	To see how new staff is adapting to the unit, & to look for areas of improvement, project team members conducted interviews with 6 new staff nurses. Based on feedback, the team arranged for revision of the new staff orientation packages. Also, the team arranged for the physician on-call list to be posted in an accessible location to save time & reduce stress.
Discharge teaching & planning	Moved the unit's information pamphlet holders to make these resources more accessible to patients, family and staff.
Patient expectations about preferred accommodations	Preferred accommodations (i.e., private rooms) were advertized as being available to patients for a fee, but these rooms were often not available at Richmond, resulting in dissatisfied patients and this impacted nurse workload. The team's work prompted the removal of preferred accommodations posters from the elevators & revision of the preferred accommodations information given by admissions.

Cowichan District Hospital – 2 South

Work Environment Concern	Intervention carried out by 2S PNWP team
Staff lacked a 'voice' in the changes that were occurring on the unit	Distributed several surveys to staff throughout the course of the project term. The surveys provided 2 South staff with opportunities to give feedback about issues in their workplace, informing the project team about possible issues to be addressed through project work.
Nursing care model in use	Through surveys and brainstorming, the project team identified team nursing care model as an alternative to the current primary care nursing. The team shared this information with the Care Delivery Model Redesign (CDMR) team who took this initiative forward. The PNWP collaborated with CDMR to pilot and evaluate a team leader pilot project on the unit.
Duplication and inconsistencies in charting	Identified the need to address charting processes. They revised an existing 24-hour charting document, gathering feedback from other 2 South staff members about their needs and preferences and undertook the necessary steps to have the document approved and printed for use on the unit. Project team members developed a plan for roll-out of the document, including a comprehensive education plan, and have served as trainers for use of the document.

Brock Fahrni Pavilion

Work Environment Concern	Intervention carried out by BF PNWP team
Medication delivery practices	Engaged in a LEAN process of Value Stream Mapping to determine if their medication delivery system could be streamlined to eliminate any unnecessary steps. This initiative served to communicate potential issues with the medication delivery to leadership, and resulted in PNWP team members being asked to sit on Providence Health Care's Pharmacy/Nursing Committee. The team identified a lack of ongoing education for RCAs. Furthermore, the project team's work resulted in a medication delivery pilot project in another Providence Health facility.
Time wastage associated with searching for supplies	Engaged the LEAN process to organize and standardize their utility rooms. This initiative led to time savings for nursing and other team members, reduction of redundancy, and compliance with infection control and accreditation standards. Furthermore, it helped the team reflect on how they provide care, and how other members of the interdisciplinary team provide care.

Conflict with differing communication styles	Collaborated with their leadership to launch the Lift Every Voice campaign, a year-long initiative. The PNWP team spearheaded the initiative, ran workshops and formed the core group of trainers and mediators. They worked on conflict management, assertiveness and respectful communication. The team feels that Lift Every Voice has helped significantly with collaborative practice and effective interdisciplinary communication at Brock Fahrni.
Care guides not always updated, leading to miscommunication about residents' treatment	Put a care guide updating system in place with the goals of standardizing practice, providing a common place to record changes to resident care guides, and allowing for care guide changes to be made at convenient times.
Staff not having adequate and restful breaks	Conducted a survey about breaks, and presented the results to their leadership. They discussed possible solutions to this with their leadership, including having a dedicated lunch room away from the unit. They determined that, given the resources at hand and the parameters of the project, addressing this issue further was not the best use of their limited time and/or that they wouldn't be able to address it adequately.

Yucalta Lodge

Work Environment Concern	Intervention carried out by YL PNWP team
Interruptions & communication issues	Devised a nursing team huddle protocol to decrease interruptions during medication delivery, to ensure that relevant resident care information was passed on in a focused and effective manner, and to help nursing staff meet their professional care standards.
Search time for appropriate slings	Developed a new system for organizing slings which led to a more efficient system for storage and use of slings.
Cluttered Medication Administration Records	Put in place a treatment binder system to decrease clutter in their Medication Administration Records and to make treatment sheets easier to find.

Terrace Mental Health

Work Environment Concern	Intervention carried out by Terrace PNWP team
Staff retention and recruitment	The team created the "Share a Smile" program at Seven Sisters & Birchwood to help improve morale. This program involved staff and clients giving each other positive feedback (staff to staff, staff to client, client to client and client to staff), establishing greater rapport and improved morale through encouraging a more positive focus.
Birchwood – Staff members giving report	The team developed and piloted a digital report protocol, but found that the staff preferred reporting face-to-face over recording report digitally. The team clarified issues of WCB coverage when they remained at their worksite to give report after their shift was finished.
Seven Sisters – frequent interruptions to nurse throughout shift due to phone calls	The team developed a phone call algorithm. The team then modified the phone call algorithm into a new Information Release Consent Form specifying who the clients allow staff members to speak to regarding client information, and implemented this form at Seven Sisters. The team also implemented a new phone messaging system utilizing clerical staff as well as an automated phone messaging system.
Seven Sisters – frequent interruptions during shift change report	The team instituted a policy of having one staff person on the floor during report.
Seven Sisters and Birchwood - staff meeting attendance and effectiveness	The team identified that there was poor attendance at staff meetings and that these meetings were not always specifically relevant to staff. They conducted a survey about staff meetings to identify strategies for promoting staff meeting attendance and redesigning meetings to meet the needs of the staff. The team used this information to revise their staff meeting procedures and found that this increased attendance.
Opportunities for in-depth care planning & staff education	Responding to feedback from the staff meeting survey, the team planned and implemented monthly Grand Rounds first at a local level, and then expanded throughout the Northwest region via video presentation. The team received very positive feedback from the staff about the Grand Rounds.
Staff safety	The team aided with planning to ensure staff were offered safety training promptly. This team has worked with the hospital to develop a training program and protocol to address safety issues. Prevention and Management of Aggressive Behaviours and Code White (a protocol to respond to aggression) training has been rolled out across the NorthWest. There is a plan to provide ongoing training Q6mo, and run through monthly Code White scenarios.

Abbotsford Community Mental Health

Work Environment Concern	Intervention carried out by Abbotsford PNWP team
Staff safety	The team assessed the use and effectiveness of panic alarms, as well as the office and desk layout in the site's offices. Furthermore, the team developed policies and procedures for a Working Alone program, including a staff call-back system and protocols for emergency response.
Staff orientation & evaluations	Through the initial staff survey, the team identified that there was a need for updates to the staff orientation binder and increased frequency of staff evaluations. Team members therefore updated the orientation binder and implemented regular staff evaluations.
Heavy caseloads	The team collected data about the impact of high needs cases on workload, and referral and "no-show" rates. They compared these data to data collected 2 years earlier to examine trends. They then planned for a reorganization of service delivery intended to decrease individual case manager workloads while improving services for clients, an initiative which aligned with an existing service delivery model change towards increased group therapy services.

Tri-Cities Home Health

Work Environment Concern	Intervention carried out by Tri-Cities PNWP team
Staff communications	Revision of report procedures & implementation of "area" or "kardex" reports to increase regular and structured communication about patients. This is a small group report with only the nurses who are involved with the clients, approximately 2 or 3 nurses per kardex, eliminating the need for all nurses to discuss all clients which was very time consuming.
Staff education and professional development	Planned for future implementation of wound care rounds. Brought forward staff concerns about the availability of training on specific advanced skills for consideration by management.

Chilliwack Public Health

Work Environment Concern	Intervention carried out by Chilliwack PNWP team
Weekend workload associated with Friday discharges from hospital and subsequent breastfeeding concerns	Addressed weekend workload for the PHNs (Public Health Nurses) related to breastfeeding by adding a breastfeeding clinic on Friday afternoons, adding a PHN to their Monday Babytime Drop-In, and collaborating with the hospital to advertise these new services. This employed the principles of Baby Friendly and addressed variances in feeding. The additional resources allowed parents to access care early, reducing weekend breastfeeding concerns. The PHNs reported fewer weekend calls related to breastfeeding, good clinic attendance, and increased client confidence that support was available to them.
School nursing procedures – efficiency & safety	Developed a new checklist for school immunization programs to help orient new staff and to generally make school immunization days more organized. Developed a list of 'helpful tips' for the school immunization programs to help staff avoid common pitfalls.
School vaccination forms	A survey was distributed to supervisors and staff to gather feedback about the current immunization forms. The team made suggestions for changes to the forms, and this information was passed on to the appropriate Forms Committee for review.
Children resistant to immunization	Designed an initiative to decrease workload and support nurses in child immunization clinics by preparing nurses to help parents of children who are resistant to immunization, and the children themselves. The team, in collaboration with an expert on their staff, has begun putting together video clips. They intend to continue with this initiative beyond the project term.
Education and professional development & Acknowledgement and recognition of time spent on committees/professional development groups	Implemented quarterly in-house in-services and education sessions pertaining to topics such as Hepatitis B & C screening and immunization procedures, STIs, TB and new staff orientation material. Because a concern was raised from the Quality Practice Environment Survey about the acknowledgement and recognition of PHNs' time and energy spent on professional practice committees, this concern was taken to management and steps have been taken to account for or recognize the time made available for these types of activities on the PHN schedule.

Issues transporting immunization clinic supplies to offsite clinics	Clinic in a Bag initiative was developed and launched by the project team. Each nurse has supplies for full flu and/or school clinic (150 immunizations), prepared in advance, and individualized to suit clinic needs. Unneeded stations are not set up and therefore do not require de-assembly, saving time and energy. Bags are lightweight, and easy to carry and store. The team collaborated with the health unit aide to set out re-stocking procedures. Stools were also purchased that could be easily carried from site to site and transporting in a PHN's vehicle. This helped with maintaining ergonomics and comfort at different sites.
Inefficiencies and potential for medication errors in adult immunization clinics	The team performed a LEAN evaluation of adult clinic and clinic rooms: the team organized files, countertops and posters in all the clinic rooms using Lean principles. They assessed and streamlined clinic procedures, and made recommendations based on their findings, which have resulted in more time being allotted per vaccination. The team is planning for ongoing assessment with the staff.

USE OF THE SYNERGY MODEL

At all of the sites, we introduced the synergy model as a way to measure workload, and some of the sites implemented the synergy model to classify patients/residents/clients as one of their longer-term initiatives. The sites began by adapting the language of the synergy model to represent their specific patient/resident/client population. They then scored their population together to ensure agreement among the scorers and to revise the language for clarity. After the team was comfortable using the tools, we spent significant time evaluating whether the tools captured the patient/resident/client characteristics which impacted caregiver workload. In going through this process, all sites agreed that this captured the factors of import to the caregivers when planning and communicating about their workload. Both project teams and site managers agreed there are factors which impact workload (such as complex family involvement) that are difficult to define and quantify with existing tools. They found that the synergy model provided a structure and common language to discuss and capture these factors.

Adapting the synergy language, ensuring scorer agreement, and evaluating the tool's relationship to workload took a significant portion of project time. The following table will outline how each site worked with the synergy model after going through this initial process.

Project Site	Project Team's Use of the Synergy Model
Richmond Hospital 6 North	The Richmond 6 North team scored patients from three 12-hour shifts (approximately 75 patients) using the adapted synergy model. They then created an ideal staffing assignment based on data collected from one shift. From that, they created guidelines for making safe staffing assignments based on synergy scores (see attached toolkit). They found the model captured increases in patient acuity and better allowed them to communicate about acuity with management. They had discussions with management about implementation of the tool in hospital, but this implementation has not occurred at this point.
Cowichan District Hospital 2 South	The Cowichan 2 South team scored all patients on the unit over a 24-hour period using the adapted synergy model. They found the model captured the workload associated with their patient population well, but not the general busyness[17] of the unit. They were unable to implement the synergy model due to time pressures.
Brock Fahrni Pavilion	The Brock Fahrni Pavilion team scored all of the residents on their unit (approximately 75 residents). They found the model captured the characteristics of their resident population well, but did not capture the general busyness of the unit. Using the synergy scores, they created guidelines for making safe staffing assignments (see attached toolkit) that helped inform their recommendations to management about workload and staffing. The team agreed the synergy model allowed them to demonstrate the increasing acuity of their population and to highlight specific areas of concern to their population, such as residents' vulnerability. Because they focused on and had great success with addressing work environment concerns and because they believed focusing on staffing would not increase the number of staff on the unit, they decided not to implement the tool for regular use.

[17] Factors which contributed to the general busyness at the eight sites include but are not limited to processing doctors' orders, lack of adequate clerical support, work environment issues such as faulty elevators, increased ADTs (admissions, discharges, and transfers), and frequent family requests.

Yucalta Lodge	The Yucalta Lodge team scored all of the residents on their unit (approximately 100 residents) using the adapted synergy model, and created an ideal staffing assignment based on that data. From that, they created guidelines (see attached toolkit) for making safe staffing assignments. They found the model captured increases in resident acuity and they determined that such a tool might allow them to better communicate about acuity with management. In going through this process, they found the tool identified an area of high workload in the facility that the nurses had previously identified, but had difficulty articulating. They decided not to implement the tool for regular use on site for a variety of reasons, including the amount of change happening at the site at that time.
Terrace Mental Health	The Terrace Mental Health team scored clients at their residential and short-stay facilities (approximately 8 clients) and the caseload of one Community Mental Health case manager (32 clients). They found that the tool helped with treatment planning and captured the workload associated with clients. They developed a plan for wide use of the tool, including an education plan, and have served as trainers for the rest of the staff. Management on-site wanted something to help with equitable caseload distribution, and has expressed the synergy model will meet this need. The team has introduced the tool to leaders throughout the health authority, and is planning for further implementation, including integrating the tool with their electronic documentation system. They are also using the tool as a structure for their grand rounds and have discussed using it in client case conferences.

Abbotsford Mental Health	The Abbotsford Mental Health team identified long wait times for new clients admitted to the service as an issue for their centre. In developing a plan to increase accessibility to the service, the team identified the synergy model as being an integral part of identifying workload, distributing workload equitably, and improving client flow. They scored 3 clients from each team member's caseload (approximately 12 clients). They developed a plan for roll-out of the tool, including an education plan, and have served as trainers for use of the tool. The entire staff of case managers has now scored their caseloads. The team has developed preliminary guidelines to use the tool to help case managers determine appropriate services for clients. The next step for the team is to create guidelines for equitable caseload assignments. In addition, the team identified 17 clients who would benefit from an ACM (Assertive Case Management) team by using another centre's ACM suitability criteria and the synergy model, which gave complimentary information. They determined that 3 of the 17 clients are currently in residential care, and could be managed in the community with appropriate ACM support. They then presented a case to their director for an ACM team using synergy scores as inclusion criteria for the service. The team intends to continue evaluating the tool and exploring its uses beyond the project term.
Tri-cities Home Health	The Tri-Cities Home Health team members each scored their own full caseloads (54 clients in total). They investigated potential relationships between current workload allocation system and the adapted synergy model. They found that their current workload allocation tool was generally accurate for clients rated less acute (more stable, less complex, etc.) on the synergy tool, but less accurate for clients rated more acute (less stable, more complex, etc.). They identified the usefulness of the model, particularly with their more acute and variable clients, in allocating appropriate time to see clients. They decided not to implement the tool for regular use given the number of changes at their site at the time, but planned for potential future implementation.
Chilliwack Public Health	The Chilliwack Public Health team explored various uses for the adapted synergy model. However, due to the nature of their work as public health nurses, which often has them seeing clients for single, short visits (e.g., in an immunization clinic), regular use of the tool was not clearly beneficial to the team. The team did see utility in using the tool as a structure for assessing clients on an as-needed basis and/or for use in nurse orientation. They also saw utility in using the tool to score a population, such as the students in a school, to identify populations with greater nursing support needs. The team considered possible uses for the tool in their longer-term programs, but decided not to move forward with implementation of the tool during the course of the project.

PROJECT EVALUATION

To evaluate the project we conducted focus groups with the project teams, as well as separate focus groups with interested staff members at each site at the conclusion of their year of involvement with the project. We also distributed an electronic survey to members of the leadership teams involved with each site.

TEAM FOCUS GROUP FEEDBACK

Over the course of the project, we made note of team feedback about the project. Also, we conducted focus groups with all of the project teams. The following is a compilation of their comments.

Positives

The feedback we received from the project teams was overwhelmingly positive. All teams expressed that the project resulted in useful recommendations that streamlined processes and/or addressed identified workload concerns at their sites. Some of the benefits the teams identified were improved communications, personal development, strengthened ties with management and interdisciplinary staff members, and exploring the utilization of the synergy model. However, two themes emerged at all sites as being the most notable benefits of the project. The first was having time away from regular duties to reflect on workload issues. The time for reflection helped the groups to realize they already were experts within their own work environments, to articulate their expertise regarding workload, to collaborate with staff and management to address specific workload issues, and to allow them to identify ongoing concerns. The second main theme was having the point-of-care staff directing the problem solving. The project groups expressed appreciation for the chance to be heard, to be considered the experts of their work environment, and to be given tools and resources to address the issues that were most concerning to them.

Example comments by the project team:

- Made us think about our work in a different way. I would have one perspective, and listening to the other team members and their perspectives would give me "ah'ha" moments. Project work highlighted some issues that still need to be addressed. Having time funded to work on this project highlighted the importance of workload. Was a good use of money.
- Importance of front-line involvement vs. top-down directives - working on the project has given us a voice. Helpful that the staff hear about workload issues from us directly. Through engagement with staff on the floor, we got some issues identified and discussed, and we were able to really work through some things.
- This has been a great process. Regular team meetings have been something to look forward to. Excellent. Pleased to have been able to both personally benefit from the experience, and to have helped in enhancing worksite functionality and climate through involvement in the project. I learned a lot about myself. I learned that I can challenge myself to see the workplace differently. I would definitely recommend this project for anyone else to help them grow professionally. Has been exhausting and rewarding.
- We have developed the knowledge, skills, and confidence to navigate the change process. Process of identifying, solving, recommending is not something we normally do. Learned about the challenges in navigating policies. Provided a platform where we were able to go though the whole process – step-by-step on a micro scale was helpful.

- Communication has improved. Communication with management has improved. Pleased with developing abilities with mentorship and communication.
- Synergy model provided a common language for discussing care and a consistent way to measure and demonstrate acuity. There is a direct benefit to the clientele and the usefulness is seen immediately.
- More cohesiveness and collaboration between teams and disciplines. The mix was really good. Gave us a bigger understanding – wasn't just nurses. Having diverse backgrounds was very beneficial and gives better perspective.
- The small wins were big wins for staff. Shows you can do some simple things that have an impact over time on workload.
- "This project helped to build trust and understanding between management and frontline." I see our educator differently now-seeing her perspective of what her role/responsibilities are. She is in the middle of two fires. It is helpful to see what management is trying to do. We are lucky because the "higher ups" are interested in the project and will keep an eye out for our results.
- The tools have been very helpful in providing visuals, and materials to look back on. Having reference material increased confidence that you know what you are saying.

Challenges

While most of the feedback from the project teams was positive, challenges were also identified. These challenges included specific things such as not enough "face time" with the facilitators, scheduling the project around Christmas and summer holidays, staffing difficulties related to backfill, and need for a more robust project orientation. Historical problems in some of the work areas contributed to disruption in the project and the team work. One such challenge was the history of various initiatives being started and not being followed through, resulting in mistrust and lack of engagement by project team members and staff. Some project members also had negative past histories with each other, with leadership, and/or with other staff. Another challenge was that teams had difficulty engaging leadership in the project. At sites where this continued to be an issue, project work was hindered. Even at sites where leadership was engaged with the project, the teams expressed that further involvement by leadership might have been beneficial.

Example comments from the project team:

- Staffing issues put a damper on things – had to compromise and some people could sometimes not attend meetings. Sometimes had to re-schedule resulting in long gaps between meetings, which led to lost momentum. There have been a lot of staffing shortages – when we are short-staffed, you don't want to advertise that you're off the unit and not seeing clients because you have a project meeting. When we did some of our projects on the floor, some other staff members expressed disapproval at the team being paid to engage in project activities rather than helping on the floor.
- We need to work out better dialogue with leadership. They often did not have time to digest what we were talking about-to respond to it thoughtfully. Relationships with management need to be reciprocal. Management often listened, but was not a part of the process and did not necessarily commit to specific support. It is a difficult balance since they need to be involved enough to have the comfort level established, but it is also important to have time to work in confidence with one another on the frontline team.
- Being here in person made a really big difference, and helped with productivity. We missed a lot of interaction during videoconferences and technical difficulties really detract from the process.
- Energy waned at the end of the project. And timing is important. For instance, around Christmas holiday planning got in the way.

- Management was interested in the objective data we produced. That is why we like the synergy tool to be further developed - it will give us a standard language to use with management. And this tool also captures the other piece that involves the families.
- Many staff are still not sure who we are or what we did. In some cases they recognize initiatives, but don't recognize that they came from the PNWP. The project was not very easy to explain to people – this made it difficult to communicate about the project work. There is still confusion between different groups and initiatives and it was perceived by some that when we started something, it was taken over by another group. We don't think there should be 2 separate groups working on one unit simultaneously for other sites due to these types of complications.
- People are focused on their work and there are not that many who want to get involved.
- There has been some negative feedback from the staff that things will change only when there is money available and other changes will not be effective.
- We don't know where our recommendations go and what will be achieved. We were able to bring back only partial solutions to staff concerns. Fearful this will get lost in the abyss.

Recommendations by teams
Throughout the course of the project and during the focus groups, project team members made recommendations for how the project could have been improved.

Recommendations from the project team:

- More specific examples when going through the tools would be really helpful to solidify the content so there is more learning when the support is available. Tools provided early in the PNWP process may have been better utilized if they were revisited later.
- We [the project team] could have been more transparent about the project. Increased education with the staff could have made things smoother.
- Would have been helpful to assess communications in the middle of the project.
- We hope that in the future, before management implements something, they will consult with front-line staff first.
- Consistent membership was key, and accountability to the group by each member.
- We suggest meetings occur more frequently from the outset for future groups (more utilization of the available budget for better overall effectiveness).
- Important to recognize that management is part of the team and to involve them more. Leadership has been kept up to date, but need to be more involved in the process – have them a part of the process – they become the champions of the process. Having leadership involvement allows them to take pride in what their team is doing.
- Support was really important for success (unit level, mid management, and upper management).
- A lot of PRFs (Professional Responsibility Forms) are around caseload, the synergy gives us a way to communicate to managers.
- Would like to do the Quality Practice Environment Survey yearly. Would be helpful to use on an ongoing basis.
- Would have been helpful to do one thing at a time and see things through before going on to the next thing instead of splitting up and doing multiple projects at the same time.
- We needed a template for reporting our backfill. It was confusing.

STAFF FOCUS GROUP FEEDBACK

We conducted focus groups with all interested staff at all sites except for Richmond Hospital (due to scheduling and staffing difficulties). Extra support (in the form of backfill) was provided to relieve staff from their work to attend feedback sessions. Focus groups were held by the Project Manager and Nurse Consultant, or the Project Manager and Academic Lead. Feedback sessions were typically attended by 2-5 staff members at a time and lasted 15-30 minutes each.

Positives

Of the staff that participated in the focus groups, everyone identified positive aspects of the project. Overall, staff members were very positive about their project teams and appreciative of their service on the project. Also, the majority of participants agreed that project was valuable and an important endeavour at their site. The major themes which emerged from the focus groups are the project highlighted the importance of workload issues, gave staff time to reflect on their practice and evaluate long standing processes, and recognized the importance of involving point of care staff in problem solving and change management.

Example comments from the staff:

- Having any pilot project here is good. Gives us more insight into how we function as a team and how we cover ourselves with staffing. A lot of us like to work here because we like to be involved – we like these types of projects. Anytime you share information, it's positive. It's good to evaluate a process that's been in place for a long time. This project fits this role. Liked having access to the nurses on the team and having "go to" people where you knew things would be addressed when you bring them forward.
- Was good having project teams that were inclusive of different team members (different designations, different teams, etc.). Positive to see different nurses getting involved. The team did a fantastic job. Was really good that rural groups were included – we are sometimes overshadowed by what's happened in the urban centres.
- Project teams asked us for input on changes. I think this works really well because you get the input from the people doing the work. Has improved awareness for people. Gave our staff a chance to talk about issues affecting us. Allowed us to brainstorm to make a more positive work environment. Liked having the response brought back right away by the team. Explanations were given when things needed to stay the same.
- Like the fact that someone recognizes workload issues are a problem and need to be addressed. Having time funded to work on this project highlighted the importance of workload. It's not something that can be addressed just off the side of your desk. Having funds gave me the sense that the importance of workload was being recognized.
- Problem solving for some work environment issues (helpful initiatives), making work more efficient.
- Teams dealt with relevant subjects, had initiatives that were tangible for us (and more tangible initiatives were easier for us to identify). Felt there was good communication; they were realistic and dealt with relevant subjects.
- Synergy model was an "eye opener" and validated what we were saying. I can see the synergy model being effective in a lot of instances. Would be good to use synergy to make sure staffing is at the appropriate level. Use of the synergy model was beneficial to having a common language. The synergy scale is a more accurate reflection of where each client is at. Gave meaning to numbers.

- Improved staff safety. Increased awareness of safety. The safety changes put in place are working really well.
- Improved patient/resident/client care. The huddles have improved patient care – are now touching base no longer in passing. Organization has hugely improved. Positive impact on resident care. It has taken off some of the pressure from us, we are now able to spend a little time with clients. Was very beneficial for my interaction with clients.

Challenges
The staff that participated in the focus groups also identified some challenges associated with the project. Although staff liked having the project at their site, most staff identified that they would like improved communications about the project, and to be more closely involved in project initiatives. The major themes which emerged from the staff focus groups are need for improved communication, ongoing workload issues, and lack of confidence that the project will result in higher level change.

Example comments from the staff:

- Staff were not as aware of initiatives as they would have like to have been – made it difficult for them to give input - need for more communication about the project. Would be nice to be more informed. Lack of information sharing. Need something to update the casual staff. Felt far removed from the project. Communication was lacking – didn't hear about what was going on and would have been nice to know about before hand. We get so much in e-mail, I delete things that are not-client specific, so wasn't very aware of project initiatives.
- Until there is a basic staffing level you just can't register anything else. Such heavy workload that we feel they could only address issues that were directly client-specific and/or immediately at hand. Short staffed and just unable to do the things proposed. Team members were not always back-filled, so sites were sometimes short-staffed on meeting days. There's no staff and it's hard to get help. Even when you do have extra staff booked, they often get pulled and you end up short-staffed anyway.
- No change in workload. When people are worked to the ground, they call in sick and are burned out and they feel like they haven't done enough for their patients. But this is happening now everywhere.
- Expectations of concrete changes on-site showing that the staff had been heard were not met. Everyone on the floor wanted to be heard, they would expect concrete changes showing that they'd been heard and that didn't happen. Sometimes were being heard, but sometimes get shot down at higher levels.
- The project was good, but now that it's gone who is going to follow up and make sure things happen? Don't know that out of the project that any of the suggestions are being taken to the board and implemented to lighten the load. Huge financial deficit in the health authority happened in the middle has eroded confidence that anything coming out of this project will be considered.
- When there were several projects happening at one site at the same time, it was hard to keep them straight and manage competing priorities. Timing with other projects was not ideal. A lot of time was spent trying to figure out the differences. Both projects wanted the same

thing, so it was really frustrating to have 2 groups going on at the same time. Confusion about who did what.

- Lack of confidence that recommendations arising from the project will be heard and acted upon (mid-project cutbacks eroded this confidence further).
- Would be good to make it more meaningful for point of care staff.
- Aware there was a group working on things, but didn't know much. Thought it was a "nurse thing". Not enough regard for disciplines other than nursing (such as OT/PT).
- Some staff disliked some changes brought about by project initiatives.
- Synergy scores have been done, but we don't know what to do with them. We need clearer direction about how they're supposed to be used.

Recommendations by staff

During the focus groups, the staff made recommendations for how the project could have been improved.

Recommendations from the staff:

- Want to see something come of the final report – would like to see follow through.
- Would like to see a group continue meeting to address issues and represent staff on floor.
- Would be good to use synergy ratings again and re-distribute workload accordingly.
- Because workload is a continuing struggle, we would like continued, ongoing analysis of the workload. Need for a system to monitor and document rising acuity and workload issues. Measurement tools can be useful if the tool is flexible and qualitative as well as quantitative.
- Would like to have something to monitor and document rising acuity and recognize that there are workload issues so we can advocate for workload issues. We need something ongoing, not just for a period of time.
- The synergy model could prove itself, we need clearer guidelines about how to use it in practice.

SITE LEADERSHIP FEEDBACK

We received some feedback from site leadership at team meetings and project team presentation sessions. We also invited any leadership associated with the demonstration site teams to complete an online survey about the project.

Positives

Of the leadership that provided us with feedback, everyone identified positive aspects of the project. The major themes which emerged from the leadership are improved communication and teamwork, improvements in nurse worklife and patient/resident/client care, and increased capacity among staff to create successful change.

Example comments from the leadership:

- There were many benefits. Along with RNs, we opted to include RCAs on the team; everyone learned valuable skills in critical thinking about non-clinical issues, project management, and change management. Staff felt (and were) empowered to make changes that were meaningful to them.

- The nature of the project enabled the staff to examine other work sites / workload issues and come to an understanding of the work that others were doing. This resulted in a tool that is now being utilized in all of our sites and has developed a common language for staff.
- There has been one main project, which has been extremely successful and the staff loves it. They worked very hard as a staff to set it up, did a lot of education and coaching. It was quite a learning curve for them. I think they learned a lot of valuable information, especially seeing that change is not easy - when you're in the trenches, you want things to move quickly. This group has seen how difficult it is -and not because they were dragging their heels. I've heard them say to other staff: "You have no idea of how hard it is to get change going." I think they will continue to lobby for things—we are continuing with some of the things they identified.
- It was a very worthwhile project. Nursing break time was improved, quiet computer workspace was established, a site-wide communication program was established and is still operating, utility rooms are much more efficient and safer for residents…it was a very positive experience.
- We are already seeing positive results in the patent/client/resident care. The development and implementation of the tool enables staff to assess in an efficient reliable manner the challenges and progress of their individual clients and assess their case loads objectively.
- There was a substantial focus on improvements in nursing worklife. I think that is worthwhile and would encourage that to continue.
- The PNWP did a lot of legwork as far as surveys, questionnaires, and getting staff input. This really helped me as a Coordinator to find out how the staff was feelings about what the unit needed. I referenced the questionnaires when I started. It gave a sense of meaning to the project team members.
- Having the monies set aside to allow dedicated time for this project was of great benefit to the team and is seen in the end results of an operationalized workload tool. The workload tool is now being looked at by other departments in our area.
- Really helped give me a big picture focus. It's easy to get bogged down in the details of what you need to do in a day.
- This project has helped strengthen the idea that we are all part of one service. Streamlines things.
- We have been looking for a way to quantify caseload – these are steps in the right direction.
- Getting the bedside perspective was huge to me.
- Improved efficiency for areas where the team focused. Improved knowledge by the team (where in-services done), which ensured more standardization of care provided by entire team, including newer staff members. Increased efficiency with clinics, which assists to provide timely access to health services.
- Project leads were helpful by providing tools and assisted the team to focus on areas of concern. Project offered the chance for staff to have more time to reflect on activities and build sustainable processes. Provided opportunity for leadership and staff to communicate.

Challenges
The leadership that provided us with feedback also identified some challenges associated with the project. The major theme which emerged from leadership feedback was difficulties in the logistics of managing the relief of staff from regular duties and making maximal use of project funds.

Example comments from the leadership:

- We needed to replace one team member during the project and a slight delay increased the other staff members' work.
- We weren't very good at keeping track of who attended what sessions, and the full funds that were allocated were not used.
- I think the focus on improving resident care could be enhanced.
- I have concerns about sustainability – the team has unplugged from the project.
- I did not find that discussions around the staffing model were as transparent as I would like to have seen. It seemed that there was a pre-determined agenda, and at the end there were rushed recommendations based on fairly anecdotal data.
- Timing was sometimes difficult – when other organization resources were needed, it wasn't always easy to time activity with resource availability.
- Challenge presented that smaller team heard leadership responses to concerns, and then it needed to be repeated in larger group.

FINANCIAL

- Project funds provided for up to 0.2 FTE per project team member for one year. Funds were only for release time of project team members.

- All of the sites had some difficulties with backfill. This was often a staffing level/availability issue.

- There were additional costs to this project including honorarium to academic lead; salary/contract costs of Project Manager and Nurse Consultant; travel; and teleconferences.

- Additional demonstration site costs included site manager and administrative staff time and costs associated with project initiatives.

Site	Team composition	Funding disbursed	Funding used for release time	Hours paid/ relief costs
Richmond Hospital	1 DC2, 3 DC1, 2 LPN	$93, 500	$26, 370	647 hours
Cowichan District Hospital	1 DC2, 3 DC1, 1 LPN, 1 RCA	$93, 500	$34, 338	822 hours
Brock Fahrni Pavilion	4 DC1, 2 RCA	$97, 300	$37, 885	931 hours
Yucalta Lodge	1 DC2, 3 DC1, 1 LPN, 1 RCA	$92, 500	$44, 340	1180 hours
Terrace Mental Health	1 DC3, 2 CH2, 1 LPN (facilities), 1 LPN (community)	$80, 685	$80, 685 *(Plus $15, 945 from HA)*	2414 hours
Abbotsford Mental Health	1 CH3, 2 CH2, 2 CH1, 1 SPO (Masters)	$107, 517	$29, 226	667 hours
Tri-Cities Home Health	1 CH3, 1 CH2, 4 CH1	$105, 829	$40, 710	888 hours
Chilliwack Public Health	1 CH3, 4 CH1	$67, 754	$57, 827	1351 hours

CONCLUSIONS

Phase 1 of the project (evaluation of the work environment and planned change initiatives) proved valuable. Providing front-line teams with time away from regular duties to reflect on processes and workload issues allowed staff to improve communication channels, build better functioning teams, identify workload concerns, engage in the change process, and ultimately to enhance and improve worksite functionality and climate which positively affected workload through the projects in which they engaged.

Foundational team building and change management training delayed introduction of the synergy model at many sites. All demonstration sites saw potential for use of the synergy model, and found that it enhanced their ability to examine patient/resident/client care needs, provided a common language to articulate care needs and workload concerns, and assisted them in determining the appropriate care provider for patient/resident/client needs.

Barriers and Enablers

- **Leadership engagement:** The sites that were most successful were those that had leadership engagement and visible support from all levels of leadership (front-line leaders, operations leaders, senior management, etc.).

- **Group dynamics and teamwork:** Sites that had well-functioning teams to begin with had much less work to do around team building and ongoing negotiation of group guidelines, etc. than those groups who struggled with how to work effectively as a team. Teams were unable to move forward effectively with project work until group dynamic issues were addressed. The facilitators presented the teams with tools and information about communication, change management and how to engage effectively in meetings (see attached project toolkit), as well as engaging in significant conflict management with many of the teams to aid them in working effectively with each other, the facilitators, and with their managers.

- **Release time:** All the sites except for one had difficulties not only arranging backfill, but also in getting the teams to take time away from their regular duties to work on the project, despite funding being available.

- **Collaboration with other initiatives (e.g., CDMR, Lean):** In some cases, collaborating with other initiatives on-site allowed for increased efficiency, resources, learning and buy-in. However, in some cases competition between initiatives resulted and became a barrier to project work. Also, there was sometimes confusion among the staff and project teams about the PNWP team's role and scope for their project work and how it fit within the larger picture.

Recommendations

The following section outlines some of the lessons learned from working with the eight demonstration sites, and includes recommendations for engaging in similar work.

- **Point of care team involvement**: Provision of paid time and facilitation services for teams of point of care staff was beneficial in identifying some workload concerns, in generating solutions, and engaging in the change process. We recommend health authorities consider the use of such teams in decision-making.

- **Synergy model:** Given the potential uses for the synergy model noted at all sites, further evaluation of its uses is recommended. Furthermore, rigorous evaluation of the model's use, including evaluation of the effects on patient/resident/client outcomes, should be done at those sites that have committed to using it past the term of the PNWP demonstration projects.

- **Specific recommendations for the structure of similar projects:** the following recommendations arise from our lessons learned from having worked on the project.

    - **Project orientation:** We recommend comprehensive orientation to the project including an education session for project team lead and site manager before beginning project work to clarify roles and responsibilities, project scope and structure, communications structures, and financial reporting. We also suggest engaging in a robust project orientation with the project team, as well as with the full staff.

    - **Communications:** We recommend ongoing, site-wide communication throughout the course of the project, including periodic evaluation of the effectiveness of the project communications structure in place.

    - **Facilitation:** We recommend having consistent facilitation at all site meetings for the course of the project and it is beneficial to have facilitators with backgrounds in group work and nursing.

    - **Structure of project work:** We recommend providing structure to how release time is used, ensuring teams commit to project work, use their time efficiently, and are action-focused.

    - **Use of tools:** It is important that tools used for this type of work include specific examples to help teams envision how to use them. Furthermore, tools should be inter-related, and facilitators should refer back to tools used earlier in the process.

    - **Financial:** We recommend providing teams with a structured financial reporting template at the beginning of their work, and checking in early in the process to ensure there is no confusion about the reporting structure. Furthermore, future project should consider recording hours actually spent on the project, hours backfilled, and management and administrative hours.