

INTERNATIONAL COUNCIL OF NURSES

## POSITIVE PRACTICE ENVIRONMENTS:

**QUALITY WORKPLACES =  
QUALITY PATIENT CARE**

Information and Action Tool Kit



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for the International Council of Nurses

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# **ADVANCING POSITIVE PRACTICE ENVIRONMENTS**

## **Table of Contents**

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<b>Introduction</b>	<b>1</b>
<b>Chapter 1: The Nurse and Positive Practice Environments</b>	<b>5</b>
<b>Chapter 2: Issues of Job Satisfaction, Staffing and Safety</b>	<b>9</b>
<b>Chapter 3: Organisational Climate and Work Performance</b>	<b>21</b>
<b>Chapter 4: Global Worklife Issues</b>	<b>25</b>
<b>Chapter 5: What National Nursing Associations Can Do</b>	<b>29</b>
<b><i>Annexes</i></b>	
<b>Annex 1: Nurse Work Environment Assessment Tool</b>	<b>35</b>
<b>Annex 2: Strategies for the Development of Positive Practice Environments</b>	<b>39</b>
<b>Annex 3: Fact Sheet on Preventing Needlestick Injuries to Health Care Workers</b>	<b>41</b>
<b>Annex 4: Fact Sheet on Immunisations for Health-Care Workers</b>	<b>45</b>
<b>Annex 5: Position Statement on Patient Safety</b>	<b>49</b>
<b>Annex 6: Position Statement on Abuse and Violence Against Nursing Personnel</b>	<b>51</b>
<b>Annex 7: Position Statement on Occupational Health and Safety for Nurses</b>	<b>55</b>
<b>Annex 8: Press Release on Positive Practice Environments</b>	<b>59</b>
<b>References</b>	<b>61</b>



# Advancing Positive Practice Environments

## Introduction

It is a pressing reality. Health systems worldwide are increasingly challenged – faced with a growing range of health needs and financial constraints that limit services' potential to strengthen health sector infrastructures and workforces. We are immersed in a global nursing workforce crisis – one marked by a critical shortage of nurses. The reasons for the shortage are varied and complex, but key among them are unhealthy work environments that weaken performance or alienate nurses and, too often, drive them away – from specific work settings or from the nursing profession itself.

Yet there are environments that do just the opposite, that support excellence and have the power to attract and keep nurses. These have come to be called positive practice environments. Their beneficial effect on everything from nurse satisfaction to patient outcomes to innovation is documented by a substantial body of evidence. Still, much work needs to be done to make positive practice environments the norm.

Toward this end, ICN has chosen *Positive Practice Environments: Quality Workplaces = Quality Patient Care* as the theme of International Nurses Day 2007 and the focus of this tool kit. Designed to help nurses raise awareness and take action, the kit can be used by managers, front-line nurses, chief executive officers, professional associations and/or regulatory bodies. The kit is designed to provide data on positive practice environments to all health stakeholders who are interested in improving the delivery of quality services.

The pages that follow explore the nurse/workplace interface, overlapping factors that shape nurses' work environments, the cost of unhealthy workplaces, and the characteristics and

### ***Positive practice environments are characterised by***

- *Innovative policy frameworks focused on recruitment and retention.*
- *Strategies for continuing education and upgrading.*
- *Adequate employee compensation.*
- *Recognition programmes.*
- *Sufficient equipment and supplies.*
- *A safe working environment.*

benefits of positive practice environments. A list of recommended actions and tools to help nurses negotiate for improved environments is also included.

## **Background and Key Points**

- In almost every country nurses provide the majority of health services – up to 80 percent in some cases.
- We are in the midst of a global nursing workforce crisis, one characterized by an intensifying shortage of nurses in most countries.
- The shortage varies by type of nurse, geographic location, level of care, sector, service and organisation and is coupled with an increased demand for nursing services.
- In developing countries the situation is often dramatic – a chronic nursing shortage worsened by heavy external migration of nurses in search of better working conditions and quality of life, often accompanied by the unemployment and underemployment of nurses due to financial constraints.
- In Ghana, more than 500 nurses left the country in 2000 for higher-paying jobs in richer countries – three times the total recorded for 1999 and more than double the number of nursing graduates Ghana produced that year.
- In a survey conducted by Penn State University, nurses’ organisations from 33 countries – primarily Oceania, Africa, Central America and the Caribbean – reported that the outflow of nurses to more affluent countries was a serious to extremely serious problem that worsened the already-existing shortage.
- The current shortage is undermining the goals of health systems globally and challenging our ability to meet the needs of our citizens.
- In 2006, the World Health Organization identified the global health workforce crisis, including the critical shortage of nurses, as a priority item for action.
- The reasons for the health care and nursing crisis are varied and complex, but evidence underlines that unhealthy work environments are key among them.
- Unhealthy environments affect nurses’ physical and psychological health through the stress of heavy workloads, long hours, low professional status, difficult relations in the workplace, problems carrying out professional roles, and a variety of workplace hazards.
- Evidence indicates that “long periods of job strain affect personal relationships and increase sick time, conflict, job dissatisfaction, turnover, and inefficiency” (Baumann et al. 2001).

- Nurses who are stressed because of heavy workloads, friction with colleagues, inappropriate tasks, insufficient skills and knowledge, poor management or unsafe working conditions are challenged to provide the highest standards of care.
- Positive practice environments affect not only nurses but other health care workers and support excellence in services, ultimately improving patient outcomes.
- Evidence indicates that one third of newly qualified nurses in the United Kingdom do not register; negative experiences in the workplace or clinical placements seem to turn these new graduates away from the profession.
- A study of nurses in the United States, Canada, England, Scotland and Germany showed that 41% of hospital nurses were dissatisfied with their jobs and 22% planned to leave them in less than one year; findings confirmed the relationship between workplace stress and nurses' morale, job satisfaction, commitment to the organisation and intention to quit.
- There is increasing concern that work environment issues have affected nurses' organisational and professional commitment (Tovey & Adams 1999) and contributed to a breakdown of the psychological contract between employer and employee (Rousseau 1996).
- The beneficial effects of positive practice environments on health service delivery, health worker performance, patient outcomes and innovation are well documented.
- When there are more nurses available to care for patients, stress is less of an issue.
- A healthy work environment is a practice setting that maximizes the health and well-being of nurses, quality patient outcomes and organisational performance (RNAO 2006d).
- Employers have begun to realize that positive changes in the work environment result in a higher employee retention rate.
- Evidence shows that keeping employees leads to better teamwork, increased continuity of care and improved patient outcomes.
- In ICN's comprehensive examination of the nursing workforce crisis – the Global Nursing Review Initiative – positive practice environments and organisational performance together emerged as one of five global priorities for action.



# CHAPTER 1

## The Nurse and Positive Practice Environments

Two considerations merge when examining positive practice environments: (1) nurses' professional identity and (2) characteristics of the environments themselves

### Professional identity

Regardless of their type of practice, work setting or country, nurses share a defining attribute: they are committed professionals who embrace a holistic philosophy of care. This, perhaps more than anything else, shapes their expectations and fit within today's challenging workplaces.

As professionals, nurses need a practice environment that acknowledges the social and health mandate of their discipline and the scope of practice as defined by country/regulatory legislation (Rowell 2003). Institutional policy structures must recognise the importance of education and ongoing learning, emphasize team work and collegiality, and encourage creativity and innovation.

In quality professional practice environments, the needs and goals of nurses are met and patients are assisted in meeting their individual health objectives. This takes place within the cost and quality framework mandated by the organisation in which the care is provided.

#### ***What defines a professional?***

*As early as 1910, Abraham Flexner identified several characteristics that are still relevant today:*

- *knowledge;*
- *specialization;*
- *intellectual and individual responsibility; and*
- *well-developed group consciousness.*

*Since then, authors from various fields have provided further perspective on the basics of professionalism. One contemporary view points to knowledge based on scientific principles, accountability, autonomy, inquiry, collegiality, collaboration, and innovation (Registered Nurses' Association of Ontario [RNAO] 2006d).*

Organisations vary in their ability to support care in challenging practice environments. When people, resources and/or structures are lacking there is a conflict between nurses' professional responsibility and the provision of adequate patient care. If, for example, intense workloads only leave nurses time for tasks related to the physical needs of patients, patients' psycho-social and spiritual needs may not be completely met (Baumann et al. 2001) nor holistic care achieved.

## **Characteristics of positive practice environments**

Models applicable to nurses' work environments have emerged from studies conducted in Europe during the last decade. The benefit of these models is that they are relevant to any work location – from small rural community settings to large urban acute care hospitals.

Kristensen's (1999) model for social and psychological well-being combines six stressors, relating them to both the individual and the organisation. This work was supported by Seigrist's (1996) model on high-effort/low-reward conditions. According to Kristensen, the following are required for optimal social and psychological well-being:

- demands that fit the resources of the person (absence of work pressures);
- a high level of predictability (job security and workplace safety);
- good social support from colleagues and managers and access to education and professional development opportunities ((team work, study leave);
- meaningful work (professional identity);
- a high level of influence (autonomy, control over scheduling, leadership); and
- a balance between effort and reward (remuneration, recognition, rewards).

***Magnet hospitals.*** More specific to nursing is the magnet hospital literature. The term *magnet hospital* is often used to refer to a facility that is able to attract and retain a staff of well qualified nurses and consistently provide quality care. Started in the United States (US), the spread of magnet hospitals and their underlying principles is now becoming international.

During a nationwide wave of nurse shortages in the early 1980s, certain hospitals in the US were identified as exceptional cases: they reported unusually low vacancy and turnover rates. Nurses perceived these institutions as good employers who offered attractive work environments.

Intrigued, the American Academy of Nursing sponsored a study of these so-called magnet hospitals, identifying a long list of defining characteristics. A follow-up study by the Department of Health and Human Services identified three strategies the hospitals had undertaken that successfully reduced their nurse turnover and nurse vacancy rates: management commitment to nurses and nursing; strong nursing leadership; and competitive salary and benefits.

*The term magnet hospital is often used to refer to a facility that is able to attract and retain a staff of well qualified nurses and consistently provide quality care.*

Nurses in magnet hospital environments have lower burnout rates, higher job satisfaction, and better patient outcomes (Aiken, Clarke, Sloane, Sochalski & Silber 2002). Criteria for magnet hospitals that are applicable to all work environments range from the general (e.g. a reputation for quality care and being a good place to work) to the specific (e.g. high retention and low turnover rates, adequate staff, flexible schedules, strong leadership, and adequate salaries) (Havens & Aiken 1999; McClure, Poulin, Sovie & Wandelt 1983; Scott, Sochalski & Aiken 1999).

More recently, the American Nurses Credentialing Center launched the magnet service recognition programme for excellence in nursing services (Lowe 2005). Magnet criteria emphasize the concept of autonomy and the involvement of nurses in defining their work environment. They also reinforce the need for basic and continuing education to carry out high quality nursing care.

The freedom to act in an autonomous, accountable manner related to their scope of practice is consistently related to nurses' job satisfaction (Baguley 1999). A recent nursing work life satisfaction survey found that attributes of leadership, autonomy and teamwork were important aspects contributing to nurse satisfaction (Best & Thurston 2004 2006). There is also evidence that providing greater latitude in decision-making decreases turnover (Alexander, Bloom & Nuchels 1994). When nurses have limited say in patient care they feel their expertise is not valued, which lowers their commitment to employers. This control over practice is affected by environmental variables such as time and supportive leadership.

## CHAPTER 2

### Issues of Job Satisfaction, Staffing and Safety

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In recent years, the issues of job satisfaction, staffing and safety have gained increasing attention in discussions surrounding nurses' workplaces. They are briefly explored here.

#### **Job satisfaction**

Job satisfaction relates to how nurses feel about their work life. A study by Weisman and Nathanson (1985) reported that the job satisfaction level of nursing staff was the strongest determinant of the aggregate satisfaction level of clients. It is difficult to measure, however, because it is closely related to economic and social issues associated with the provision of adequate work environments.

Recent studies have found that nurses prefer to stay in the region where they received their education (Baumann, Blythe, Cleverley, Grinspun & Tompkins 2006), but they will leave if employment conditions do not meet their personal or professional requirements. The absence of adequate remuneration is a major reason for migration in many parts of the world. However, studies have shown that in developed nations money becomes a major issue only in the absence of other sources of satisfaction (Weisman & Nathanson 1985). Nurse satisfaction is also affected by overall factors such as government support, physical infrastructure support, and employer commitment to nursing services.

Zurn, Dolea and Stilwell (2005) report that in the UK, a survey of London national health service staff showed that, when health workers were asked for suggestions to improve their working lives, 'better pay' ranked only fourth on their 'wish list', behind 'more staff, 'better working conditions' and better facilities'. It is true however, that pay was higher on the list for people who reported an intention to leave the system, but it still only ranked second or third (Pearson et al. 2004).

In *Nurse Retention and Recruitment: Developing a Motivated Workforce*, part of the Global Nursing Workforce Project (2005), Zurn, Dolea and Stillwell report that there is empirical support for the link between job satisfaction, lack of motivation and intention to quit (Carlson et al. 1992). Low job satisfaction is a concern in many resource-poor countries. In Lesotho, Schwabe et al. (2004) found that, overall, 37% of the nurses are not satisfied with their current job. This percentage varies by the occupation of the nurses; it reaches 80% for mental health nurses, for example.

According to this study the main factors causing job dissatisfaction are inadequate remuneration and poor working conditions, including deficiencies in the working environment such as lack of equipment. Inadequate training or qualifications are also mentioned as a significant problem. These findings are supported by a survey undertaken in five African countries, where low motivation resulted in migration of the health worker out of the country (Awases et al. 2003).

Worker performance clearly depends on the level of motivation, which stimulates them to come to work regularly, work diligently, be flexible and be willing to carry out the necessary tasks. However, motivation affects only those aspects of performance that can be brought under the worker's personal control. For example, when organisations fail to provide workers with essential equipment, workers may not be able to accomplish their jobs for reasons beyond their control.

Institutional deficiencies in material and human resources, in supplies and suitable maintenance of equipment lead to progressive deterioration of health services (particularly in state services) and create work dissatisfaction. Such conditions caused nurses to resign at hospitals in Ribeirao Preto in 1990 (Anselmo, Angerami and Gomez 1997). This study found that working conditions comprised of various elements such as salaries, benefits, volume of activity, hours and shifts featured in all accounts given by workers as one of the reasons for resigning. Similar results were found in another study carried out in Colombia (Correa, Palacia and Serna 2001).

It thus appears that the productivity of health workers is not just a matter of how motivated they are for the job: it is also a matter of how well trained and prepared they

are for the job (this being a consequence of training, appropriate recruitment and employment policies). It also depends on whether workers are provided with the necessary equipment, drugs and technology to do their work. Therefore, motivation is not synonymous with performance, nor is performance unequivocally determined by motivation (Kanfer 1999). Motivation affects performance, although the latter also depends on organisational infrastructure and environments.”

## **Staffing considerations**

An important early definition of staffing links it to the number and kind of personnel required to provide patient care (Giovanetti 1978 as cited in McGillis Hall 2005). Subsequent authors have realised that staffing goes beyond numbers and have included other variables that affect patient coverage and the provision of safe care. These variables include workload, work environment, cost efficiency and effectiveness, patient complexity, skill level of the nursing staff and mix of nursing staff.

In *The Global Shortage of Registered Nurses:*

*An Overview of Issues and Actions* (2005), James Buchan states: “A global analysis focusing of WHO regions can blur important distinctions between countries, and a country level analysis can hide significant geographic variations in the level of availability of nurses. Even in countries with low

nurse:population ratios there is often a maldistribution of available nurses, which exacerbates the impact of shortages. Rural areas in developing countries tend to be the most underserved areas.”

*Staff numbers often reflect funding contingencies rather than staff or patient needs. As a result, there is a poor fit between the need for nurses and job requirements.*

There is a need for health systems to have the potential to financially support effective infrastructures and workforces. While often recognising the need for nurses, national health services are often faced with the realisation that sufficient finances are not allocated to support the necessary numbers. For example, in *Overview of the Nursing Workforce in Latin America*, also part of the Global Nursing Workforce Project (2005), Malaren and Agudelo, report that in countries such as Nicaragua “though the output of nurses is low, even these are not absorbed into the health system due to the low economic capacity and sustainability of these systems.”

This is also the case in countries such as Kenya, Zambia, Tanzania, the Philippines and parts of Eastern Europe.

In recent years, the importance of safe staffing has emerged, in large part as a result of changes in the health care system worldwide. These changes have been sparked by crises such as the AIDS pandemic, SARS, escalating health care costs and economic recessions leading to nursing shortages. Safe staffing is linked to issues of accountability, staff safety and patient safety.

**Staff level and mix.** The American Federation of Teachers (1995) defines safe staffing as “an appropriate number of staff with a suitable mix of skill levels . . . available at all times to ensure that patient care needs are met and that hazard-free working conditions are maintained.” Safe staffing depends on the context of care. In a small rural community, for example, it includes adequate staff to assure a safe environment. In the community and hospital sector, staff mix and skill levels are important ingredients of optimal care.

Staff numbers often reflect funding contingencies rather than staff or patient needs. As a result, there is often a poor fit between the need for nurses, nurses’ needs and job requirements. High percentages of nurses in Canada, the US, the United Kingdom (UK), and Sweden have reported work pressures severe enough to affect patient care (Nolan, Lundh & Brown 1999; Shullanberger 2000; White 1997), and there is evidence that lower nurse to patient ratios lead to complications and poorer patient outcomes (Kovner & Gergen 1998; Lancaster 1997; Shullanberger 2000). The ICN Safe Staffing Saves Lives tool kit (ICN 2006) reinforces that higher staffing levels are linked to better outcomes (Aiken et al.2002; Lancaster, 1997). The tool kit reviews strategies that can be used to promote safe staffing. Overarching legislation, professional frameworks, and effective policies have all been found useful in reinforcing and planning adequate staffing (ICN 2006).

## The Evidence on Staff Mix

There is considerable research to support the effect of staff mix on patient outcomes. Most studies suggest that the higher the educational and professional status of nurses providing care, the better the patient outcomes.

- Blegen, Goode and Reed (1998) found that a higher registered nurse (RN) skill mix corresponded to a lower incidence of medication errors, fewer pressure ulcers, and higher patient satisfaction.
- In a study of 799 hospitals in 11 American states, a higher proportion of nursing care provided by RNs and a greater number of hours per patient day were associated with better patient outcomes.
- Sovie and Jawad (2001) found higher RN hours with patients was associated with fewer falls and greater satisfaction with pain management.
- A study conducted in the US by Needleman, Buerhaus, Mattke, Stewart and Zelevinsky (2002), using administrative data from a large multi state sample of hospitals, examined the relation between nurse staffing levels and the rate of adverse outcomes among patients. The results demonstrated that a higher proportion of hours of nursing care provided by RNs and a greater number of hours of care by RNs per day were associated with better care outcomes for hospitalized patients.
- Person et al. (2004) found that patients with acute myocardial infarction were less likely to die in hospitals with higher RN levels.
- A large retrospective study (Tourangeau, Giovanetti, Tu & Wood 2002) conducted in Canada on patients diagnosed with acute myocardial infarction, stroke, pneumonia, and septicemia found a lower 30-day mortality rate associated with a richer RN skill mix and more years of experience on a clinical unit.

There is also evidence that higher educational qualifications among RNs are correlated with better patient outcomes (Aiken, Clarke, Cheung, Sloane & Silber 2003).

**Nurse:patient ratios.** In *The Global Nursing Shortage: Priority Areas for Intervention* (2005), ICN reports that “Several countries, including the US and Australia, are turning to minimum, mandated nurse:patient ratios as one of a number of strategies to improve working conditions and facilitate the return of nurses to practice, as well as promote safe staffing and patient care.

Shortly after the implementation of mandated ratios in Victoria, Australia '5,000 unemployed nurses applied to return to work and fill vacant posts in the health services' (Kingma 2006, p.225). Further, research commissioned by the Australian Nursing Federation (ANF) found that 'more than half of Victoria's nurses would resign, retire early or reduce their hours if mandated, minimum nurse:patient ratios were abolished' (ANF 2004, p.1)."

**Teamwork.** There has been recent emphasis on the importance of team work in providing continuity of care. Teams may be cross-disciplinary or within the discipline.

In many parts of the world, financial and other constraints prevent the hiring and deployment of high numbers of professional nurses. Staff mix and what constitutes safe staffing varies depending on local circumstances. Nurses collaborate with various professional and non professional health care workers, particularly those that work in the community (ICN 2006). In hospital settings, the roles and position of nursing staff may differ from those in North America and Western Europe. However, regardless of the type of nursing and interdisciplinary team, the quality of team relations will likely affect both nurse and patient well-being.

Factors that facilitate the establishment of teamwork are critical if quality care is to be provided. The multi-national and cultural nature of the nursing team is increasingly common. The International Centre on Nurse Migration, established by ICN and the Commission on Graduates from Foreign Nursing Schools, has initiated a series of workshops to support the integration of the migrant or international nurse (see [www.intlnursemigration.org](http://www.intlnursemigration.org)).

Collaboration with other health professionals is also important. There has been a great deal of research done on the detrimental and antagonistic relationship that frequently exists between physicians and nurses. In a hostile or rigidly hierarchical environment, nurses may be intimidated to question written or verbal orders that are errors or miscommunicated (Institute of Medicine 2000)

## **Safety considerations**

A safe workplace is a prerequisite for a positive practice environment. Dangers to nurses and patients result from excessive workloads, preventable injuries, and violence in the workplace.

**Excessive workloads.** A lack of fit between the work demanded of nurses and what they can reasonably provide threatens their health and puts patients at risk. Time pressures, contradictory demands, interruptions, skill and knowledge deficits, and insufficient or unavailable resources are exacerbated by high workloads.

Research by O'Brien-Pallas, Thomson, Alksnis, and Bruce (2001) indicates that heavy workloads contribute to job strain (defined as a combination of high job demands and low decision latitude) and suggests that short-term increases in productivity lead to inflated long-term health costs. The study noted a strong correlation between the hours of overtime worked and sick time.

In *Nursing workforce planning: mapping the policy trail (2005)*, O'Brien-Pallas, Duffield, Tomblin Murphy, Birch and Meyer report that: "Excessive workload remains a key labour issue in many countries (Baumann et al. 2001; Canadian Nursing Advisory Committee 2002; Aiken et al. 2001) and, in Australia, it is a documented reason for why nurses leave the profession altogether (Duffield, O'Brien-Pallas and Aitken 2004b)."

Malvarez and Agudelo (2005) also report that another study of nurses in Argentina and Uruguay (Carrasco and Espejo de Vinas 2000) showed "the relationship between the number of patients assigned and the accidents suffered, showing that the group with a higher number of patients (more than 30) suffered the most accidents," thus making this a patient safety issue.

**Workload measurement.** It is a challenge for administrators to establish workloads that optimize productivity without compromising the welfare of nurses or patients. Because much nursing work is excluded from current workload measurement tools, nursing effort and expertise are not adequately recognised, measured or compensated (ICN 2004).

Research is proceeding on nursing workload and criteria for staff to patient ratios, but empirically based approaches incorporating a theoretical framework and the many factors that influence nursing workload are still in the development stage. Efforts to create better systems must be intensified to enable human resource planners to make better staffing decisions.

*Because much nursing work is excluded from current workload measurement tools, nursing effort and expertise are not adequately recognised, measured, or compensated (ICN, 2004).*

Ideally, organisations with inadequate staffing levels should increase their capacity by hiring more nurses and creating more full time positions. They should also ensure that bedside nurses are able to concentrate on patient care rather than on administrative tasks. There is data demonstrating that the time spent with patients is decreasing, but the time spent dealing with administration is increasing. The creation of senior nursing positions such as clinical coordinators is critical. In some countries, hiring additional clerical staff, personal care attendants, and nursing assistants provides the necessary support that surrounds the provision of care.

**Preventable injuries.** Health care workers suffer more musculoskeletal injuries than other occupational groups. Nurses in particular experience high rates of strains and sprains (Choi, Levitsky, Lloyd & Stones 1996). Several studies have found a relationship between staff density, work overload, stress and musculoskeletal injuries in the nursing workplace. A longitudinal study of 4,000 health care workers in British Columbia, Canada showed that job strain increased the risk of musculoskeletal injury and claims (Koehoorn, Kennedy, Demers, Hertzman & Village 2000). A cross-sectional study of Swedish nurses found job strain increased the risk of low-back injury (Ahlberg-Hult, Theorell & Sigala 1995).

Evidence suggests that work conditions and practices of nurses may contribute to preventable injuries. Many nurses injure their backs when units are short staffed and they must lift patients by themselves (Schindul-Rothschild, Berry & Long-Middleton 1996). A prospective study of overexertion back injuries by 24,500 Swedish nurses over one year revealed that most incidents occurred during patient transfer, often when nurses were working alone (Engkvist, Hagberg, Wigaeus Hjelm, Menckel & Ekenvall 1998).

Education and appropriate procedures decrease the risk of injury, but organisational factors also make a difference (Canadian Centre for Occupational Health and Safety, 2005). In one study, higher needlestick injury rates were associated with temporary nurse staffing, while lower injury rates characterized magnet hospitals – organisations with stable staffing and reputations as excellent nursing workplaces (Aiken, Sloan & Klocinski 1997).

It can be inferred that strategies to decrease workload may decrease injury rates. Many workplace safety programmes exist. However, the literature indicates that they may be unsuccessful where work pressures and staff instability encourage dangerous work practices. Evidence from the field suggests that poor workplace maintenance, inadequate equipment, and supply shortages increase nurses' risk of injury and that equipment such as patient lifts could prevent injuries (Baumann et al., 2001).

*Many workplace safety programmes exist. However, the literature indicates that they may be unsuccessful where work pressures and staff instability encourage dangerous work practices.*

The ICN Guidelines on Occupational Health and Safety (2007) reports that: “Exposure to biological hazards, such as HIV, Hepatitis B and C, is estimated to have a serious impact on nursing. In countries where the prevalence of HIV is the highest in the world, nurses suffer an average of two to four needlestick injuries per year, thereby increasing their chances of contracting HIV, Hepatitis B or C. A study of health care workers in three Indian hospitals reported that 60% of the 100 respondents (35 of whom were nurses) confirmed that contact with blood, and without the benefit of personal protective equipment, occurred from “many times” to “always” in each week. Nine of the 35 nurses said that injuries from sharp-edged instruments or broken glassware, without personal protective equipment, were an every day occurrence (PRIA 2005)... Failure to protect nurses has implications for patient care. Hazards that adversely impact nurse retention and recruitment frequently lead to errors, threaten patient safety and negatively affect the patient’s treatment outcomes.”

**Workplace violence.** Violence in the workplace is a reality for many nurses. Potential perpetrators include fellow nurses, other professionals, patients, or their families. A survey of selected hospitals in British Columbia and Alberta, Canada reported a high rate of physical or verbal violence in the past five shifts (Duncan et al. 2001). However, it is difficult to estimate the

prevalence of workplace violence because it is not consistently defined and is likely under reported (Health Care and Health Safety Association of Ontario 2001).

Many health care organisations are working towards violence-free environments and have increased security. Other nurses (e.g., those working in small hospitals with few resources) remain vulnerable (Baumann, Hunsberger, Blythe & Crea 2006).

The ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector has commissioned case studies in representative countries worldwide and developed guidelines and a training manual ([www.icn.ch](http://www.icn.ch)). Ironically, the health sector is more prone to workplace violence than any other. In Sweden, close to one quarter of the reported cases of workplace violence occurred in health facilities whereas the retail, police, prisons and banking sectors represented only 5% each.

The Joint Programme studies confirm that workplace violence in the health sector is a global occupational hazard, growing public health concern and a violation of human and workers' rights. Case studies from Australia, Brazil, Bulgaria, Lebanon, Portugal, South Africa, and Thailand highlight the similar vulnerability of health care workers, especially ambulance staff and nurses. This issue requires greater international coverage to obtain a better understanding of what is required to improve workplace security. In the past, prevention measures have focused on training of the carers. However, there is growing recognition that organisational and environmental factors (e.g. job design, patient flow, management style, ward structure, noise/heat levels) must also be addressed in order to stop the increasing spiral of workplace violence.

Framework Guidelines Addressing Workplace Violence in the Health Sector and an accompanying training manual have been developed by the Joint Programme and are available free of charge ([www.icn.ch](http://www.icn.ch)). Using these materials, ICN, with the Norwegian Nurses Organization, is working with five African nurses' associations to reduce workplace violence in their countries. Activities are already underway in Botswana, Lesotho, Mauritius, Swaziland and Tanzania – raising awareness among health care workers, policymakers and the public; documenting the prevalence and nature of violent incidents; developing position and policy statements; and introducing local reduction strategies.

Following the March 2006 Workplace Violence Workshop, the Nursing Association of Mauritius carried out a series of activities to address this issue.

- ✓ Regular meetings held with participants of Workplace Violence to monitor and evaluate their activities at their respective site of work.
- ✓ An anti-violence Committee established in all the 11 hospitals of the island, which meets every month to assess progress made and initiate actions as appropriate.
- ✓ A violence report book placed in all the wards and units of all hospitals to encourage nurses and midwives to record all incidences of verbal or physical violence made against them.
- ✓ Visits to various hospitals made by the National Representative to check progress.
- ✓ A campaign of posters and pamphlets displayed in all wards and units of the country's Health Institutions
- ✓ Several meetings held with officials of the Ministry of Health to discuss issues of violence, including the NNO/SANNAM/ICN project to encourage zero tolerance against violence in the workplace.
- ✓ Partnership developed with the Ministry of Health, which has given instructions to all the Regional Health Directors at operational level to collaborate and support activities carried out by the Nursing Association in their health institutions.
- ✓ Collaboration with the media to create public awareness on the negative impact of violence on health care workers.



## CHAPTER 3

### Organisational Climate and Work Performance

Organisational climate refers to the perceptions that employees share about their environment. Despite its abstraction, organisational climate is a useful term for describing and understanding work environment issues (Al-Shammari 1992). When individuals report on organisational climate, they sum up their experiences or their sense of others' experiences, leading to a cognitive map of the organisation (Al-Shammari 1992). The concept of organisational climate is closely aligned with – but separate from – notions of job satisfaction, corporate culture and leadership style.

#### **What are the attributes of climate?**

Climate is a multifaceted term for overall organisational tone. Culture and climate are near synonyms used to describe the values, beliefs, philosophy and customs of an organisation (Al Shammari 1992). However, where qualitative methods are generally used to research corporate culture, quantitative methods are used to investigate climate.

Many workplace attributes can be related to organisational climate. Three that are intrinsic to positive practice environments are (1) a climate of safety for nurses and patients; (2) a climate of organisational support for life long learning; and (3) a climate of leadership.

**Safety climate for nurses and patients.** Safety climate is a universally accepted term that is often used in conjunction with safety culture, with little if any differentiation (Cox & Flin 1998; Mearns & Flin 1999). Both are defined in a variety of ways.

However, despite the range of definitions, a review of various reports suggests that there are at least five global components or indicators of safety culture (Wiegmann, Zhang, von Thaden, Sharnam & Mitchell 2002): organisational commitment, management involvement, employee empowerment, reward systems, and reporting systems.

*Many workplace attributes can be related to organisational climate. Three that are intrinsic to positive practice environments are culture of safety for nurses and patients, organisational support for life long learning, and leadership.*

Safety climate comprises safety within the organisation and safety related to policies, procedures, and rewards (Brown & Leigh, 1996). Safety within the organisation is both physical and psychological. The physical aspects include the provision of adequate equipment, safe physical structures, and an appropriate practice environment. The psychological component of safety includes rewards for employees and requires employees to feel comfortable asking questions without fear of reprisal. Safety climate has recently been featured in several high profile reports that place safety at the forefront of the health and work environment agenda. The seminal Canadian Adverse Events Study (Baker et al, 2004) began to draw attention to safety in all health care environments. Griffin and Neal (2000) described safety climate as an antecedent of safety performance.

Studies on patient safety document the link between competitive or abusive organisational climates and the fear of reporting mistakes, near misses and adverse events. Abusive behaviour is often never reported because of the lack of trust that any preventive action will be taken. Poor attitudes, behaviour and care may thus be perpetuated, influencing not only patient outcomes but health care worker recruitment and retention.

***Climate of learning.*** A climate of learning sets the stage for a positive and safe work environment. When organisations encourage life long learning by supporting professional development and the mutual sharing of knowledge, they become learning organisations. In a climate of learning, employers understand the importance of investing time, effort, and resources to enhance the practice of their employees and improve their knowledge, skills, and judgment.

*When organisations encourage life long learning by supporting professional development and the mutual sharing of knowledge, they become learning organisations.*

In recent years, professional bodies have encouraged the concept of reflective practice in which nurses prepare a written portfolio that summarizes practice issues that have occurred throughout the year. The use of journals allows nurses to reflect on their work in a safe environment. This approach enables individuals and teams to receive feedback from fellow employees and patients.

**Climate of Leadership.** Leadership is important for setting the tone of an organisation (Al Shammari 1992). Leaders provide the vision for an organisation's objectives and a blueprint for how they can be achieved. It is their responsibility to ensure that the motivation, tools, knowledge and skills required to reach established goals are present in the workplace.

Lowe (2004) points out that commitment by top management is critical to a positive work environment and must take the form of visible leadership. Employees judge the organisation by the actions of the CEO and the executive team. In general, nurses who are employed by organisations with positive climates will become more committed to the organisation and are less likely to leave. Individuals whose values are congruent with those of their organisation may perform better and express more job satisfaction than individuals whose values diverge (Downey, Hellriegel & Slocum 1975).

Leadership must also permeate an organisation and include line managers. Studies show that good nursing leaders can increase group cohesion and ameliorate job stress (Leveck & Jones 1996), and there is evidence that leadership that supports and empowers nurses reduces turnover (Laschinger, Wong, McMahon & Kaufmann 1999; Kramer & Schmallenberg 1988; Morrison, Jones & Fuller 1997). Wilson and Laschinger (1994) found nurses' views on access to power and opportunity in their own jobs depended on their perceptions of their managers' power. Good leadership throughout the organisation requires allocation of resources to provide managers and supervisors with the education, time, incentives, and other supports needed to initiate and sustain improvements (Lowe 2004).

*When the organisational climate enhances the empowerment of individual employees, nurses express greater job satisfaction and patients achieve better outcomes.*

Leadership attributes in positive work environments are not confined to formal leaders. Studies of magnet hospitals demonstrate that positive practice environments allow nurses to be autonomous, practice to their full scope, and employ initiative. It is in the best interests of an organisation to use the full capabilities of all employees. When the organisational climate enhances the empowerment of individual employees, nurses express greater job satisfaction and patients achieve better outcomes (Aiken et al. 2002; McClure 2005).

ICN's Leadership For Change™ (LFC) programme helps to develop nurses as effective leaders and managers in a constantly changing health environment. Health systems and patients benefit when nurses have strong leadership skills. LFC aims to enhance nurses' contribution to health services, and to promote patient safety and quality care, through appropriate and proactive leadership strategies.

A strong, positive organisational climate is important because it encourages consistency of behaviour (Dickson, Resick & Hagnes 2006) based on shared perceptions. In particular, it provides a context in which new employees are acculturated. In nursing workplaces, a poor climate endangers the patient and exposes nurses to job burnout and absenteeism. Nurses need to examine their organisational climate to determine whether it resonates with both their professional and personal work ethic, enhances their role and performance, and promotes safety. ICN's Leadership in Negotiation project has for decades provided support to NNAs in the development of nurse leaders in the workplace, capable of identifying occupational and performance hazards and negotiating their elimination.

## CHAPTER 4

### Global Work Life Issues

Nurses pursue their profession in a diverse range of settings, which vary from small nurse-run clinics in rural South Africa and nursing outposts in Northern Canada to urban intensive care units in the United States. Equipment and supplies may be rudimentary (e.g. a thermometer and a few basic drugs) or highly complex (e.g. the latest digital imaging equipment). Nurses may work as members of multi-disciplinary teams in large teaching hospitals or practice alone in remote areas such as Northern Pakistan.

Regardless of setting, positive work environments support nurses in their professional role of caring for patients. If nurses do not have the supports they need to practice, they cannot ensure the best outcomes for patients. They may become discouraged and quit their job or even the profession.

Countries often spend a considerable portion of their Gross Domestic Product on health. Since nations differ in affluence, however, actual monies spent on health care vary considerably. Differences in resources available for facilities, services and wages influence the global migration of health care personnel, including nurses. Migrants generally move from rural to urban settings within nations and to more developed countries both regionally and internationally (Kingma 2006). This process has an impact on workloads in the areas health care workers have left behind. The effect of low workforce capacity or

#### ***Nurse to Population***

#### ***Ratios Worldwide***

*Around the world there is huge variation in nurse to population ratios, varying from less than 10 nurses per 100,000 population to more than 1,000 nurses per 100,000. The average ratio in Europe, the region with the highest ratios, is 10 times that in the lowest regions (Africa and South East Asia). Still, ratios must be considered in the context of the proportions of other health professionals in the workforce. In South America, for example, there are many more physicians in relation to nurses than in either North America or Europe (ICN, n.d.).*

maldistribution is a heavier workload for those who remain in the system (Buchan & Calman 2004).

Despite the correlation between the amounts spent on health care and rates of migration, whether nurses go or stay is influenced by other factors.

- Gender-based discrimination continues in many countries and cultures, with nursing being undervalued or downgraded as “women’s work.”
- High levels of violence in the workplace and inadequate protection against exposure to disease may affect retention in some countries (Buchan & Calman 2004). For example, in some African countries, nurses have a high risk of contracting AIDS (Kingma 2006).
- Exposure to overwork or danger in the workplace may convince nurses and other workers that they are not respected or valued.

National health care systems are limited in the resources they can make available.

Consequently, it is essential that they use the resources they have wisely and concentrate on aspects of health care that can be improved through increased efficiency, better collaboration and greater investment in health care staff.

Countries that are relatively successful in retaining their nursing workforce have certain commonalities (Baumann, Yan, Degelder & Malikov 2006). A comparison of retention in Canada, the UK, Uganda and Thailand revealed that each country had made a considerable investment in health and had overarching health policy frameworks that addressed issues such as increasing nurse recruitment, expanding the role of nursing aides, and commitment to continuing education. In Uganda and Thailand, nurse salaries were increased and some recognition was given to location of work. Canada and the UK had strategies that included healthy workplace initiatives such as housing subsidies, extended childcare facilities, more flexible working times, and continuing education.

## **Innovation at Work**

In sub-Saharan Africa, ICN and the Stephen Lewis Foundation are collaborating with national nursing associations and Becton, Dickinson and Company to provide wellness centres for health care workers and their families. The goal is to provide the necessary funding and material “to sustain a healthy, motivated and productive healthcare workforce, leading to a strengthened healthcare delivery system” (ICN 2006). The wellness centers offer a range of services, including testing, counselling and treatment for HIV and TB; antenatal services, including Prevention of Mother to Child Transmission (PMTCT); stress management; post exposure prophylaxis; screening for chronic conditions and a training and resource/knowledge center for continuous professional development. The aim is to provide care for healthcare workers who, in turn, will be able to better care for their patients and communities.



## CHAPTER 5

### What National Nursing Associations Can Do

Nationwide efforts can make a difference in improving the work environment of nurses. At the national level, professional associations and regulatory bodies function as advocates for nurses and patients alike. As advocates, nursing associations:

- campaign for legislation and regulations that put in place needed protections for members of the profession (Rowell 2003); and
- strive “to assure a professional nurturing environment with appropriate resources, and a health care system that incorporates the expertise of all providers in a decision-making process centred on the patient” (Rowell 2003)

Their aim is supplemented by the development of relevant policies that address key health and safety concerns (e.g. adequate staffing levels, adverse event reporting and “whistle blower” protection) and support for positive work environments.

The four-country comparison, mentioned in the previous chapter, found that countries with high retention rates (i.e. Uganda, UK, Canada and Thailand) had a health policy structure in place. All countries provided allowances for education, reinforced the nursing role, and created conditions to eliminate violence and maintain communication about improvement in working conditions (Baumann, Yan et al. 2006).

It is essential to have solid countrywide policy frameworks that address the working conditions of nurses and all workers. These policies can be used to develop guidelines at the association/organisational level. In the UK, for example, the

*It is essential to have solid countrywide policy frameworks that address the working conditions of nurses and all workers. These policies can be used to develop guidelines at the association/organisational level.*

Department of Health created the Improving Working Lives Standard (IWL), which establishes benchmarks for all National Health Service (NHS) employers to follow (Baumann, Yan et al, 2006) and includes healthy workplace practices. The IWL complements NHS policies such as zero tolerance on violence against staff (National Task Force on Violence Against Social Care Staff 2001).

National nursing organisations play a key role in lobbying governments about the importance of overarching labour and health regulations. They develop countrywide standards and strategies that support healthy work environments and establish mechanisms to monitor workplace-related policies. They can encourage special interest groups and/or disseminate evidence on best practice.

## **Recommendations**

With a view to advancing positive practice environments, professional nursing associations should:

- Define existing local and national policies focused on working conditions.
- Establish the link for policymakers between patient safety and positive practice environments.
- Collect all relevant fact sheets and position statements that exist at the international level.
- Encourage the mobilisation of nurses and survey them to determine priority issues for action.
- Develop guidelines that address specific work condition issues.
- Disseminate evidence on best practice.
- Prepare communication plans that centre on issues in the practice environment.
- Establish committees at the organisational level that focus on work environment issues.
- Use the tool kit to provide background data to support claims and/or position statements.
- Present effective arguments for the purchase and maintenance of safe equipment and disposal mechanisms in health care settings (e.g. needle disposal).
- Become involved in organisational committees that examine issues of work and initiative effective strategies to address the challenges.

- Lobby employers and organisations to provide positive work environments and improve retention.
- Advocate in favour of blame-free reporting to encourage the identification of problem practices and actions to eliminate them from the workplace.
- Integrate improvement in healthy workplace initiatives with existing human resource plans and the vision of the organisation.



# **TOOL KIT**

**POSITIVE PRACTICE ENVIRONMENTS:**

**QUALITY WORKPLACES =  
QUALITY PATIENT CARE**



## Nurse Work Environment Assessment Tool

The following questions are intended to stimulate thinking and develop strategies that lead to positive work environments. Each organisation or health facility varies depending on the context of care. Consequently, the answers to the questions will be unique to the setting.

### **Organisations**

- Does the environment/organisation recognise nurses as professionals?
- Do nurses receive adequate compensation for their work?
- Are there opportunities for career advancement in nursing?
- Do the working conditions allow for optimal nurse recruitment and retention?
- Does the organisation have policies in place to guide work environments?
- Are there work environment/organisational policies that address occupational health hazards and promote safe working environments?
  - Is policy enforcement monitored?
  - Are policies reviewed regularly and revised as required?
- Is safe equipment available and well maintained?
- Are there effective grievance procedures?
- Are there “whistle blowing” procedures? Are there policies that protect the “whistle blower”?
- Is there a policy in place to give nurses control over their practice and scheduling?
- Is there a policy in place that establishes predictability and job specification?
- Are retention and recruitment policies in place?
- Are the turnover and vacancy rates excessive or negatively affecting patient outcomes?
- Are there programmes of recognition and reward?
- Are there policies about workplace violence?
- Does staff participate in the organisation’s decision-making?

### ***Nurse***

- Does the nursing staff practice under an overarching code of ethics?
- Is there good communication between nurses and other health disciplines?
- Are there rewards/incentives for nurses who demonstrate strong communication skills with other nurses and between disciplines?
- Are there programmes that encourage personal health?
- Are there adequate physical and equipment supports that encourage safe practice?
- Are there policies in place that allow nurses to address workload issues?
- Are mentorship and coaching programmes readily available?
- Do nurses have access to continuing education programmes?

### ***Government***

- Is there a specialty area within the government for health care?
- Does the government allot funding to continue/commence work environment research?
- Are there any provincial and regional strategies?
- Does the government policy support the nursing workforce to adopt/maintain a professional status?
- Does the government provide a regulatory framework for ensuring safe working environments?
- Does the government invest in health and work environments?
- Is there enough funding/support from the government towards its health care system?

### ***National Nursing Association (NNA)***

- Does the NNA advocate for and promote healthy work environments for nurses?
- Does the NNA advocate for and promote professional standards for nurses?
- Is the NNA involved in educating the public about nursing and professional development?
- Does the NNA encourage and provide opportunities for continuing education?
- Are alliances sought with patient organisations or other professional groups to ensure a safe work environment?
- Is there a way for nurses to provide comments or feedback to the NNA?

***Regulatory Body***

- Does the body regularly review scopes of practice and competencies?
- Are practice standards clearly communicated and upheld?
- Are there appropriate sanctions in the case of violations?
- Is there an appeal process and is it widely known?
- Does the body analyse trends to inform employers and the government of emerging workforce issues?



## **Strategies for the Development of Positive Practice Environments**

The process of developing positive practice environments is multifaceted, occurs on many levels of an organisation and involves a range of players. As a starting point, each organisation should develop a workforce profile that includes such metrics as absenteeism, vacancy and turnover rates, as well as demographic information like age and experience. This type of data provides a solid base for decision-making. For their part, nurses can advance the development of positive practice environments by:

- Continuing to promote the nursing role.
- Defining the scope of nursing practice so nurses, other disciplines, and the public are aware of the profession's evolution.
- Lobbying for professional recognition and remuneration.
- Developing and disseminating a position statement on the importance of a safe work environment.
- Ensuring that other disciplines are involved in the development of policies for safe work environments.
- Supporting research, collecting data for best practice, and disseminating the data once it is available.
- Encouraging educational institutes to enhance teamwork by providing opportunities for collaboration and emphasising teamwork theory.
- Presenting awards to health care facilities that demonstrate the effectiveness of positive practice environments through recruitment and retention initiatives, reduced drop-out rates, public opinion, improved care and higher patient satisfaction rates.
- Using the tool kit to provide background information about the importance of a positive work environment.



## NURSING MATTERS

*Nursing Matters* fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues.

### ICN on Preventing Needlestick Injuries

# Fact Sheet

#### **F**acts and Issues

***At least one in eight health care workers receives a needlestick injury potentially exposing them to serious or fatal infections***

Accidental needlestick injuries are the predominant sharps-related problem in industrialized countries. American health workers suffer 800,000 to 1 million needlesticks annually, not including the vast number that go unreported. There are more than 100,000 needlestick injuries in UK hospitals each year. Needlesticks are virtually undocumented in developing countries, but probably equal or exceed those in the industrial world. More than 20 blood borne diseases can be transmitted as a result of exposure to blood. Inadequate waste disposal systems extend the problem beyond health workers to cleaners, laundry workers, porters, 'rag pickers' and the general community<sup>2</sup>.

In some countries, health care providers feel obliged to give injections to satisfy their clients' perceptions of proper treatment. Three studies in Sub-Saharan Africa and Asia found that between 60 and 80% of all injections given were unnecessary and sometimes dangerous. The most frequently injected medications were antibiotics<sup>2</sup>.

#### **This is a true scenario. How can it be prevented?**

*An AIDS patient became agitated and tried to remove the intravenous catheters. Hospital staff struggled to restrain the patient. During the struggle, an IV infusion line was pulled, exposing the connector needle. A nurse recovered the connector needle at the end of the IV line and attempted to reinsert it. The patient kicked her arm, pushing the needle into the hand of the second nurse. Three months later, the nurse who sustained the needlestick injury tested positive for HIV<sup>1</sup>.*

## **I**mpact on nurses

Nurses have the highest rate of needlestick injury among health care workers. A health worker's risk of infection from a needlestick injury depends on the pathogen involved, the immune status of the worker, and the severity of the needlestick. The probability that a single needlestick will result in disease is 3 to 5 chances in 1 000 for HIV, 300 chances in 1 000 for Hepatitis B, and 20 to 50 chances in 1 000 for Hepatitis C.

Accidental needlesticks account for 86% of all occupationally related infectious disease transmission. The emotional impact of a needlestick injury can be severe, even when a serious infection is not transmitted, particularly when the injury involves exposure to HIV. In one study of 20 health care workers with an HIV exposure, 11 reported acute severe distress, 7 had persistent moderate distress, and 6 quit their jobs as a result of their exposure<sup>3</sup>.

## **T**he economics of needlestick injuries

According to the American Hospital Association, one case of serious infection by bloodborne pathogens can result in \$1 million of employer costs related to testing, follow-up, lost time and disability payments. The cost of follow-up for a high-risk exposure is almost \$3 000 per needle stick injury even when no infection occurs. Safe needle devices cost only 28¢ more than standard devices. Hospitals in California are expected to save over \$100 million per year after implementing legislation requiring safe needle devices<sup>4</sup>.

## **N**urses` Rights

According to the International Labour Organization (ILO) all appropriate measures should be taken to prevent, reduce or eliminate risks to the health of nursing personnel. This includes<sup>5</sup>:

- A comprehensive national policy on occupational health.
- The establishment of occupational health services.
- Access to health surveillance, preferably during working hours and at no cost to the worker concerned.
- Medical confidentiality of health surveillance.
- Financial compensation for those exposed to special risks.
- Participation in all aspects of protection provisions.

### **What you can do to protect yourself and others:**

- ⇒ Avoid the use of needles where safe and effective alternatives are available.
- ⇒ Avoid recapping needles.
- ⇒ Participate in blood borne pathogen training and follow recommended infection prevention practices, including hepatitis B vaccination.
- ⇒ Report all needlestick and other sharps related injuries to ensure that you receive appropriate follow-up care.

- ⇒ Advocate for monitoring and safe work practices, including data collection.
- ⇒ Educate and lobby for the development of safer technology.
- ⇒ Advocate for screening, post exposure counseling, prophylaxis, legal aid, and support groups.
- ⇒ Use purchasing power to buy safe equipment.
- ⇒ Create/maintain a safe, comprehensive disposal system.
- ⇒ Promote safety awareness.
- ⇒ Evaluate prevention efforts and provide feedback on performance.

The International Council of Nurses is a federation of more than 125 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

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July 2000

<sup>1</sup>National Institute for Occupational Health and Safety (NIOSH). Preventing Needlestick Injuries in Health Care Settings. November, 1999. Publication NR. 2000-108.

<sup>2</sup>WHO Safe Injection Global Network

<sup>3</sup>Henry et al., 1990. NIOSH Preventing Needle Stick Injuries in Health Care Settings

<sup>4</sup>American Nurses Association, Nursing Facts: Needlestick Injury, 1998

<sup>5</sup>ILO Recommendation 157: Employment and conditions of work and life of nursing personnel



## NURSING MATTERS

*Nursing Matters* fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues.

### Immunisations for health-care workers: influenza and hepatitis B

#### Background

Vaccines are used extensively around the world to protect against disease by inducing immunity. The benefits of immunisation are widely accepted: WHO estimates that vaccination averted approximately two million deaths in 2002, while five million people have escaped paralysis due to polio since 1988, and between 1999 and 2003 deaths from measles fell by nearly 40%.<sup>1</sup> In addition to reducing disease, suffering and death, immunisation also reduces the strain on health care systems and in many cases saves money that can be directed to other health services.<sup>1</sup> Consequently, WHO recognises vaccination as one of the most cost effective health investments.<sup>1</sup>

Health care workers who work with patients have an increased risk of exposure to vaccine-preventable diseases, and of passing those infections to other patients. As a result, health-care systems around the world recommend the immunisation of health care workers against certain infectious diseases. The rationale for this is three-fold. Vaccination against key diseases will protect the health care workers, protect their families and protect their patients. However, despite the adoption of these immunisation policies, and the fact that health care workers are instrumental in implementing society-wide vaccination programmes, research demonstrates that immunisation rates of health care workers should be improved.<sup>2</sup>

This fact sheet explores the issues associated with the immunisation of health care workers against two important vaccine-preventable diseases: influenza and hepatitis B.

<sup>1</sup> WHO Fact Sheet 288 'Immunization against diseases of public health importance.'

<sup>2</sup> Hoffman F et al. *Infection* 2006; 34:142-147.

## **I**mmunising health care workers against influenza

Influenza is the most common vaccine-preventable disease and accounts for significant morbidity and mortality.<sup>3</sup> In the USA, influenza and pneumonia account for about 40,000 deaths and over 200,000 hospitalisations per year, and together are the seventh leading cause of death, greatly exceeding those caused by AIDS.<sup>3,4</sup>

Influenza is a highly contagious virus, and nosocomial transmission of influenza is often identified at health care facilities. Due to their unique work environment health care workers are at greater risk of contracting influenza, and as a result of their high levels of commitment to their work many continue to care for patients even when infected.<sup>2,3</sup> The resultant potential to spread the disease throughout health care facilities is compounded by the fact that approximately 50% of those with influenza do not develop classic symptoms and are therefore likely to be unaware of the infection, but can shed the virus for between 5 and 10 days.<sup>3</sup>

During influenza outbreaks, health care facilities are often short-staffed and have reduced capacity. Protecting health care workers through vaccination can help alleviate this situation, as well as reducing transmission to patients, thereby reducing the significantly increased hospital costs associated with nosocomial outbreaks. As a result, many institutions recommend routine influenza vaccination for health care workers. For instance, the US Center for Disease Control and Prevention (CDC) adopted this recommendation in the early 1980s and, by 2000, 12 European countries had followed suit.<sup>2</sup>

## **I**nfluenza vaccination rates amongst health care workers

Research shows that despite the benefits of influenza vaccination to health care workers and their families and patients, coverage rates vary and are often low. One review of research into vaccination rates found uptake varied from 2%-82%.<sup>2</sup> Although rates are higher in the US than in Europe, in 2002 uptake in the US was only 38% while just 12-25% of European health care workers were vaccinated.<sup>2</sup>

## **I**mproving influenza vaccination rates

Although ultimately the vaccination decision lies with individual health care workers, research shows that integrated immunisation campaigns may increase uptake. Notable features of more successful campaigns include 'notification, education and vaccination'.<sup>2</sup> Notification included individual communications such as via email, in pay slips and memos. Education can take many forms including in-house sessions and conferences. Finally, immunisation should be free and easily accessible, from, for example, walk-in clinics and vaccination carts.

The education component is important, and as well as including the rationale to protect self, family and patients, it should address the common reasons given by health care workers for not receiving the vaccine. Research shows that a number of misconceptions were responsible for health care workers avoiding vaccination.

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<sup>3</sup> Backer H. *Clinical Infectious Diseases* 2006; 42 (15 April).

<sup>4</sup> See more details at [www.ifpma.org/influenza](http://www.ifpma.org/influenza)

Notably, workers cited fear of adverse effects, belief that the vaccine can cause influenza and a perception that the risk of infection is low and the vaccine lacks efficacy.<sup>2</sup> This is despite the fact that as with any vaccine adverse events can occur, but are generally mild and short-lived injection site reactions, with other potential effects occurring less frequently. In addition, the vaccine is 70%-90% effective against influenza in healthy adults when the vaccine strains match those in circulation.<sup>2</sup> Overall, it is clear that to be successful campaigns must demonstrate that the benefits of vaccination outweigh the fears of workers.

## **I**mmunising against hepatitis B

With over 350 million carriers globally,<sup>5 6</sup> hepatitis B represents a major infectious hazard for health care workers.<sup>7</sup> Scientists estimate that in 2000 as many as 66,000 health care workers worldwide may have contracted hepatitis B due to occupational sharps injuries.<sup>8</sup> In the US, an estimated 1,450 health care personnel contracted the disease in 1993 through exposure to infected blood or serum-derived body fluids, which in itself represents a 90% reduction in cases from 1985.<sup>5</sup> In its 1997 recommendations on the immunisation of health-care workers, the American CDC suggested that 5-10% of health care personnel become chronically infected with hepatitis B, putting them at risk of liver cirrhosis, cancer and death.<sup>5</sup> Those with the disease are potentially infectious for the rest of their lives. Estimates suggest that previously 100-200 health care workers died annually in the US due to hepatitis B infection.<sup>5</sup>

Consequently, to protect against the serious effects of hepatitis B infection, those health care workers who are exposed to blood or other blood contaminated body fluids should be vaccinated. Although policies may vary between different health care systems, it may be appropriate to offer post-exposure prophylaxis to workers who are only exposed infrequently to blood, rather than providing pre-exposure vaccination.

## **T**esting those at risk

In addition to vaccination, it may be appropriate for health care workers who are likely to be exposed to blood or patients and those at on-going risk from sharps or needle injuries to receive post-immunization serological testing to ensure antibody levels are sufficient to provide protection.

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5 Maynard J. Vaccine 1990 Mar. 8 Suppl: S18-20; discussion S21-3.

6 WHO Fact Sheet 204 'Hepatitis B'

7 MMWR 1997;46(RR-18):1-42.

8 Pruss-Ustun A et al. Am J Ind Med 2005 Dec;48(6):482-90.

## **In summary**

Health care workers are at increased risk of infection due to the nature of their occupations. Exposure to patients raises the likelihood of contracting a number of diseases, including influenza and hepatitis B. Both infections result in significant morbidity and mortality, and as a consequence health care workers should be vaccinated to protect themselves, their families and their patients.<sup>9</sup>

The International Council of Nurses is a federation of more than 125 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

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ICN/01/2007

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<sup>9</sup> International Federation of Pharmaceutical Manufactures and Associations (IFPMA, 2007)

## Patient Safety

### ICN Position:

Patient safety is fundamental to quality health and nursing care. ICN believes that the enhancement of patient safety involves a wide range of actions in the recruitment, training and retention of health care professionals, performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice, safe environment of care, and accumulating an integrated body of scientific knowledge focused on patient safety and the infrastructure to support its development.

Nurses address patient safety in all aspects of care. This includes informing patients and others about risk and risk reduction, advocating for patient safety and reporting adverse events.

Early identification of risk is key to preventing patient injuries, and depends on maintaining a culture of trust, honesty, integrity, and open communication among patients and providers in the health care system. ICN strongly supports a system-wide approach, based on a philosophy of transparency and reporting - not on blaming and shaming the individual care provider – and incorporating measures that address human and system factors in adverse events.

ICN is deeply concerned about the serious threat to the safety of patients and quality of health care resulting from insufficient numbers of appropriately trained human resources. The current global nursing shortage represents such a threat.

ICN believes nurses and national nurses associations have a responsibility to:

- Inform patients and families of potential risks.
- Report adverse events to the appropriate authorities promptly.
- Take an active role in assessing the safety and quality of care.
- Improve communication with patients and other healthcare professionals.
- Lobby for adequate staffing levels.
- Support measures that improve patient safety.
- Promote rigorous infection control programmes.
- Lobby for standardised treatment policies and protocols that minimise errors.
- Liaise with the professional bodies representing pharmacists, physicians and others to improve packaging and labelling of medications.
- Collaborate with national reporting systems to record, analyse and learn from adverse events.
- Develop mechanisms, for example through accreditation, to recognize the characteristics of health care providers that offer a benchmark for excellence in patient safety.

## Background

While health care interventions are intended to benefit the public, there is an element of risk that errors and adverse events will occur due to the complex combination of processes, technologies and human factors related to health care. An adverse event can be defined as harm or injury caused by the management of a patient's disease or condition by health care professionals rather than by the underlying disease or condition itself.<sup>10</sup> Common threats to patient safety include medication errors, hospital acquired infections, exposure to high doses of radiation and use of counterfeit medicines.

Although human errors play a role in serious adverse events, there are usually inherent system factors, which if addressed properly would have prevented the errors.

There is a growing evidence that inadequate institutional staffing levels are correlated with increase in adverse events such as patient falls, bed sores, medication errors, nosocomial infections and readmission rates that can lead to longer hospital stays and increased hospital mortality rates.<sup>11</sup> Staff shortages and poor performance of personnel because of low motivation or insufficient technical skills are also important determinants of patient safety.

Poor quality health care causes substantial number of adverse events with serious financial impact on health care expenditures.

### Adopted in 2002

#### Related ICN Position Statements:

- [Protection of the title "nurse"](#)
- [Nursing regulation](#)
- [Scope of nursing practice](#)
- [Assistive or supportive nursing personnel](#)

#### ICN Publications:

- Patient Safety, WHPA, Fact Sheet (2001).

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10 Thomas, E.J; & Brennan, BMJ, Incidence and types of preventable adverse events in elderly patients: population based review of medical records. 18 March 2000. p.9.

11 Aiken, I.H. et al. Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction. JAMA (2002); 288: 1987-1993.

## Abuse and Violence Against Nursing Personnel

### ICN Position:

ICN strongly condemns all forms of abuse and violence against nursing personnel, ranging from passive aggression to homicide and including sexual harassment. Such actions violate the nurse's rights to personal dignity and integrity, and freedom from harm.

ICN condemns acts of abuse and violence perpetrated against **any person**, including other health care professionals, patients, children, the elderly, and other private citizens. However, within the employment sector, nurses are a category of worker particularly at risk and, thus attention must continue to be placed on eliminating all forms of abuse and violence against nursing personnel.

ICN firmly believes that violence in the health workplace threatens the delivery of effective patient services and, therefore, patient safety. If quality care is to be provided, nursing personnel must be ensured a safe work environment and respectful treatment. Excessive workloads, unsafe working conditions, and inadequate support can be considered forms of violence and incompatible with good practice.

ICN promotes and assists in the development of policies that reflect a “zero-tolerance” of violence, e.g. legislation, staff regulations, judicial sanctions, workplace environment standards, cultural norms. Sanctions should be taken that reflect the seriousness of any particular incident. Cooperation with other organisations having common goals in the campaign against violence is important.

ICN believes that every nurse has a personal responsibility to report and effectively intervene when incidents of violence occur in the workplace. Appropriate security measures must be applied to protect nursing students who are particularly at risk of workplace violence.

ICN urges national nurses' associations to actively:

- Sensitize the public and the nursing community to the various manifestations of violence against nursing personnel.
- Ensure access to counseling services for nursing personnel (victims and perpetrators of violence), including supporting nurses during reporting/compensation and claim procedures.
- Negotiate the introduction and maintenance of appropriate security measures and confidential grievance procedures in the work and learning environments.
- Support nurses, including facilitating access to legal aid when appropriate.

- Meet with top officials of relevant employer groups, national health and other organisations to gain their assistance in providing safe and respectful work and learning environments.
- Work to ensure that employers meet their occupational health and safety obligations, including developing adequate staffing levels, work methods that support quality care, and promoting safe behavioural patterns. This may include monitoring and denouncing employers that fail to meet these obligations.
- Ensure awareness of and access to existent resources available to nurses to deal with workplace abuse and violence.
- Provide and advocate for improved education and on-going training in the recognition and management of workplace abuse and violence.
- Assist in creating a nursing culture that does not perpetuate nurses' tendency to self-blame for incidents of violence.
- Foster positive nursing images and respect for nurses' rights to dignity and personal safety through role modelling. Integrate courses on the elimination and/or management of violence in nursing curricula.
- Assist in the collection of reliable data regarding violence in the health sector.
- Assist in the development of work methods that provide quality care, maintain adequate staffing levels and promote safe patterns of behaviour.
- Negotiate workplace violence reduction strategies that incorporate organisational and environmental as well as individual-focused interventions.
- Create or facilitate user-friendly, confidential and effective reporting mechanisms.
- Support educational institutions to introduce formal training with regard to workplace abuse and violence.

## **Background**

Sickness and potential life-threatening factors cause stress in patients, their family members, and personnel in the health workplace. Such stress can aggravate factors that lead to violence; the levels of which are reportedly on the increase in society in general, and in the health workplace in particular.

Workplace violence is universal and pervasive. The impact of psychological violence is as great if not greater than physical violence. It is also more widespread.

Working conditions in the health sector place nursing and other health personnel at greater risk of violence, because of:

- Staffing patterns, including inadequate staffing levels and supervision, the use of temporary and inexperienced staff, heavy workloads and being solely responsible for health care units.
- Shift work, including commuting to and from work at night.
- Poor security measures in health facilities.
- Interventions demanding close physical contact.
- Demanding workloads, often occurring in emotionally charged environments.
- Highly accessible worksites with little to no privacy.
- Home visiting with its associated isolation.

Research demonstrates that amongst health personnel, nursing staff are most at risk of workplace violence. The prevalence and impact of violence against nursing personnel, both male and female, is troubling when compared to other professions. The effects of violence extend beyond the workplace affecting the victim's family and observers, known as third party violence. Verbal abuse must not be minimised - the effects of which are similar to physical assault including its repercussions on care provision.

Traditionally, many cultures have covertly accepted physical violence, sexual harassment or verbal abuse against women although a violation of their human rights. Also, nurses often passively accept abuse and violence as "part of the job" – an attitude sometimes shared by the public and the judiciary. The pressures on female and male victims to remain silent are great and underreporting has hampered the development and implementation of effective strategies to reduce violence in the workplace.

Nurses have been expected to cope with violence, although few programmes train nursing personnel to identify potentially dangerous situations and develop effective mechanisms to deal with aggression.

The consequences of physical and verbal abuse, and sexual harassment include:

- Feelings of shock, disbelief, shame, guilt, anger, depression, fear, self-blame, powerlessness, and exploitation.
- Physical injury and disorders (e.g. migraine, vomiting), and sexual disturbances.
- Increased stress and anxiety.
- Loss of self-esteem and belief in one's professional competence.
- Avoidance behaviour, which may negatively affect the performance of duties, including absenteeism.
- Negative effect on interpersonal relationships.
- Loss of job satisfaction. low staff morale, and increased staff turnover rate.

Violence is destructive and has a profoundly negative impact on observers, the victims, their family members and ultimately on patient care and safety. Violence may be said to “poison” the work environment.

**Reference:**

Guidelines on coping with violence in the workplace, Geneva, ICN, 2004.  
ILO/ICN/WHO/PSI Framework Guidelines for Addressing Workplace Violence in the Health Sector and the Training Manual  
(<http://www.icn.ch/sewworkplace.htm#Framework>;  
[http://www.icn.ch/SEW\\_training\\_manual.pdf](http://www.icn.ch/SEW_training_manual.pdf))

**Adopted in 2000**

**Revised in 2006**

**Related ICN Positions:**

- Socio-economic welfare of nurses
- Nurse retention, transfer and migration
- Occupational health and safety for nurses
- Nurses and Shift work
- Health human resources development (HHRD)
- Nurses and human rights

**ICN Publications:**

- Guidelines on Coping with Violence
- Framework Guidelines Addressing Workplace Violence in the Health Sector

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## Occupational Health and Safety for Nurses

### ICN Position:

ICN is clear that a safe work environment in the health sector significantly contributes to patient safety and supports positive patient outcomes. To that end ICN promotes the development and application of international, national and local policies or instruments that will safeguard the nurses' right to a safe work environment, including continuing education, immunisation and protective clothing/equipment. ICN reconfirms its mandate to encourage research in this area and to circulate relevant information on a regular basis to appropriate stakeholders.

ICN deplores the lack of appropriate national occupational health and safety legislation covering nurses in their place of employment, the often inadequate mechanisms for workers' participation in the monitoring/elimination of professional hazards, and the insufficient resources allocated to ensure optimal occupational health and safety services and labour inspection.

ICN strongly supports the various ILO Conventions relating to occupational health and safety and believes that national nurses' associations should:

- Urge their respective governments to ensure that all health agencies fall within the provision of occupational health and safety legislation. This can be done through lobbying, individual and/or collective political action.
- Initiate and/or support research in their countries into the safety and suitability of the work environment of nurses as well as risk behaviours, attitudes, procedures and activities.
- Sensitise nursing personnel, employers and the public to occupational hazards in the health sector, including violence or abuse.
- Raise nurses' awareness of their rights (as workers) to a safe environment and of their obligations to protect their safety and promote the safety of others.
- Convince governments and employers to adopt and implement all necessary measures to safeguard the health and well-being of nurses at risk in the course of their work, including vaccination when appropriate.
- Urge governments/employers to ensure the access of nursing personnel to protective measures (e.g. clothing) and equipment at no extra cost to staff;
- Encourage nurses to undergo vaccinations relevant to their health and safety in the workplace.

- Cooperate with the competent authorities to ensure the accuracy of the List of Occupational Diseases and periodically evaluate its relevance to nursing personnel.
- Support nurses' claims for compensation in relation to occupational disease and/or injury.
- Obtain and disseminate information on the incidence of work-related accidents, injuries and illnesses of nurses.
- Cooperate with other organisations supporting the worker's right to a safe work environment.
- Recognise the important relationships between workers and their families in the development of culturally appropriate occupational health and safety policies and treatment plans.
- Support nurses' freedom from being intimidated in their role of patient advocate.
- Call for adequate monitoring systems at all levels that will ensure appropriate implementation of policies.
- Disseminate information on the introduction of new hazards in the workplace.
- Disseminate information on non-compliance by employers of occupational health and safety legislation, including reporting mechanisms for such violations.

ICN supports the expanding role of the occupational health nurse in meeting workers' primary health care needs, and demands fair remuneration and adequate career structures that support professional development. ICN calls for the recognition of occupational health and safety as a professional nursing role with the appropriate remuneration that corresponds to the level of expertise and incentives to attract/retain nurses in this area of practice.

### **Background:**

ICN recognises the major role occupational health and safety plays in health promotion. Furthermore, ICN acknowledges the growing expertise nurses have gained in the area of occupational health and safety and the cost-effectiveness of the services provided for workers.

Patient care benefits from a safe work environment for health personnel. The work environment of the nurse is frequently unsafe, however, as a result of:

- Environmental contamination by waste products resulting from human and industrial activity.
- Risks (e.g. chemical, biological, physical, noise, radiation, repetitive work).
- Medical technology – lack of maintenance, insufficient training in the use of technology.

- Inadequate access to protective clothing and safe equipment.
- The disturbance of everyday life patterns associated with shift work.
- The increasing demands made upon the emotional, social, psychological and spiritual resources of the nurse working in complex political, social, cultural, economic and clinical settings.
- Incidents of violence, including sexual harassment.
- Poor ergonomics (engineering and design of medical related equipment, materials and facilities).
- Inadequate allocation of resources, e.g. human, financial.
- Isolation.

ICN notes that most governments fail to collect current accurate information on the incidence of accidents, injuries and illness of nursing personnel as the basis for sound policy formulation. The lack of relevant data is a matter of great concern.

In certain countries, there is no occupational health and safety legislation. In others, the means to monitor its implementation and the machinery to discipline the offending employers is ineffective or non-existent. Yet other countries have adopted legislation that excludes hospitals and other health agencies.

*Convention 149 of the International Labour Organization (ILO) concerning Employment and Conditions of Work and Life of Nursing Personnel*<sup>1)</sup> calls on member states to “improve existing laws and regulations on occupational health and safety by adapting them to the special nature of nursing work and of the environment in which it is carried out”. Section IX of the accompanying *Recommendation (157)*<sup>1)</sup> further develops the measures considered necessary to guarantee the health and safety of nurses in the workplace.

<sup>1)</sup> International Labour Organization, **Convention 149 and Recommendation 157 concerning the Employment and Conditions of Work and Life of Nursing Personnel**, Geneva, ILO, 1977.

**Adopted in 1987**

**Revised and updated in 2006**

<p><b>Related ICN Positions:</b></p> <ul style="list-style-type: none"><li>• Abuse and violence against nurses</li><li>• Shift work</li></ul>	<p><b>ICN Publications:</b></p> <ul style="list-style-type: none"><li>• Guidelines on Coping with Violence</li><li>• Framework Guidelines Addressing Workplace Violence in the Health Sector</li></ul>
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## ***ICN Calls for Positive Practice Environments to Ensure Quality Patient Care***

**Geneva, 12 May 2007** – Based on the conviction, supported by evidence, that quality health care workplaces provide quality patient care, ICN has launched a global call to address and improve the serious deficiencies currently existing in the health work environment in all regions. The delivery of safe, high quality and efficient health services depends on the competence of health workers and a work environment that supports performance excellence. The ongoing underinvestment in the health sector in many countries has resulted in a deterioration of working conditions. This has had a serious negative impact on the recruitment and retention of health personnel, the productivity and performance of health facilities, and ultimately on patient outcomes. Positive practice environments (PPE) must be established throughout the health sector if national and international health goals are to be met.

“The goal of ICN’s call for positive practice environments is to improve the quality of health services through health care work environments that support performance excellence,” declared Hiroko Minami, President of ICN. “We believe patients and the public have the right to the highest performance from nurses and other health care professionals. This can only be achieved in a workplace that enables and sustains a motivated, well prepared workforce.”

ICN has brought this issue to light on the occasion of International Nurses Day, with the publication of an information and action toolkit entitled, “*Quality workplaces=quality patient care*”. The toolkit is designed to raise awareness and stimulate action, and can be used by managers, front-line nurses, chief executive officers, professional associations and/or regulatory bodies. It provides data on positive practice environments to all health stakeholders who are interested in improving the delivery of quality services. The toolkit has been distributed to all ICN member associations and to nursing representatives worldwide. It can be accessed online at [www.icn.indkit.htm](http://www.icn.indkit.htm)

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The establishment of positive practice environments will continue to be a priority programme in the years to come, both for ICN and its recently launched International Centre for Human Resources in Nursing (ICHRN). The goal of ICHRN is to improve the quality of patient care through advancing nursing and health care services and promotional activities for positive practice environments will be supported by the data, tools and standards found on its website ([www.ichrn.org](http://www.ichrn.org)).

**Editor's note**

The International Council of Nurses (ICN) is a federation of 129 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses since 1899, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

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## References

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- Ahlberg-Hulten GK, Theorell T & Sigala F (1995). Social support, job strain and musculoskeletal pain among female health care personnel. *Scandinavian Journal of Work, Environment and Health*, 21(6), 435-439.
- Aiken L, Clarke SP, Sloane DM, Sochalski J & Silber JH (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, 288, 1987-1993.
- Aiken L, Clarke SP, Cheung RB, Sloane DM & Silber JH (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association*, 290(12), 1617-1619.
- Aiken LH, Sloane, DM & Klocinski JL (1997). Hospital nurses occupational exposure to blood: Prospective, retrospective, and institutional reports. *American Journal of Public Health*, 87(1), 103-107.
- Alexander JA, Bloom JR & Nuchols BA (1994). Nursing turnover and hospital efficiency: An organization-level analysis. *Industrial Relations*, 33(4), 505-520.
- Al-Shammari MM (1992). Organizational climate. *Leadership & Organization Development*, 13(6), 30-32.
- American Federation of Teachers (1995). *Definition of "safe staffing."* Available from the American Federation of Teachers Web site, <http://www.aft.org/topics/healthcarestaffing/definition.htm>
- Baguley K (1999). *Workplace empowerment, job strain, and affective organizational commitment in critical care nurses: Testing Kanter's structural theory of organizational behavior.* Unpublished master's thesis, University of Western Ontario, London, Ontario, Canada.
- Baker R, Norton P, Flitoff V, Blais R, Brown A, Cox J, et al. (2004). The Canadian Adverse Events Study: The incidence of adverse events among hospital patients in Canada. *Canadian Medical Association Journal*, 170(11), 1678-1686.
- Baumann A, Blythe J, Cleverley K, Grinspun D & Tompkins A (2006). *Health Human Resource Series Number 3. Educated and underemployed: The paradox for nursing graduands.* Hamilton, Ontario, Canada: Nursing Health Services Research Unit, McMaster University.
- Baumann A, Yan J, Degelder J & Malikov K (2006). *Health Human Resource Series Number 4. Retention strategies for nurses: A four country comparison.* Geneva: International Council of Nurses.
- Baumann A, Hunsberger M, Blythe J & Crea M (2006). *Health Human Resource Series Number 6. The new healthcare worker: Implications of changing employment patterns in rural and community hospitals.* Hamilton, Ontario, Canada: Nursing Health Services Research Unit, McMaster University.

- Baumann A, O'Brien-Pallas L, Armstrong-Stassen M, Blythe J, Bourbonnais R, Cameron, et al. (2001). *Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system*. Ottawa, Ontario, Canada: Canadian Health Services Research Foundation.
- Becton, Dickinson and Company (2006). *BD and International Council of Nurses collaborate to address the health human resource crisis in Africa*. Available from the BD Worldwide Web site, <http://www.bd.com/>
- Best M & Thurston E (2004). Measuring nurse job satisfaction. *Journal of Nursing Administration*, 34(6), 283-290.
- Best M & Thurston E (2006). Canadian public health nurses' job satisfaction. *Public Health Nursing*, 23(3), 250-255.
- Blegen MA (2006). Patient safety in hospital acute care units. *Annual Review of Nursing Research*, 24.
- Blegen MA, Goode CJ & Reed L (1998). Nurse staffing and patient outcomes. *Nursing Research*, 47(1), 43-50.
- Bryce EA, Ford J, Chase L, Taylor C & Scharf S (1999). Sharps injuries: Defining prevention priorities. *American Journal of Infection Control*, 27(5), 447-452.
- Brown SP & Leigh TW (1996). A new look at psychological climate and its relationship to job involvement, effort, and performance. *Journal of Applied Psychology*, 81(4), 358-368.
- Buchan J & Calman L (2004). *The global shortage of registered nurses: An overview of issues and actions*. Geneva: International Nursing Council.
- Canadian Centre for Occupational Health and Safety (2005, January). *Needlestick injuries*. Available from the Canadian Centre for Occupational Health and Safety Web site, [http://www.ccohs.ca/oshanswers/diseases/needlestick\\_injuries.html](http://www.ccohs.ca/oshanswers/diseases/needlestick_injuries.html)
- Canadian Nurses Association (2006). *Vision and mission*. Retrieved December 1, 2006, from [http://www.cna-nurses.ca/CNA/about/mission/default\\_e.aspx](http://www.cna-nurses.ca/CNA/about/mission/default_e.aspx)
- Choi BCK, Levitsky M, Lloyd RD & Stones IM (1996). Patterns and risk factors for sprains and strains in Ontario, Canada 1990: An analysis of the workplace health and safety agency database. *Journal of Occupational and Environmental Medicine*, 38(4), 379-389.
- Cox S & Flin R (1998). Safety culture: Philosopher's stone or man of straw? *Work & Stress*, 12(3), 189-201.
- Dickson M W, Resick C J & Hanges PJ (2006). When organizational climate is unambiguous, it is also strong. *Journal of Applied Psychology*, 91(2), 351-364.
- Downey HK, Hellriegel D & Slocum JW (1975). Congruence between individual needs, organizational climate, job satisfaction and performance. *The Academy of Management Journal*, 18(1), 149-155.
- Engkvist IL, Hagberg M, Wigaeus Hjelm E, Menckel E & Ekenvall L (1998). PROSA study group. The accident process preceding overexertion back injuries in nursing personnel. *Scandinavian Journal of Work, Environment & Health*, 24, 367-375.

- Flexner A (1910). *Medical education in the United States and Canada. A report to the Carnegie foundation for the advancement of teaching*. Retrieved October 18, 2006, from [http://www.carnegiefoundation.org/files/elibrary/flexner\\_report.pdf](http://www.carnegiefoundation.org/files/elibrary/flexner_report.pdf)
- Gaudine AP (2000). What do nurses mean by workload and work overload? *Canadian Journal of Nursing Leadership*, 13(2), 22-27.
- Griffin MA & Neal A (2000). Perceptions of safety at work: A framework for linking safety climate to safety performance, knowledge, and motivation. *Journal of Occupational Health Psychology*, 5, 347-358.
- International Council of Nurses (n.d.). *Nurse: Patient ratios*. Available from the ICN Web site, [http://www.icn.ch/matters\\_rnpratio.htm](http://www.icn.ch/matters_rnpratio.htm)
- International Council of Nurses (2004). *Workload measurement in determining staffing levels*. Geneva, Switzerland
- International Council of Nurses (2006). *Safe staffing saves lives information and action tool kit*. Available from the ICN Web site, <http://www.icn.ch/indkit2006.htm>
- Institute of Medicine (2000). *To Err Is Human: Building a Safer Health System*, Institute of Medicine 2000). Available from <http://www.nap.edu/books/0309068371/html/>
- Kingma M (2006). *Nurses on the move*. New York: Cornell University Press.
- Koehoorn M, Kennedy S, Demers P, Clyde Hertzman C & and Village J (2000). *Musculoskeletal injuries among health care workers: Individual, biomechanical and work organization factors*. Available from the Work Safe BC Web site, [http://www.worksafebc.com/about\\_us/library\\_services/reports\\_and\\_guides/wcb\\_research/Default.asp](http://www.worksafebc.com/about_us/library_services/reports_and_guides/wcb_research/Default.asp)
- Kovner C & Gergen PJ (1998). Nurse staffing levels and adverse events following surgery in U.S. hospitals. *Image: Journal of Nursing Scholarship*, 30(4), 315-321.
- Kramer M & Schmallenberg C (1988). Magnet hospitals: Part 1 institutions of excellence. *Journal of nursing Administration* 18(1), 13-24.
- Kristensen TS (1999). Challenges for research and prevention in relation to work and cardiovascular disease. *Scandinavian Journal of Work, Environment and Health*, 25(6), 550-557.
- Lancaster AD (1997). Consult stat: Understaffing can increase infection rates. *RN*, 60(10), 79.
- Laschenger HKS, Wong C, McMahon L & Kaufmann C (1999). Leader behaviour effect on staff nurse empowerment, job tension and work effectiveness. *Journal of Nursing Administration*, 29 (5), 28-39.
- Leveck ML & Jones CB (1996). The nursing practice environment, staff retention and quality of care. *Research in Nursing and Health* 19(4), 331-343.

- Lowe GS (2004). *Healthy workplace strategies: Creating change and achieving results*. Available from the Canadian Policy Research Network Web site, <http://www.cprn.com/en/doc.cfm?doc=536>
- Lowe GS (2005). Raising the bar for people practices: Helping all health organizations become “preferred employers.” *Healthcare Quarterly*, 8, 60-63.
- McClure ML (2005). Magnet hospitals: Insights and issues. *Nursing Administration Quarterly*, 29(3), 198-201.
- McClure M, Poulin M, Sovie M & Wandelt M (1983). *Magnet hospitals: Attraction and retention of professional nurses*. Kansas City, MO: American Academy of Nurses.
- McGillis Hall L (2005). Nurse staffing. In L. McGillis Hall (Ed.), *Quality work environments for nurse and patient safety* (pp. 9-37). Jones and Bartlett: Sudbury, MA.
- Mearns KJ & Flin R (1999). Assessing the state of organizational safety—Culture or climate? *Current Psychology: Development, Learning, Personality, Social* 18(1), 5-17.
- Morrison R S, Jones C B & Fuller B (1997). The relationship between leadership style and empowerment on job satisfaction on nurses. *Journal of Nursing Administration* 29(5), 28-29.
- National Task Force on Violence Against Social Care Staff (2001). *Report and national action plan*. Retrieved December 1, 2006, from <http://www.dh.gov.uk/assetRoot/04/06/28/20/04062820.pdf>
- Needleman J, Buerhaus P, Mattke S, Stewart M & Zelevinsky K (2002). *Nurse-staffing levels and the quality of care in hospitals*. *New England Journal of Medicine*, 346(22), 1715-1722.
- Nolan M, Lundh U & Brown J (1999). Changing aspects of nurses' work environment: A comparison of perceptions in two hospitals in Sweden and the UK and implications for recruitment and retention of staff. *NT Research*, 4(3), 221-233.
- O'Brien-Pallas L, Thomson D, Alksnis C & Bruce S (2001). The economic impact of nurse staffing decisions: Time to turn down another road? *Hospital Quarterly*, 4(3), 42-50.
- Person SD, Allison JJ, Kiefe CI, Weave, MT, Williams OD et al. (2004). Nurse staffing and mortality for Medicare patients with acute myocardial infarction. *Medical Care*, 42(1), 4-12.
- Registered Nurses' Association of Ontario (2006a). *Healthy work environments best practice guidelines: Collaborative practice among nursing teams*. Toronto, Ontario, Canada: Author. (Forthcoming: Winter 2006).
- Registered Nurses' Association of Ontario (2006b). *Healthy work environments best practice guidelines: Developing and sustaining effective staffing and workload practices*. Toronto, Ontario, Canada: Author. (Forthcoming: Winter 2006).
- Registered Nurses Association of Ontario (2006c). *Healthy work environments best practice guidelines: Developing and sustaining nursing leadership*. Toronto, Ontario, Canada: Author.
- Registered Nurses' Association of Ontario (2006d). *Healthy work environments best practice guidelines: Professionalism in nursing*. Toronto, Ontario, Canada: Author. (Forthcoming: Winter 2006).

- Rousseau DM (1996). *Psychological contracts in organizations: Understanding written and unwritten agreements*. Newbury Park, CA: Sage.
- Rowell P (2003, September 30). The professional nursing association's role in patient safety. *Online Journal of Issues in Nursing*, 8(3), Manuscript 3. Retrieved December 1, 2006, from [www.nursingworld.org/ojin/topic22/tpc22\\_3.htm](http://www.nursingworld.org/ojin/topic22/tpc22_3.htm)
- Schindul-Rothschild J, Berry D & Long-Middleton E (1996). Where have all the nurses gone? *American Journal of Nursing*, 96(11), 25-39.
- Scott J, Sochalski J & Aiken L (1999). Review of magnet hospital research: Findings and implications for professional nursing practice. *Journal of Nursing Administration*, 29(1), 9-19.
- Seigrist J (1996). Adverse health effects of high-effort/low-reward conditions. *Journal of Occupational Health Psychology*, 1(1), 27-41.
- Shullanberger G (2000). Nurse staffing decisions: An integrative review of the literature. *Nursing Economic\$, 18(3)*, 124-132, 146-148.
- Sinclair CM (2000). *Report of the Manitoba pediatric cardiac surgery inquest*. Available from the Province of Manitoba Pediatric Cardiac Inquest Web site, <http://www.pediatriccardiacinquest.mb.ca/>
- Sovie MD & Jawad AF (2001). Hospital restructuring and its impact on outcomes. *Journal of Nursing Administration*, 31(12), 588-600.
- Tourangeau AE, Giovanetti P, Tu JV & Wood M (2002). Nursing-related determinants of 30-mortality for hospitalized patients. *Canadian Journal of Nursing Research*, 33(4), 71-88.
- Tovey EJ & Adams AE (1999). The changing nature of nurses' job satisfaction: An exploration of sources of satisfaction in the 1990s. *Journal of Advanced Nursing*, 30(1), 150-158.
- Weisman CS & Nathanson CA (1985). Professional satisfaction and client outcomes: A comparative organizational analysis. *Medical Care*, 23(10), 1179-1192.
- White JP (1997). Health care, hospitals, and reengineering: The nightingales sing the blues. In A. Duffy, D. Glenday, & N. Pupo (Eds.), *Good jobs, bad jobs, no jobs: The transformation of work in the 21st century*. Toronto, Ontario, Canada: Harcourt & Brace.
- Wiegmann DA, Zhang H, von Thaden T, Sharnam G & Mitchell A (2002). *A synthesis of safety culture and safety climate research*. Technical Report ARL-02-3/FA-02-2. Prepared for Federal Aviation Administration Atlantic City International Airport, NJ. Contract DTFA 01-G-015.
- Wilson B & Laschinger HKS (1994). Staff nurse perception of job empowerment: A test of Kantor's theory of structural power in organizations. *Journal of Nurse Administration*, 24(Suppl. 4), 39-47.