QUALITY WORK ENVIRONMENT STUDY (QWEST) SYMPOSIUM

Summary of Qualitative Data Analysis

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Background

In the first phase of the QWEST study (*exploratory theory development and refinement*), our goal was to ensure the congruence between our theoretical constructs and the reality of the work contexts through qualitative inquiry. We invited manager and staff participants to participate in focus group or individual interviews to discuss their work environment, factors that influenced their work life, and hindered or facilitated their ability to provide safe patient care. We asked managers about their perceptions and experiences of effective leadership and current challenges and contrasted this with our staff data. Dr Jude Spiers conducted most interviews and analysed the data with the help of graduate students and research assistants Heather McArthur, Eliza Lo, Zahra Komelian, and project coordinator Tara MacGregor. Marloes Bijl and Donna Schalk, students in Master of Health Science & Policy, Faculty of Health, Medicine and Life Sciences, Department of Health Care and Nursing Science, Maastricht University, Netherlands took leadership in some of the initial interviews and analysis for their master's thesis work. Qualitative (inductive analysis) generated concepts which were then compared and combined with our previous literature search and the research theoretical framework to refine and ground the theoretical framework and item selection for the surveys for phase two of the study. We interviewed 31 managers from the three settings (Acute/Tertiary care n= 10; Community hospitals n= 11, long term care n=10) and conducted 10 focus groups with nursing staff (RNs, LPNs and NAs). We used the qualitative analysis to screen and tailor survey tools to our context. This document provides a description of the main themes emerging in our analysis.

Characteristics of the ideal quality work environment

We asked managers and staff to describe the characteristics of an ideal work environment, and to identify the factors that contribute to quality, enhance quality of care or interfere with the provision of quality care. Participants identified the following attributes as characteristic of a quality working environment: team work and respectful interpersonal relationships, full and appropriate staff complement and stability, sufficient resources to do complete their work, fair scheduling decisions, working to scope of practice, appropriate and fair supervision, and reasonable work load that reflected equality in distribution of responsibility and individual strengths and preferences. Particularly in LTC settings, lack of rigid hierarchical siloing facilitated assistance and coaching between team members, and reduced any sense of marginalization between professional and unregulated care providers.

> *Where everybody respects each other, everybody trusts each other. We have a policy of respect in the workplace. I would like to see that where nobody is looked down upon, everybody is treated with respect. The ideal situation where you would have full staffing and then nursing staff would be able to realize their potential, you know, be more active in preceptorship, work to their full scope instead of doing a lot of the duties that could be done by non-nursing staff.*

Clinical leadership had an integral relationship to the work environment. In LTC settings, the norm appeared to be team based models of practice, in which there were consistent RN team leadership, In the acute care settings, the role of the unit/patient care manager varied from no clinical role to a significant presence. There was little consistency about preferred models of care delivery, except that the model *only* worked if was a mutual agreement between staff and management. Consistent clinical leadership was important in settings where a leader is appointed on a daily basis.

> *It's really wonderful to work here, and especially when we do the day shift and somebody is there who can who you can ask if there is any problem like the manager will be here*

Some RNs reported that they avoided taking clinical leadership roles because the "*work was not worth the lack of pay".*

No one had difficulties in identifying the characteristics of a quality working environment even though they clearly stated that they did not currently have that kind of environment. Quality of work environment was equated to quality of nursing care, defined as professional and accountable, comprehensive, and holistic.

Full and appropriate staffing complements were essential to equally distribute and manage workload and to foster the potential for staff to real their individual potential. At the time of data collection, there were significant staffing issues in all three settings. In acute care areas, managers reported huge competition for staff, limited numbers of graduate which resulted in long term vacancies and the need for "workarounds" to cope which mainly consisted of mandatory overtime. Very few staff or manager participants reported sufficient staffing, and this was restricted to highly specialised areas.

For all levels of staff (RNs, LPNs and NA), this referred to working to full scope of practice, being active in preceptor ship and minimizing non-nursing activities. Cutbacks to staffing, and inadequate pay rates (for the complexity and emotional involvement in work) for nursing attendants in long term care has resulted in many attendants taking other jobs. Some NAs work multiple jobs to meet their financial needs, and this reduces their energy and motivation when faced with a heavy patient load as a NA> Managers describe this as "working to rule", "having blinkers on to avoid having to acknowledge the need to help other staff, and reluctance to support new staff. Some managers pointed out that even in situations of short staffing, if there is adequate teamwork and collegiality in the unit, and appropriate leadership that provides a sense of controlled stability, then adverse effects of short staffing are mitigated. The existence of dysfunctional relationships or interactions, manifested as "childlike" or unprofessional behaviour (backstabbing, gossip, and lack of conflict resolution, constantly running to managers) is a major threat to effective team work. Team cohesiveness deteriorates, and territoriality escalates. Although it is often perceived as "simpler" to solve the problem themselves, managers articulated the need to call the individuals to account and to encourage them to problem solve themselves. Team stability was an integral factor in a quality work environment. Excessive staff turnover and reliance on casual staff destabilises the group. Fear of losing staff was reported to inhibit some managers' ability to effectively foster, encourage accountability particularly in LTC.

> *It's such an issue that people are afraid that people will quit if they're held accountable, and if we say anything negative, well you know if we're too hard on them they're going to quit. Well you know when an RN leader says that, it worries me, because if you're afraid to act on anything because you're afraid to lose your staff, that's a very serious concern because you're going to turn a blind eye because you don't want Susie to get upset and quit.*

Staff told us that they became frustrated when asked to do significant overtime, yet requests for vacation were denied. Usually this is due to not understanding the reason for the denial, a perceived violation of the "give and take" relationship in which nurses step in to cover shortages and managers give time off when staff needs it. Rules such as "*one nurse is allowed off in 24 hours*" are inappropriate and unfair. The results is that "*people just stop asking for vacation and they call in sick because they know they're not going to get it off…you can't get denied sick time.*" On the other hand, staff also reported managers who were aware of their staff's personal circumstances and able to respond to their needs;

> *Not that long ago my mom was sick and passed away and my manager-just the type of person she is – when it was time for me to say, " okay I need a leave of absence to be with my mom" she's going… "When were you going to do that? I thought you would have done that long time ago." So, so it's that type of manager – I wouldn't change anything about her.*

Lack of regard as individuals rather than work units on the part of managers was never accepted by staff

> *I think some of them just see you as a body and they could really care less. I don't really care who you are or what you do or what your home life is. I just care that you're here and you're filling my space up.*

Physical Working environment: A major contributor to quality nursing environments in long term care settings was the physical environment. Long distances for staff to walk contributes to physical stress, especially with an ageing staffing demographic. Open concept spaces help staff see each other and fosters a sense of assistance and team work. In all settings, there was significant variation in the supports for staff to reduce potential for injury. Lifting tools were essential for staff; however some staff saw that equipment was unavailable due to economic constraints, poorly maintained or in scarce supply. This did not necessarily apply only to specialised equipment, but basic needs such as blood pressure monitors at each bedside, or sufficient bedpans in the unit. New equipment especially when purchased in response to staff request is a huge morale booster as it indicated that management was listening to staff. Some mangers noted the contribution of nurse educators to investigate equipment alternatives and evidence to support their use as critical to supporting staff. Managers noted that they often would not have time to do this or knowledge about where to start looking for the information.

Job Satisfaction: This was both a characteristic and outcome of a quality work environment. During the time of data collection, most health care settings were experiencing extreme staffing shortages. Many managers told us that short staffing caused physical exhaustion, stressed collegial interpersonal relations, and a sense of dissatisfaction about the quality of care offered to residents or patients; "*going home with a heavy heart*". Staff tired of providing only minimal essential care, worried about the potential for errors, mistakes and accidents for patients/residents when staff cannot promptly attend to their needs, or do not have opportunity for adequate assessments. We repeatedly heard about efforts on the part of managers to reassure staff that doing the best they can in current stressed environments included safe care but may not include some of the traditional "*comfort*" measures which were now seen as "*luxury*". Managers recognised that for many nurses, the inability to incorporate comfort or individualised care was a major stressor and source of dissatisfaction for staff.

Working to full scope of practice: While most managers in community and acute care settings perceived that their staff was working to their full scope of practice, this was a concern for some managers in long term care settings. Some mangers reported success in encouraging staff to work toward their full scope of practice by solidifying knowledge and skills and professional accountability but also by changing traditional culture of care and nursing work organisation in the units. It was acknowledged that long term settings are in an acute phase of change in terms of scope of practice for RNs and LPNs. Managers would like to see RNs focus on critical thinking and leadership roles and LPNs focus more on direct patient care. Changing traditional role boundaries was not easy for some long term staff. Some mangers pointed out that it were unfair to just "*expect staff to do it*" and that they needed support and education to move into their full scope of practice. Managers noted that LPNs and NAs are encouraged to work to full scope of practice more in long term settings than in acute care because of the lack of complete RN coverage.

Specific Factors adversely influencing quality working environments

Complexity of Care: In all settings, increasing complexity of care in response to increasing patient acuity or multiple chronic conditions was placing extra stress.

Workforce Turbulence: Manager turn over: Some contexts had experienced frequent manager or departmental leadership changes (e.g. new manager every 8 – 12 months). Manager workloads are increasing, and it is becoming more difficult to recruit and retain the right individuals to the right positions. The consequence is perception that staff feel unimportant, unheard and un-valued. It created distance and friction between staff and managers, with staff inclined to avoid or ignore managers. Staff reported that they "*if we don't get the answer we want, we'll just go do it ourselves, because the manager isn't going to be here long of enough anyway—so we'll just flip it and do it ourselves*".

Firefighting: many staff perceive that morale is low when there is high manager and staff turnover. Lack of staff support means that staff are not retained, and managers are occupied in "*putting out fires*" to cope with the immediate situation (e.g. dealing with new staff, incidents happening because of an inexperienced nurse) reducing their ability to really lead and proactively manage.

Prioritising patient and staff needs: In some instances, managers recognised that prioritising resident/patient or family needs over staff needs caused conflict and resentment.

> *Resident's first. Family's second. And staff's third in that pecking order, ok? I won't do a staff function before I do a resident function. I will not sacrifice something for the resident at the expense of one of my staff, i.e. I had a request for a lady to go on holidays. Her holidays would have caused hardship to the residents, and I did not allow her to go on that holiday.*

The new generation: Managers perceived that the work ethic and commitment by the newer generations of nursing graduates differed markedly in the areas of willingness to work overtime, flexibility in work shifts and patterns of sick leave. While it was perceived that new graduates have a more sense of need for work/private life balance, it was seen to foster some conflict with older nurses with a different work ethic. Many mangers expressed concern at the **ageing workforce.** Work patterns of older staff are changing, moving to part time work or casual work, which was managing to alleviate staffing shortages in many instances; however, most managers predicted major problems with mass retirements in the next five years.

Factors specific to Long term care:

- ***Deteriorating quality of recruits for NA positions:*** many managers noted that due to staffing shortages, they are currently hiring people that normally would not be hired. These people now require significant support and performance management efforts. Changing the focus on addressing deficits mean that quality of care deteriorates. Some examples given were basic communication skills with elderly residents, expression of compassion, conflict resolution. Mangers also recognised that cultural differences had the potential to create misunderstanding and conflict in the work environment, particularly when views and values around care, accountability, and team work differed. The staff participants tended to couch cultural differences in regard to responsibility and accountability in terms of maturity rather than culture. Some RN and LPN participants disliked their roles in supervising and monitoring nurse aides;

> *Constant reminders [to do tasks] … are really frustrating… when they all are working here, I consider everybody as adult. Once it's delegated to them I expect them to be finished rather than reminding. Constant reminding is like it's a waste of time for me.*

- ***Relief Pooling:*** One factor that seemed to be particular to long term care settings was the pooling of staff to other units to cover staff shortages. Overtime, double shifts exhausted staff, but a primary problem appears to be reluctance of staff to take equal turns in moving out. Staff become distressed because they are forced out of their comfort level – they do not know the unit or the residents. Managers emphasised the need to appear to be unbiased and fair in expecting all staff to "*take their turn*".
- ***Violence from Residents/patients:*** Abuse from residents or relatives toward staff was a major contributor to decreased quality of work environments and safe practice cultures. While most managers and staff reported an official zero tolerance policy for abuse, many people could cite instances when this policy was not enacted. Manager willingness to protect and advocate for staff was seen as a major indicator of good leadership.

Strategies to support staff and improve working environment:

This was hard for both staff and manager participants to articulate. Most strategies revolved around the persistence of managers in making an argument for funds and change, and that this needed to be substantiated by clearly documented benefit/cost analysis. Staff education, a traditional way of supporting staff was changing as staff cannot be released for off-unit time when there is insufficient staffing. All participants spoke to the importance of the clinical nurse educator role to initiate change through education. In the same way, staff meetings was seen as important, but not always effective in getting every nurses' input. Performance reviews were controversial, with many staff reporting they have not received one on an annual basis, and they were less effective than immediate performance feedback (both positive and negative) provided by an on-site manager.

> *Our manager will give us verbal compliments saying you guys did a really good job, you know I know you were really stressed out and worked and stretched to the max but you know keep up the good work and we do appreciate it – and I mean if we screw up she'll tell us too. She doesn't need to haul us into her office once a year to tell us that. She'll tell us right on the spot.*

Empowerment was the general term used to encapsulate how managers tried to foster a supportive environment. This was spoken of as a general principle and less in terms of specific strategies. Empowerment was described as "*resolving issues without manager involvement*" and enabling staff to make their own changes, which have an effect on staff morale. This notion combines professional accountability, individual maturity, and support on the part of the manager to recognise and respect the staff solutions. Part of this involves active encouragement of staff, and part is the manager knowing when to absent themselves from a situation and when it is critical to seek staff feedback for a decision to be made. Some mangers noted that some staff were reluctant to talk to managers, and would prefer to share ideas amongst themselves. Reasons for this ranged from fear of being seen as stupid, having ideas ridiculed. Mangers actively work on drawing staff out, getting to know them and to show their appreciation and valuing of staff input. Some managers deliberately altered their working hours to ensure that they could attend nursing report at 0700 hours, because it was impossible to interact with staff once they are on the floor. Many mangers noted that staff had great ideas, but manager's ability to access these people was limited. Despite different working groups or committees that staff could volunteer for, there is a lack of a forum to allow people to come forward with their ideas. Managers saw that encouraging staff who suggested initiatives to "*go for it*" recognised individual motivation and

expertise. "*People who are highly motivated, highly effective and highly trained need more autonomy.*" Mangers strive to move individuals from complaining about care or processes to problem solving as a team, and finding solutions. Negotiation and cooperation is key in working together.

Mentoring; coaching staff to move them forward is important in expanding practice to full scope, and to encourage staff to take on new initiatives. Mentoring involved role modeling, mutual discussion making, fostering trust in management, and advocacy for staff and resident/clients. Helping staff see the "*bigger picture*" e.g., from an organisational perspective is more challenging; however, obtaining staff "*buy-in*" is critical to any progress and change in care.

Leadership Characteristics

We asked participants to describe features of both strong and weak leadership and their effect on the quality of work environments. We also asked them what they thought their staff wanted, and if this was congruent or appropriate with the reality of the situation. Staff were perceived by mangers to want some different characteristics in a leader: strong, confidence, competent, positive, reassuring, will to advocate, protect and be proactive. *Being firm but fair* was the best mixture. Managers worried that some staff put too much importance on the manager role rather than relying on their own competence. Managers saw that staff truly desires *a leader to be present, visible and accessible and approachable*. These terms are not synonymous. Some staff are not comfortable in approaching a manager even if there is an "*open door policy*". Managers must be *proximal and visible*: if the manger is not around, they cannot help. While staff know managers can be contacted by phone or email, leaving a message leaves them wondering if the manager will read it, or respond to the message.

However, being a **good manager** was more important than being a **popular manager**. In fact, there was a perception that a very popular manager was one "*who could can sit in my office and do nothing', that doesn't cause any ripples at all.*" **Manager role balance;** Being able to balance being "*friendly, personable, one of the group"* with being a manager and supervisor was important for all managers. Their chosen balance was individual, based on philosophy of leadership and styles of behaviour, especially in terms of their task versus relationship focus. . However, all managers recognised the need to differentiate between these aspects, particularly if they had "risen" from the grassroots in that unit that they now managed and to clarify the role distinction that now appeared.

Staff will appreciate a leader who insists on best practice even if it is a painful change process for everyone, and who is willing to facilitate that change. The manager's role is to not only communicate the need for the change, but to provide the resources and supports for that change. Difficulties arise when managers have expectations but do not provide resources to meet that expectation. Part of this issue is time: staff do not mind new initiatives, but managers fear that constant demands for change without sufficient time to adequately implement and evaluate, and become accustomed to the change burns staff.

Manager Style: Both manager and staff participants were asked to describe the characteristics of effective leaders and managers. To a large extent, they were similar; the greatest difference occurred in the amount of clinical time/energy investment in the particular unit and associated familiarity with staff as individuals. Participative leaders had the most impact on the work environment by knowing what is going on, having clinical credibility and being present to make/foster changes. Participants told us that focusing on the team effort, facilitating strategies to solve problems or issues and working to find the best way to "*make things work*" was the factor that produced the most supportive environment. Being seen by staff and being a leader rather than a manager is critical. Staff need to know that the managers

central focus is standards of care and best practice, and they need to "*walk the talk*". Managers who have "*come up through the ranks*" know the facility and have earned credibility and respect. On the other hand, there was a need to "*parachute in new blood*" particularly in areas where there were difficulties.

Interestingly, what constituted participative leadership varied. Some managers were "participative" in that they expressed willingness to "*step in*" to provide direct care or to help with administrative functions (e.g. answer phones, staff the desk), or engage in direct patient care (a way to ensure clinical credibility) while others saw that this fostered inappropriate and unrealistic expectations and reliance of the manager. Staff expectations in long term care that managers would cover lack of staff in the weekends ignored the fact that managers, too, need time off. Others described participative as cooperative and that encouraged staff feedback and initiative in questioning practice and care processes. Some mangers told us that they would welcome staff providing reasonable argument and documentation for the need for a change in practice, and that based on this, they would be willing to "*go to bat*" for the staff. Unfortunately, most managers concluded that "*most of the time it just boils down to the bottom line – money*".

We asked our manager participants if it was important that front line managers were also RNs. Many perceived that it was, because of the understanding and perspective, the ability to understand day to day issues, the kinds of needs, obstacles staff face because they had experienced the same when in that role. In direct patient care, or in discussions with relatives, knowing the health language and processes enabled managers to build relationships by being able to provide information and explanations rather than referring them to a nurse. Lack of front line nursing experience was seen to disadvantage mangers in their ability to comprehend severity of patient conditions or staffing situations. On the other hand, a few managers disagreed, with the belief that cooperative leadership ensured that managers would consistently ask and respect staff for this information, so it was not necessary to have personal experience.

Invisible work of managers: there was clear discrepancy between staff perceptions of the manager role and work, and the actual work and roles reported by managers. While staff often said they thought the manager role was extremely tough, and often was like being between a "*rock and a hard place*" in terms of their ability to achieve change, most staff were very vague about the activities, tasks and roles of their managers. Also noted was the use of technology to facilitate manager work. While managers appreciated the ability to manage their work using email/blackberry devices, staff perceived that if the manager is not physically present, they were not engaged in work "*for the unit*". Time spent in meetings held external to the facility was a major drain on manager time.

Micro managing: There was diversity in perceptions of whether or not managers ought to be closely managing the work context. This was dependent on the scope of the manager role and clinical context, and most staff could see there needs to be a balance between attention to detail and not knowing what is going on:

> *The one thing that… is a positive and it's also a bit of a negative is the micromanaging. Sometimes they [managers] are so hands-off that they don't really know what's going on….. Like they'll phone up and ask us something and not be aware of what's happening. Or, …. part of that's okay because that means that they're trusting us to keep things going but on the other hand if there's ever any issue they don't even know – how can you go to them to deal with something if they don't even know what's going on?*

In some areas, manager groups were changing roles to ensure leadership visibility in the work areas:

> *Our patient care manager is really making herself – because our unit managers aren't around so much, she's making more of an effort to be on the floor and make herself available to come and step in and she's – you know, our staff has felt a lot of respect for her which has helped.*

Time management: Many of our manager participants struggled with time management. With experience, some activities became routine, which provides space and time for innovative thinking and proactive planning, however, many participants felt that they were very qualified to do the job, were motivated, had plenty of ideas have ideas to improve team work, team spirit, scope of practice but simply did not have the time. Leader ship involves working with people, and competing managerial demands mean that coaching activities were often eliminated. Some managers reported regularly or constantly missing breaks, working significant overtime hours, and taking work home. Some mangers make this choice because it helps ensure that the unit functions in the manager's absence (at meetings, vacation) which benefits everyone.

Patient Safety: This was defined by focus group participants in terms of areas where patient safety initiatives or concerns can be linked to quality of work environment.

> *I think that if you have good quality of work, meaning that you have enough staff to look after the patients, you work as a team to care for the patients, and you have knowledge, I think that you will provide better care. And I think if you don't have those things, then patient safety is compromised.*

Managers have an important role in constant teaching and constant encouragement and reinforcement of safe practice. Safety is always compromised if there is inadequate staffing or equipment, with particular risk associated with casual staff that is unfamiliar with unit or patients/residents. Immediate actions to address unsafe practice included education, fostering team work, and restructuring the physical environment (e.g. extra equipment) in order to prevent future incidents.

Managers perceive that nurses in particular – and even the service attendants are all safety-minded. However, that is the first thing to suffer when quality is threatened and staff begin to rush. Staff in all contexts spoke about "*cutting corners*" not only in quality and comprehensiveness of nursing care but in patient safety in situations of short staffing. Nurses rated short cuts – a bath once a week or nail cutting for a resident who is not at risk versus these cut backs for someone with diabetes or impaired circulation. As one long term care nurse said, "*We try to watch it but it's not possible like two RNs or two LPNs to watch 75 people. It's not possible so sometimes we do miss –*". Staff are fearful of being blamed for shortcuts and mistakes due to shortcuts. Even though there was an official proactive safety culture espoused in policy, many staff indicated their or their colleagues, reluctance to report a mistake, or to hide a mistake. Managers said how they rely on other staff to report an incident, rather than the person concerned reporting it. A possible consequence of this approach however, is *scape-goating*, people deliberately looking for mistakes that leads to a breakdown in cooperation and thus potential for more mistakes in tasks such as patient lifting.

Summary

The context of the nursing environment during qualitative data collection was one of a "crisis" in nursing staffing. Many managers and staff told us that short staffing caused physical exhaustion, stressed collegial interpersonal relations, and a sense of dissatisfaction about the quality and safety of nursing

care offered to residents or patient. Staff tired of providing only minimal essential care, worried about the potential for errors, mistakes and accidents for patients/residents when staff cannot promptly attend to their needs, or do not have opportunity for adequate assessments. Staff felt that they were doing the best they could to cope in the circumstances, however, it was clear that this crisis was becoming the "*new norm*" and staff were beginning to resent the sacrifice nurses were making in terms of overtime contributions when these could not be recognised by facilitation of requested time off. As nurses tire, their ability to work collaboratively, to support new staff and to invest in change diminishes. In relation to the quality of nursing care, the question that occupies nurses is: *What is quality nursing care – the minimum or attending to all needs*? Manager and staff differ in their perceptions of this, and a change in nursing culture, from the traditional approach of holistic care that was centered around the nurse patient relationship and ability of the nurse to tailor care for the specific needs of the patient are challenged. If a nurse enjoys the work, and finds satisfaction in it, then s/he is more able to tolerate the insufficiencies of the current work environment. However, if there is a poor or negative sense of team in the work environment, then the lack of staffing and lack of individualised care become more prominent in a person's choice to stay or leave. Lastly, in many areas there still appeared to be a leadership deficit in terms of clinical and personal overview and coaching, especially when the manager is responsible for multiple units and large numbers of people, is not physically present and cannot assist in clinical decisions.

How did we use this information in the study?

Each idea/concept identified in the qualitative data was listed. We compared the items in each of the questionnaires we intended to use to ensure that they reflected the variation of what we had found. Sometimes, we created new items/questions because there was a concept that was dominant in the data but which was not in any of our survey instruments. The qualitative data provide a story, a context for the quantitative results. In most instances, there is good congruence between what we saw in the qualitative and quantitative data. When there is not, it is an opportunity for us to wonder what is going on – was the quantitative results a characteristics of the kind of sample recruited? Did we not manage to discover the full variation in the qualitative interviewing? The qualitative analysis is intended to provide insight and illustration, not prove causal links. All of the theoretical concepts in the framework guiding the QWEST study are intricately interlinked, and this can be difficult to show quantitatively. Asking managers and staff to express their experiences and perceptions in their own words is one way to acknowledge and respect the complexity of nursing leadership and practice.