

**RNAO's 70 per cent Full-Time
Employment for Nurses Survey: Hospital and
Long-Term Care Sectors
Registered Nurses' Association of Ontario
November 27, 2014**



RNAO's 70 per cent Full-Time Employment for Nurses Survey

Acknowledgments

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Executive Summary

The 70 per cent Full-Time Employment for Nurses Survey was initiated by the 70% Full-Time Nursing Employment Working Group (FTNEWG), a working group of the Joint Provincial Nursing Committee (JPNC). RNAO led the project, which was implemented in July 2012 and targeted all employers of nurses in the hospital and long-term care (LTC) sectors. The findings of the report are relevant to nursing human resource (HR policy), and are targeted at government, employers, nursing associations and the College of Nurses of Ontario.

The purpose was to get a snapshot of progress towards 70 per cent full-time employment for nurses, and to identify opportunities and barriers from the perspective of employers. Of 762 known employers in those sectors, 275 sent responses which were included in the report. The response rate and engagement of respondents was indicative of strong interest in full-time performance.

The response rate for hospitals was 70.5 per cent and that for the LTC sector was 27.7 per cent, for an overall response rate of 36.1 per cent. The results were at times surprising. Summing of nursing head counts over all employers yielded totals that were large relative to the total population of nurses: for example, for hospital RNs, the survey summation equaled almost 89 per cent of all Ontario hospital RNs. This reflected two phenomena: broad coverage of the survey, and double counting of nurses with multiple employers. The size of the facilities responding was reflective of the sectors as well: there were 236 beds per responding hospital vs. an average of 203 in the province, while there were 137 beds per responding LTC facility vs. 123 in the province. The mean size of responding facilities was on average somewhat larger than that for the province.

Full-time shares of nursing employment were lower in the survey than they were in the province, for both sectors and for RNs (60.7 per cent vs. 65.5 per cent for all Ontario) and RPNs (47.8 per cent vs. 57.9 per cent for all Ontario). The results were the same for front-line nurses: frontline RNs (58.8 per cent vs. 63.4 per cent) and RPNs (47.5 per cent vs. 57.2 per cent) both had lower full-time shares than their non-frontline counterparts. Adjusting the numbers for double-counting of multiple jobholders can account for all of the discrepancy in the hospital sector, but not for all of the LTC sector. The substantial issue raised by double counting raises the consideration of an FTE (full-time equivalent) target, which would avoid that problem. A target of 80 per cent of FTEs delivered by full-time nurses would be roughly equivalent to 70 per cent full-time by headcount. This FTE target would be particularly useful at the facility level as a way of guiding progress to 70 per cent full-time by headcounts.

Nursing intensity as measured by nurses per bed was much higher in hospitals, for each class of nurse, ranging from over 25 times as many RN FTEs to over four times as many RPN FTEs. There was some modest positive correlation between the size of the facility and full-time performance for hospitals, but very little for LTC facilities.

Most respondents had not attained 70 per cent full-time, but very few indicated they were not attempting to achieve it. Respondents were keen to explain the challenges they faced in reaching 70 per cent full-time. The biggest single factor cited was funding – mentioned more frequently by LTC facilities. Scheduling was also commonly cited, especially around coverage for time off. Additional targeted government funding was generally seen as beneficial; certainly, the Nursing Graduate Guarantee (NGG) was widely used by respondents, particularly by hospitals. The NGG provides six months funding for full-time positions for recent nursing graduates, and is responsible for dramatically increasing full-time employment for new grads. The limitation for respondents was the availability of permanent positions. The Late Career Nurse Initiative (LCNI) allows late career nurses to spend 20 per cent of their time doing less physical activities like mentoring. This enhances retention of late career nurses and integration of new nurses. The use of LCNI was widespread in hospitals and reasonably widespread in the LTC sector.

Key Messages

- There has been significant progress towards 70% for RNs, and some progress for RPNs. The goal has been exceeded for NPs.
- There was keen interest among respondents in the survey, and a high response rate, particularly by hospitals.
- Reported full-time shares were lower than provincial averages for both sectors. A major explanatory factor is double-counting of nurses with multiple employers. Based on CNO aggregate data, double-counting can account for all of the discrepancy for the hospital respondents. It accounts for some of the discrepancy for LTC respondents, but not all of it.
- As with CNO aggregate data, the survey data show lower full-time shares for RPNs than RNs, and lower shares of full-time in LTC facilities (LTCFs) than in hospitals.
- Frontline nurses had significantly lower full-time shares of employment than other nurses, which has implications for continuity of care.
- Hospitals used nurses much more intensively (per bed and per client day) than did LTCFs. RN hours per client day in LTC were less than half of the hours recommended by the Casa Verde coroner's inquest.
- Changes in the way CNO reports nursing employment data has made nursing HR analysis more difficult. Problematic are the redefinition of full-time employment as 30 or more hours per week and no longer reporting headcount data below the aggregate level.

Recommendations

To Government

1. Develop a strategy to attain the 70 per cent full-time employment target, by headcount, for all classes of nurse (RN, NP and RPN) in all sectors and geographic areas.
 - a. Apply the target to direct care nurses, to enhance continuity of care and continuity of care giver.
 - b. Also apply the target to new nursing graduates, to ensure they are integrated into the health system and to retain Ontario's nursing graduates.
2. Continue to fund and support the NGG and LCNI programs.
3. To promote progress in securing more full-time employment for nurses:
 - a. Collect, analyze and disseminate, on an ongoing basis, nursing human resource data related to employment status, sick-time, overtime and agency nurse utilization.
 - b. Work with employers and nursing organizations to identify barriers to full-time nursing employment, and to find solutions to those barriers.
 - c. Develop and fund policy approaches, based on best practices, that maximize the availability of full-time employment
4. Narrow the gap between Ontario and the rest of Canada, of over 17,000 RN positions, by immediately focusing attention on RN recruitment and retention. This will also serve to ensure the 70 per cent full-time target is met.

To Employers

5. For individual employers in every sector, adopt full-time targets that will allow Ontario to meet its 70 per cent objective for all classes of nurse (RN, NP, and RPN).
6. Develop a strategy to attain full-time employment targets for all classes of nurse (RN, NP and RPN)
 - a. Apply the target to direct care nurses to enhance continuity of care and continuity of care giver.
 - b. Also apply the target to new nursing graduates, to ensure they are integrated into the health system and to retain Ontario's nursing graduates.
7. Work with government and nursing organizations to identify barriers to full-time nursing employment, and to find solutions to those barriers.

To Nursing Associations and Nursing Labour Organizations

8. Continue to advocate for the government to expand full-time employment of nurses in all organizations, sectors and geographic areas, with a goal of achieving 70 per cent full-time

by headcounts, as a sound evidence-driven policy that improves or enhances the provision of care.

9. Work with employers and government to identify barriers to full-time nursing employment, and to find solutions to those barriers.

To the College of Nurses of Ontario

10. Maintain consistency of reporting of data with past CNO data, and maintain consistency of reporting with CIHI data, which CNO provides to CIHI. In particular, continue to report head counts as in the past, and continue to report full-time status by the same criteria as used by CIHI. The CNO is also encouraged to release employment data on numbers of positions and numbers of FTEs.

Background

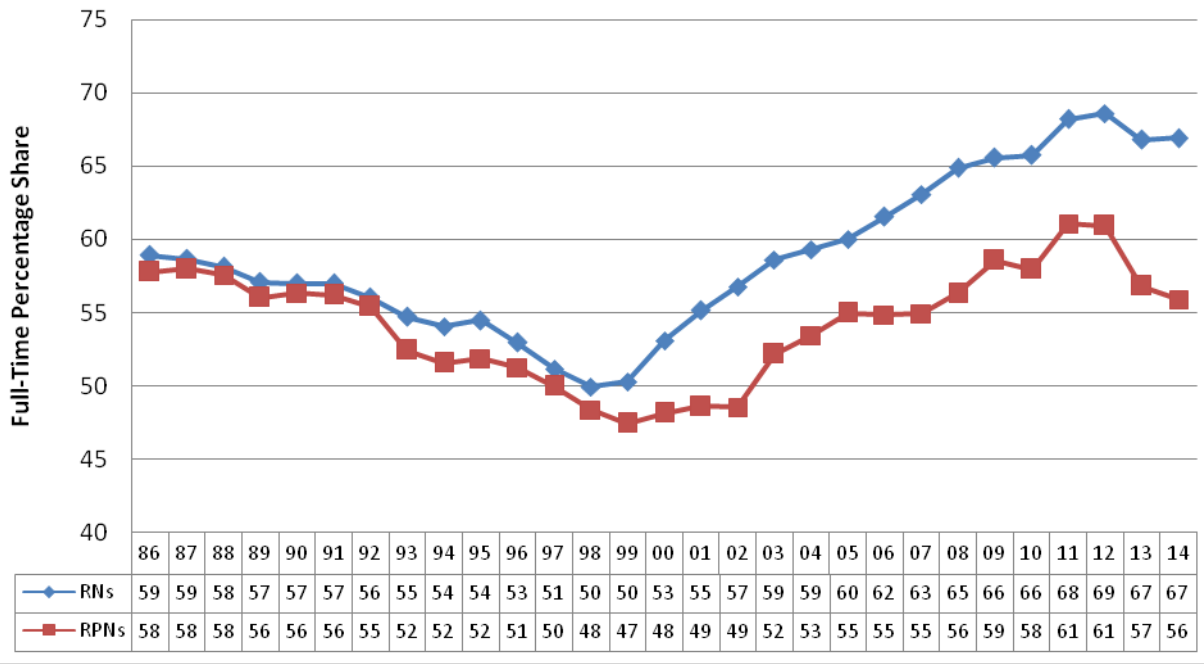
The 70 per cent Full-time Commitment

The goal of having 70 per cent of all RNs working full-time was initiated in the year 2000 by the Registered Nurses' Association of Ontario (RNAO),¹ a goal the association consistently reinforces in submissions and policy papers to government and other public documents.²³ The goal was one of many steps taken to recover and stabilize the nursing workforce after it had been severely affected by falling employment and falling shares of full-time employment through the latter half of the 1990s. The first step towards revitalization came from Ontario's Minister of Health, Elizabeth Witmer, in a series of recommendations in the 1999 Report of the Nursing Task Force,⁴ which sought to reverse the downward cycle for nursing. The human resource problems in nursing were country-wide, and triggered a series of national studies, including CHSRF (2001)⁵ and CNAC (2002).⁶ The Minister of Health provided \$375 million to create 12,000 new nursing positions by March 2001.⁷ This was followed by a campaign promise by the Liberal party (which won the 2003 provincial election) to hire 8,000 more nurses,⁸ part of which came as a \$50 million commitment to add at least 800 full-time positions in hospitals.⁹ The Liberal platform further confirmed their commitment to and investment in nurses by formally announcing a goal of 70 per cent of registered nurses (RNs) working full-time.¹⁰ Supporting this "70 per cent strategy" (as it came to be called) was the creation of thousands of full-time positions, such as the 800 mentioned above and another 2,400 full-time nursing positions announced by the Health Minister in 2004.¹¹ That commitment was reinforced yet again in the 2007 Liberal election undertaking to hire 9,000 more nurses and meet the goal of 70 per cent of nurses working full-time.¹²

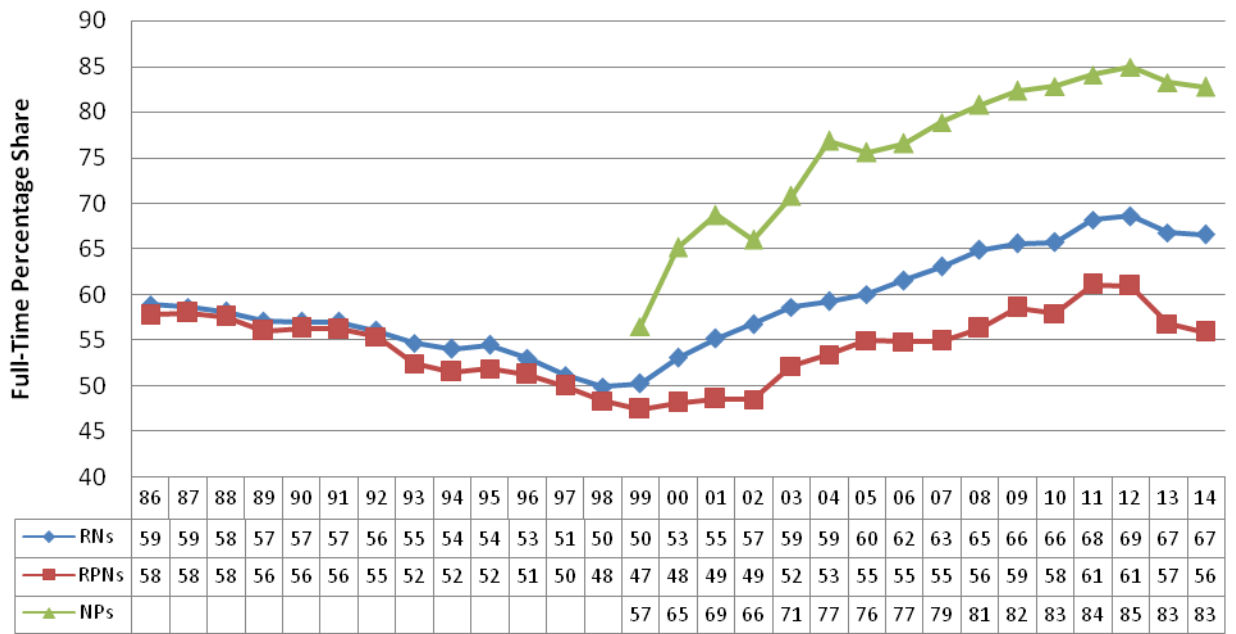
These combined nursing commitments had a significant effect on the measured share of full-time employment for RNs (general class plus nurse practitioners), which rose from 49.9 per cent to 68.6 per cent between 1998 and 2012, before dropping back to 66.8 per cent in 2013 and recovering slightly to 66.9 per cent in 2014 (see Figure 1).¹³ Registered Practical Nurse (RPN) employment followed a similar pattern, with its full-time share hitting a low of 47.4 per cent in 1999, before attaining a record high of 61.1 per cent in 2011 (see Figure 1) and falling back to 55.9 per cent in 2014.

Figure 2 breaks down the proportion of nurses working full-time into: the RN extended class (EC) (also known as Nurse Practitioners or "NPs"), the RN general class (GC) and RPNs. The province has already attained well over 70 per cent full-time for NPs (over 80 per cent since 2008), and was close to achieving 70 per cent with RNs in the general class at 68.3 per cent; that dropped to 66.4 per cent in 2013 and rose slightly to 66.5 per cent in 2014. Overall, changes in full-time employment have been more volatile for NPs and RPNs as compared to RNs, in part due to the large number in the RN pool.

1. Percent Full-time Share of Employment for RNs (General and Extended Classes) and RPNs 1986-2014



2. Percent Full-time Share of Employment for RNs, NPs and RPNs 1986-2014



Tables 3 to 7 estimate how the progress was achieved over time with a focus on progress in recent government mandates.¹⁴ In the present government's first mandate (corresponding to 2004-8),¹⁵ the numbers of full-time RN positions rose very sharply (+9,109 positions), while part-time positions dropped significantly (-2,466) and casual positions were virtually unchanged (+22) (Figure 5). Thus, numerator and denominator effects worked in the same direction to raise the combined full-time ratio. Overall RN positions rose by 6,665.

In the second mandate (using CNO data for 2008-2012, Figure 5), there was very little growth in RN positions (+1,920) and over half were NPs (1,006) (Figure 4). Much of the gain in full-time positions (+4,780) was offset by drops in part-time (-2,568) and casual (292) positions. Again numerator and denominator effects worked to raise the full-time ratio. The first two years of the third mandate (2012-2014) presented a reversal in the pattern: RN employment grew by 3,243 positions; the vast majority (2,842) of positions were part-time. The burden is falling particularly on new Ontario RNs, 53.6 per cent of whom had full-time employment in 2014.¹⁶

Over the entire 1999-2014 period (the period from the low point to the most recent data; Table 5), RN full-time employment rose by an estimated 26,292 positions, but a loss of over 6,394 part-time and casual positions brought the net gains to approximately 19,899 positions. In this same time period, the combination of the rise in full-time and the drop in part-time/casual positions resulted in a dramatic hike in the share of full-time employment from about 50 per cent to 68.3 per cent in 2012 before it fell back to 66.9 per cent.

3. Estimated Workforce Changes: Ontario RNs in the General Class					
	First Mandate 2004-08	Second Mandate 2008-12	Third Mandate 2012-14	2004-14	1999-2014
Full-Time	8,812	3,890	348	13,050	24,636
Part-Time	(2,510)	(2,671)	2759	(2,422)	(2,926)
Casual	25	(305)	(199)	(479)	(3,718)
Total	6,327	914	2908	10,149	17,992

4. Estimated Workforce Changes: Ontario NPs					
	First Mandate 2004-08	Second Mandate 2008-12	Third Mandate 2012-14	2004-14	1999-2014
Full-Time	294	890	236	1,420	1,656
Part-Time	46	103	83	232	255
Casual	(2)	13	16	27	(4)
Total	338	1,006	335	1,679	1,907

5. Estimated Workforce Changes: All Ontario RNs					
	First Mandate 2004-08	Second Mandate 2008-12	Third Mandate 2012-14	2004-14	1999-2014
Full-Time	9,109	4,780	584	14,473	26,292
Part-Time	(2,466)	(2,568)	2,842	(2,192)	(2,671)
Casual	22	(292)	(183)	(453)	(3,723)
Total	6,665	1,920	3,243	11,828	19,899

By contrast, RPNs steadily gained employment the entire period. In most periods, they added full-time, part-time and casual positions, but the numerator effects dominated the denominator effects, meaning that ratio improved over time. They didn't get the same hike in full-time share (47 per cent to 61 per cent; 1999 to 2012, before dropping off), but their share of total nursing employment hit a record high.

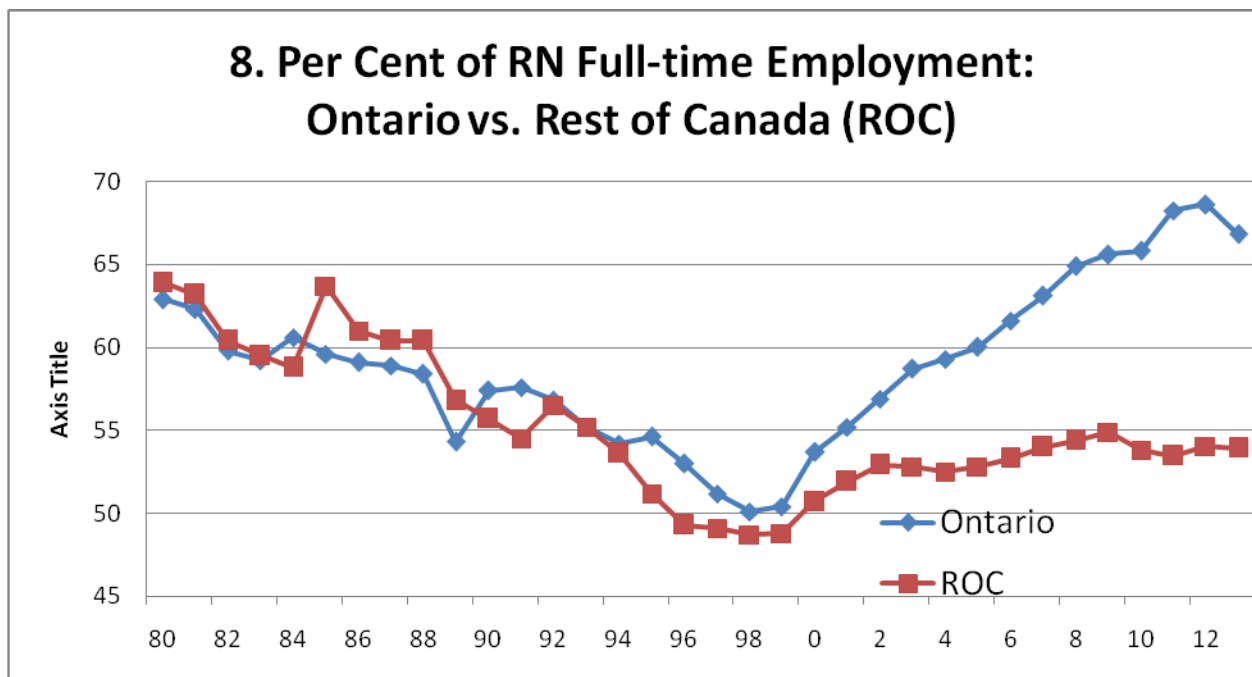
6. Estimated Workforce Changes: Ontario RPNs					
	First Mandate 2004-08	Second Mandate 2008-12	Third Mandate 2012-14	2004-14	1999-2014
Full-Time	2,390	4,576	814	7,785	8,915
Part-Time	475	458	3,049	3,984	3,919
Casual	139	384	571	1,095	(686)
Total	3,004	5,418	4,434	12,864	12,149

When RN and RPN employment are added together, an estimated 35,207 full-time nursing positions have been added from 1999 to 2014. The total employment gain is lower due to the drop in part-time and casual positions, however both factors worked together to raise the full-time share of nursing employment. Recently, rapid growth in RPN employment has exceeded the loss in RN positions.

7. Estimated Workforce Changes: All Ontario Nurses					
	First Mandate 2004-08	Second Mandate 2008-12	Third Mandate 2012-14	2004-14	1999-2014
Full-Time	11,479	9,356	1,398	22,238	35,207
Part-Time	(1,972)	(2,110)	5,891	1,811	1,249
Casual	162	92	388	643	(4,408)
Total	9,669	7,338	7,677	24,692	32,048

Working Status: Ontario vs. the Rest of Canada (RNs (General plus Extended Class))

Based on statistics from the Canadian Institute for Health Information,¹⁷ Ontario and the rest of Canada experienced similar patterns with respect to shares of full-time employment over time. In 1980, both started well above 60 per cent in full-time employment, but thereafter both followed a general downward trend, with the lowest figures bottoming out at or below 50 per cent by 1999. After that, both jurisdictions trended upwards, with Ontario rising much more quickly than the rest of Canada. As of 2013, 66.8 per cent of Ontario RNs were working full-time as compared to only 53.9 per cent of RNs in the rest of Canada. Full-time shares in the rest of Canada began to deteriorate again after 2009 highlighting the significant divergence Ontario has made from the rest of the country in full-time employment. In fact, Ontario RNs in 2012 enjoyed higher full-time shares of employment than at any other time in the past 30 years.



Literature Review

The following literature review is in part based on an extensive summary of full-time nursing research and reports completed in 2010 by the 70% Full-Time Nursing Employment Working Group.¹⁸ The review has been augmented with inclusion of relevant literature between 2010 and 2014. The following three categories are used in this report to reflect the major themes in the current literature: patient outcomes, nursing outcomes, and nursing workforce sustainability.

Patient Outcomes

Currently, the evidence supporting a relationship between full-time shares of nursing employment and patient outcomes is mixed. In 2002 and again in 2006, Tourangeau et al.^{19,20} tested a variety of explanatory variables, but did not find that a higher proportion of full-time nursing staff was statistically related to 30-day mortality in patients with acute myocardial infarction, stroke, pneumonia, or septicemia. More recently however, Estabrooks²¹ found that 30-day mortality “with a primary diagnosis of acute myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, stroke, or pneumonia.” was higher in hospitals with higher proportions of temporary and casual nurses. A small study of the impact of school nursing on asthma management found student absenteeism reduced with full-time (vs. part-time) school nurses (Rodriguez et al. (2013)).²² Given that the degree of full-time nursing employment affects patient outcomes indirectly through quality of nursing care (see below); it is not surprising that separating the full-time effect from other influences is very difficult when controlled experiments are not possible.

More conclusive evidence, however, supports a strong positive correlation between full-time nursing employment and quality of care. Chu & Hsu²³ investigated the impact of hospital nurse employment status on work-related attitudes, organizational citizenship behavior, and job performance and found nursing job performance of full-time nurses was rated more highly by supervisors than that of contract nurses. Similarly, a study of four central Indiana nursing schools rate full-time nursing faculty as more effective clinical instructors (DeSantis).²⁴ Duffield et al.²⁵ confirmed this finding noting full-time employment is associated with higher compliance with best practices, which required fewer interventions to promote higher quality of care. Nichol et al. (2008)²⁶ provides further support of compliance with its finding that full-time nurses were three times more likely than part-timers to say they complied with facial protection to reduce transmission of communicable diseases. In a similar vein, Arbon et al. (2013) found that full-time Australasian emergency nurses were more likely to attend their workplaces during disasters if they were working full-time.²⁷ Moreover, Rafferty, Ball & Aiken²⁸ found a small but significantly higher proportion of full-time than part-time nursing staff had high teamwork scores (27 per cent vs. 21 per cent). This research suggests that more management effort is required to oblige part-time nurses to achieve optimal performance.

Studies of non-full-time employment yield similar conclusions. Jamieson et al. (2008)²⁹ found part-time nurses in Australia believed they were not reaching their nursing potential and this affected their ability to deliver patient care (they also found that, regardless of employment status, nurses were not able to achieve their perceived personal optimal nursing potential). Causal factors included exclusion from decision-making, not being known or valued by other health professionals, disconnectedness from the workplace and less access to professional development.

Research points to particular risks to care from casual nursing employment. In a literature review on the relationship between casualization of nursing and communication of nurses in health care, Batch, Barnard & Windsor³⁰ found that fragmentation of the nursing workforce, brought about by more flexible working arrangements, is counterproductive to optimal communication and organizational cohesion, which are essential for achieving higher quality of patient outcomes. May et al. raised general concerns about quality of care provided by temporary and inexperienced staff.³¹ In a 2006 study, Baumann, Blyth and Underwood³² identified casual and agency employment of nurses as problematic and unreliable when confronted with a need for surge capacity, as during epidemics (consistent with Arbon et al).³³ The Ontario Expert Panel on SARS and Infectious Disease Control (2004)³⁴ found that current rates of casual, part-time and agency work reduced the capacity to deliver stable and cohesive workplaces, and limited organizations' ability to deliver care when nurses could no longer move between hospitals. Recommendations included reducing the degree of casualization of health care employment, raising the share of hospital health care worker full-time employment to 70 per cent, raising the number of full-time positions and minimizing the use of agency staff. Suggested strategies included creation of resource teams, cross-training, and increased base staffing. Furthermore Hurst and Smith³⁵ found that staff mixes with permanent and temporary nurses spend less time with clients and were more expensive to run, impacting the sustainability of the health care organization.

There is a substantial body of evidence that raises concerns about temporary nursing staff. Hurst and Smith note that they may lack sufficient organizational knowledge to work effectively (e.g., lack of information about policies, procedures, resource and client population),³⁶ Part of the problem comes from compressed orientations and exclusion from training. The National Audit Office (NAO) found that mandatory training was not given to 70 per cent of UK temporary nurses in hospital internal resource pools.³⁷ The same study reported that lack of familiarity with the environment caused 13 per cent of clinical incidents, while a further lack of training and experience caused 8 per cent. The NAO also found that infection control was hampered by use of temporary staff.³⁸ Use of temporary staff contributes to turnover of staff (Creegan et al.³⁹ and Duffield et al.⁴⁰), which in turn can hurt continuity of care. That in turn can affect quality of care and outcomes (as Lerner et al. (2014) concluded in a study of nursing homes).⁴¹

In the early 2000's, Grinspun⁴²⁴³⁴⁴ noted how fragmentation of the workforce adversely affects nurses, which in turn has a negative impact on client outcomes. Nurses may be driven away by care fragmentation, and their departure further hampers the relationship between employers and the remaining nurses. When this occurs, patient care suffers from a reduced continuity of care and caregiver, a reduced capacity of the nurse to know the patient and a reduced ability of the nurse to participate in decision-making. Continuity of care in health care itself is associated with reduced hospitalization and greater patient satisfaction (Beattie et al.⁴⁵, better quality of care (Solberg et al.)⁴⁶, and cost effectiveness (Sander et al.)⁴⁷. In a later report, Grinspun⁴⁸ summarized the case for full-time employment, suggesting it was essential to healthy workplaces and productive teamwork to acknowledge full-time nurses know the patient better, and that continuity of caregiver improves outcomes and system utilization. In addition Grinspun notes that it is particularly crucial for new graduates to obtain full-time employment, although that is often a major challenge.

As noted above, enhancements to care associated with full-time nursing employment are often linked to the provision of continuity of care. Duffield et al.⁴⁹ found that continuity of care was enhanced by full-time employment, due in part to a higher awareness of the skills, expertise, strengths and weaknesses of fellow staff members, which resulted in an overall efficiency requiring less supervision by nursing managers. A survey of Italian nurses reported that part-timers complained about insufficient information on clients and lack of involvement in ward projects and planning (Ferrazzo et al (2012)).⁵⁰ Similarly, Edwards et al.⁵¹ reported that significant numbers of surveyed managers reported part-time care interfered with continuity of care and task completion (28 per cent), with exchanging information (40 per cent) and with team communication (25 per cent). They also found a longer-term threat to quality of care with part-time nursing due to skills erosion and weakened career advancement.

Further indirect effects on clients by employment status operate through impacts on the nurse, as discussed below.

Nursing Outcomes

A number of studies identified that the disconnect between preferred and actual employment status had a number of significant impacts. Burke (2004)⁵² found that nursing staff who had their preferred employment status were emotionally and physically healthier. Havlovic et al. (2002)⁵³ similarly found that nurses who had their preferred shift and work week were healthier, more satisfied and more positive about their quality of care, while Kapborg⁵⁴ found that Swedish nurses forced into part-time (due to government budgetary policy) reported reduced self-confidence and health problems.

A few surveys found a degree of mismatch between preferred and actual employment status. In 2002, McGillis Hall et al.⁵⁵ surveyed nurses in adult medical, surgical and obstetrical units in Ontario teaching hospitals and found that 63 per cent were full-time, the large majority of all

nurses (89 per cent) had their preferred work status, and that 6 per cent wanted more hours. In 2005, RNAO⁵⁶ found that in particular, many part-time and casual RNs preferred full-time, and concluded that if Ontario RNs had their preferred work status, 64.5 per cent would be full-time as opposed to the then 59.3 per cent. Many other part-time and casual RNs would conditionally go full-time, assuming that workplace challenges that drove them away from full-time were addressed. If all of those RNs obtained full-time employment, the province would have had 78.4 per cent full-time RNs. In 2002, The Canadian Labour and Business Centre⁵⁷ found 26 per cent of Canadian RNs were part-time, in contrast to the 41 per cent reported by CIHI (due to different methodologies). It concluded that if involuntary part-time RNs were able to work full-time, 4.7 million more hours, which is the equivalent of 2,592 more FTEs, could have been added in 2001. Most recently, CNO (2014) reported that 72.0 per cent of RNs in the general class preferred full-time employment, while only 66.6 per cent actually had it. The figure was even more striking for RPNs: 55.9 per cent had full-time employment in 2014, while 76.8 per cent wanted it.⁵⁸

Recent grads tend to have a strong preference for full-time, yet often have the greatest difficulty in obtaining it of all nurses. Montour et al.⁵⁹ found that younger nurses in particular seek professional opportunities including full-time work in large urban centres, thus contributing to “urban drift”. Sloan et al. (2006)⁶⁰ had similar findings when it studied small non-urban hospitals.

Because nurses face different circumstances and have different employment status preferences, the literature identifies problems with each employment status. Full-time employment does have a number of advantages, such as greater job security and more opportunities for career advancement.⁶¹ As discussed above, temporary staff members do not get the same level of training and orientation.^{62,63} And, variable shift work brings its own health risks, including increased risk of needlestick injuries (Rohde, Dupler, Postma and Sanders).⁶⁴ However given the demanding nature and workload of many health-care settings, nurses often experience fatigue⁶⁵. To the extent that some nurses experience fatigue, client care may be compromised; Scott et al. (2014) found that nurses with decision regret were more likely to report fatigue, daytime sleepiness, less inter-shift recovery and worse sleep quality.⁶⁶

There is abundant literature on adverse effects experienced by full-time nurses. For example, full-timers experience greater volumes of stress, including more intense psychological effects of bullying (Rodwell and Demir).⁶⁷ A systematic review by Toh et al (2012) of the effects of a nursing shortage in oncology/haematology settings found that full-time nurses were more likely to identify staffing shortages as contributory to job dissatisfaction, stress and burnout.⁶⁸ Edwards et al.⁶⁹ reported part-timers work fewer hours and are less stressed (Hegney et al (2014) also found that Australian nurses who were younger, full-time and lacking post-graduate qualification experienced higher anxiety.),⁷⁰ which may result in better retention of part-time nurses. A South African study (Colff and Rothmann, 2014) similarly found that full-time employment was a factor in burnout, along with language, age, rank, job satisfaction, reciprocity, and specialized training.⁷¹ Gui et al (2014) found that full-time nurse teachers in China and the UK faced greater

work challenges than their part-time counterparts.⁷² A small older study of Canadian women nurses found no statistical differences in the well-being of full-time, part-time and casual nurses, although job-share nurses did better (Kane and Kartha (1992)).⁷³ Part-time and casual work is chosen by some nurses for the flexibility it offers, which provides individuals with more control over work-life balance or time for further education (Kemp;⁷⁴ Philip;⁷⁵ Wetzel, Soloshy and Gallagher⁷⁶). Studies in the US, UK and Australia found the appeal for some nurses was the flexibility, higher pay rates, and control of the schedule (Gordon;⁷⁷ Lumley, Stanton, and Bartram;⁷⁸ Creegan, Duffield, and Forrester⁷⁹). McGillis Hall et al.⁸⁰ found that rising workload and patient acuity could be contributing to nurses' preference to work part-time or casual. Several participants added that part-time and casual employment increased their autonomy. Burke & Greenglass (2000)⁸¹ discovered hospital restructuring in Ontario had different impacts on full-time and part-time nursing staff. According to their research, full-time nurses reported heavier workloads, were more likely to be absent, and were less likely to quit. Furthermore, they reported more exhaustion and cynicism, poorer physical health, more medication use, and poorer lifestyles. Zboril-Benson⁸² studied frontline long-term and acute care nurses in Saskatchewan and also found that full-time nurses were more likely to experience absenteeism.

Other research has documented the physical toll of full-time employment. In 2008, Alamgir, Yu and Ngan⁸³ found that in British Columbia, full-time RNs in hospitals had significantly higher risk of injury than part-time and casual nurses. In general, full-time health care workers have higher injury rates than in other industries. In 2002, Shamian et al.⁸⁴ studied hospital RNs and found that full-time RNs had more illness, burnout and job dissatisfaction than part-time RNs. In fact, Jameson et al.⁸⁵ identified that nurses' reasons for working part-time were: their health; work intensification; non-work responsibilities; scheduling inflexibility; finances; and "the need to maintain workplace and professional links."

The above suggests workload may be a causal factor to burnout and job dissatisfaction, and that while more full-time positions may improve the stability of the workforce, workloads in some settings should be addressed to guarantee enough RNs will take those positions.

Nursing Workforce Sustainability

Nevertheless, a solid majority of nurses are full-time, meaning that substantial advantages remain for nurses in full-time employment, despite significant workload concerns. Those advantages include superior benefits, higher income, more certainty about hours and better working conditions.⁸⁶ There are also additional cost advantages of full-time nursing employment to the system. O'Brien-Pallas et al. (2001)⁸⁷ point out the irony that reducing the full-time/part-time ratio was employed as a cost-minimizing strategy. However, insufficient full-time employment incurred higher system costs due to effects on quality of care that were in turn caused by reduced

continuity of care and less familiarity with the organization. Moreover, as Drebit, Ngan, Hay and Alamgir point out, creation of full-time positions from the costly and growing overtime nursing bill is one way to reduce costs.⁸⁸

Benefits of increasing the proportion of full-time employment arise in other related ways. In 2008, O'Brien-Pallas, Tomblin Murphy, and Shamian,⁸⁹ found that higher full-time shares of nursing employment were associated with lower turnover. This was also found by Heinen et al (2013) (OR = 0.76 for turnover),⁹⁰ Burke and Greenglass (2000),⁹¹ Zeytinoglu, Denton, Davies & Plenderleith (2009),⁹² Toren, Zelker, Lipschuetz, Riba, Reicher & Nirel (2009),⁹³ Rajacich et al, (2013, for Canadian male nurses),⁹⁴ and Austen et al. (2013).⁹⁵ Alameddine et al (2014) concluded subsector stickiness (persistence in a given subsector) increased with the offering of full-time jobs.⁹⁶ Toren et al (2012) found that part-time RNs in Israel were more likely to leave.⁹⁷ May et al. found that a heavy reliance on temporary staff worsened nursing shortages.⁹⁸ This is consistent with findings that nurses who preferred full-time were leaving Ontario or seeking multiple employers to obtain full-time hours (Baumann A, O'Brien-Pallas L, Armstrong-Stassen M, Blythe J, Bourbonnais R, Cameron S, et al.;⁹⁹ and Registered Nurses' Association of Ontario. (2001)).¹⁰⁰ Results must be interpreted carefully as correlation between turnover and work status may be driven by other factors; for example New Zealand nurses over 50 who reported lower health-related quality of life were more likely to move to casual employment and to retire earlier (Clendon 2013).¹⁰¹

A few studies had somewhat contrary findings. Brewer et al (2012) found that full-time employment and injury were associated with more turnover, in a survey of newly licensed American hospital RNs.¹⁰² The report advised policies to reduce strains and sprains. In a small study of medical-surgical nurses, Jolma (1990) found that full-time status, hospital size and unit size were all positively associated with higher workload and intent to leave. Kachi et al (2010) found that full-time professional caregivers for the elderly in Japan were more likely to intend to leave.¹⁰³

In a study of a sample of Ontario LTC facilities, McGilton, Tourangeau, Kavcic and Wodchis (2013), conclude that access to full-time work and benefits is a part of a nurse retention strategy that also includes opportunities for self-scheduling, models of care that strengthen resident relationships, and management of workload to minimize burnout.¹⁰⁴ Jurisdictional retention was addressed by McGillis Hall et al. (2013a), who identified the following factors in interprovincial mobility: access to full-time work, flexible scheduling, and career advancement.¹⁰⁵ McGillis Hall et al (2013b)¹⁰⁶ and (2009)¹⁰⁷ warn that availability of full-time employment is also a retention strategy to keep nurses from moving to the US. Cameron et al. (2010) found that on both sides of the Canada-US border, the primary reason for choosing their current workplace was full-time work.¹⁰⁸

But nurses do not have the same needs at all points in their careers, and employers must attend to changing needs and preferences. A New Zealand study by Clendon and Walker (2013a)

recommended more flexible scheduling (and greater access to part-time hours) as a retention strategy for older nurses.¹⁰⁹ Clendon and Walker (2013b) found New Zealand nurses were more likely to switch to casual and flexible hours as they age.¹¹⁰

Turnover costs are a major consideration. O'Brien-Pallas, Griffin, Shamian et al.(2006)¹¹¹ found the average unit cost of turnover was \$21,514 and the mean turnover rates for medical and surgical units were 9.49 per cent and 11.4 per cent. The highest direct cost was that associated with temporary replacements and the highest indirect cost was reduced productivity of the new hire. Hayes et al. noted adverse effects on staff morale and staff productivity, with potential effects on quality of care.¹¹² Much higher unit costs were estimated by Jones (2008) for replacement of nurses in the US: \$82,000 to \$88,000.¹¹³ Jones points out the ease of underestimating the largely hidden turnover costs (burnout, low morale and effects on patient care).Doran et al.¹¹⁴ found that full-time employment status was associated with more job security in home care nurses, and recommended creating more opportunities for full-time positions.

One mechanism for permanent employment to promote gains is via enhanced social cohesion, due to lower stress and more stable schedules (Shader et al.).¹¹⁵ Yeh et al. found lower stress and higher commitment among permanent than temporary nurses.¹¹⁶ In turn, that commitment yields more supportive action by permanent than temporary staff (Van Dyne and Ang).¹¹⁷ Temporary nurses may contribute to loss of team cohesion (Kalisch and Begeny).¹¹⁸

As noted above, new nursing graduates are most severely affected by lack of full-time positions. Given their propensity for mobility, there is strong likelihood that new graduates may leave Ontario in search of full-time employment elsewhere, which negatively impacts the workforce's long-term sustainability. McGillis Hall et al. (2009)¹¹⁹ concluded key factors for keeping Canadian RNs from moving to the US included opportunities for full-time employment and ongoing education. McGillis Hall et al. found that those Canadian RNs in the US were more likely to have full-time than their US and Canadian counterparts, which strengthened their conclusion. In 2002, the Canadian Nursing Advisory Committee¹²⁰ identified lack of full-time employment and excessive part-time work as factors contributing to the nursing shortage, along with other causes, such as insufficient numbers of nursing education seats combined with an aging nursing workforce, HR management issues, and lack of funding for nursing positions. This result was supported by a study of Ontario nurse faculty by Tourangeau et al. (2014), which identified full-time employment and having preferred job status (full-time or part-time) as both positively correlated with intention to remain employed in the current position.¹²¹

Prior to the introduction of the Ontario government's Nursing Graduate Guarantee program in 2006, new graduates were leaving the province in droves. In 2004, Cleverly et al.¹²² found that 79.3 per cent (2004) and 70.7 per cent (2005) of new Ontario RN graduates wanted full-time, but only 31.7 per cent (2004) and 42.5 per cent (2005) obtained it after six months. For new RPN graduates, 60.2 per cent preferred full-time but only 14.2 per cent reported having such work

after six months. As a result, a significant number of new grads considered moving out of Ontario, particularly in the southwest part of the province. Graduates were concerned about the lack of full-time jobs, the surplus of casual employment, and unstable employment. The report recommended that government provide financial support for more full-time employment and to increase employment of new nursing grads. It also recommended that nursing employers should convert casual positions into full-time positions.

Based on data from a survey of nurses from three southern Ontario hospitals, Zeytinoglu et al. (2006)¹²³ also identified non-full-time status as a risk factor for departure. (see also Zeytinoglu et al. (2007)).¹²⁴ While nurses in this study displayed interest in leaving their facility, few seriously considered leaving the profession. Casual nurses had the highest propensity to leave their hospitals (26 per cent vs. 16 per cent part-time and 13 per cent full-time) and profession (21 per cent vs. 14 per cent part-time and 12 per cent full-time). Income of full-time nurses was more important to family economic wellbeing, and thus was negatively correlated with their tendency to leave. Casual nurses were most likely (26 per cent) to prefer other employment statuses. Stress was the biggest factor affecting desire to leave the hospital. Zeytinoglu et al. recommended attention to key departure factors of stress, job preference, importance of earnings, and unpaid overtime, suggesting separate policies should be geared to each employment category (full-time, part-time and casual). To complete the circle, turnover may beget turnover, as the elevated workloads and stress lead some of the remaining staff to quit themselves (Hayes et al.¹²⁵).

Confirming the work of Zeytinoglu et al, Daniels, Laporte, Lemieux-Charles, Baumann, Onate and Deber (2012) found casual nurses had the greatest tendency to leave, while full-time nurses were least likely to depart, with part-time nurses falling in-between. They found a number of other variables correlated to departure risk: 1) sector: hospital nurses were least likely to leave, followed by LTC nurses and nurses in other sectors; 2) age: older (over 55) and younger (under 31) nurses were more likely to leave; 3) gender: male nurses were more likely to leave; education: RNs with higher education were more likely to leave; and 4) nurses with higher levels of education were more likely to leave.¹²⁶

Malette (2005) found more of a relational psychological contract for full-time nurses, which is associated with higher reported job satisfaction and lower intent to withdraw.¹²⁷

MacPhee and Svendsen Borra (2012)¹²⁸ noted that there are many concepts of flexibility in nursing work arrangements (e.g., over hours, scheduling, location, and multi-skilling), and that it is important to distinguish between those that reflect nurses' choices and needs to accommodate work-life balance (e.g., flexible scheduling, the late-career/80/20 model in Ontario, and phased retirement) and those that reflect institutionalized insecurity and lack of nursing choice. The latter is more associated with the pejorative sense of casualization of nursing employment. MacPhee and Svendsen Borra argue that inappropriate flexibility is ultimately bad management practice that benefits neither nurse nor client nor employer. It is worrisome that Houseman et al.¹²⁹ and Mercer et al. found that temporary employment was primarily initiated by employers¹³⁰

MacPhee and Svendsen Borra concluded that choice around flexible work options was associated with enhanced job satisfaction, greater commitment to the organization, and intent to stay. They added that it was a powerful recruitment and retention tool.¹³¹ Choice on work status and work flexibility remains a powerful recruitment and retention tool.¹³² Nurses with preferred shifts and scheduling perform better and have greater job satisfaction (Havlovic et al. as noted above by MacPhee and Svendsen Borra 2002,¹³³ Shader et al. 2001,¹³⁴ Pryce et al. 2006).¹³⁵

Other studies supporting the recruitment and retention virtues of choice-based flexible arrangements include Hart (2006; RNs),¹³⁶ Durand and Randhawa (nurses),¹³⁷ Arun et al. (women workers),¹³⁸ Aiken et al. (nurses),¹³⁹ Heath et al. (nurses),¹⁴⁰ Schmalenberg and Kramer,¹⁴¹ Baumann,¹⁴² Stone et al.,¹⁴³ and Buchan and Calman.¹⁴⁴ A number of articles cite flexibility as a way of mitigating the stress of high workloads (Vetter et al.,¹⁴⁵ Pryce et al.,¹⁴⁶ Kane,¹⁴⁷ and Lea and Bloodworth¹⁴⁸). Tanaka et al found that choice was an important element linking nurses' self-assessed health and flexible work practices.¹⁴⁹ Ingersol et al found that when nurses had the ability to adjust their schedules to fit family obligations, they exhibited greater satisfaction and organizational commitment.¹⁵⁰ In a case study, Abney-Roberts and Boll (2014) found that self-scheduling led to greater satisfaction and no reported resignations due to dissatisfaction related to scheduling.¹⁵¹ An important consideration in retaining late career nurses is their family care obligations; Jacobs et al (2014) concluded that encouraging later retirement may require more flexible work options.¹⁵² Dissatisfaction with work schedules is a departure risk, according to a study of Finnish nurses (Flinkman et al. (2008).¹⁵³ Inflexible work schedules are one of the causes of stress, job dissatisfaction, intent to leave, and voluntary turnover.¹⁵⁴¹⁵⁵ They are not the principal cause, but they compound or fail to mitigate problems like excessive workloads (Strachota et al,¹⁵⁶ Pillay,¹⁵⁷ Josten et al.¹⁵⁸).

A different strand of research speaks to empowerment. Yang et al. (2013) found that work environments that empowered nursing practice among Chinese staff nurses strengthened the commitment of those nurses.¹⁵⁹ Choice may be seen as a component of empowerment. More generally, involvement of nurses in decision-making is important to job outcomes and nurse-assessed quality of care (Bogaert et al. (2013).¹⁶⁰ Additional resources tailored to job demands can help to reduce work-related strain (Lavoie-Tremblay et al. (2014).¹⁶¹ More generally, "the empowerment dimensions of support, resources and opportunities were strong predictors of intention to stay, with support being the strongest predictor" (Milanese, 2013).¹⁶²

Finally, the literature shows that retention is enhanced by accommodating nurses' preference for work status (Zeytinoglu et al (2006),¹⁶³ Baumann et al (2003),¹⁶⁴ and Zeytinoglu (1993)¹⁶⁵). Hiscott (1994) found ease of changing employment status was associated with duration of employment for Ontario RNs.¹⁶⁶ Not all nurses have their preferred employment status; some want more hours and some want fewer. Nurses have different preferences depending upon age and work-life requirements.¹⁶⁷ This mirrors findings in research on workers' preferences (Reynold,¹⁶⁸ Fagan (2001),¹⁶⁹ Boheim and Taylor (2004)¹⁷⁰ and Isaksson and Bellagh (2002)).¹⁷¹ A study of Norwegian nurses (Halvari, H., Vansteenkiste, M., Brorby, S., and Karlsen, H.P.

(2013))¹⁷² identified in more detail factors influencing the desire to move to full-time: managerial support of part-time (reduces preference), negative feedback from colleagues on part-time status (increases preference), household income (negatively correlated), income aspirations (positively correlated), age (negatively correlated), involvement in the work rotation planning (positively correlated), and share of an FTE worked (negatively correlated).

As noted above, RNAO (2005) concluded that Ontario would have increased its full-time share for RNs by over 5 percentage points by accommodating the preferences of all its nurses; this is because there were more non-full-time nurses seeking full-time than the reverse. Furthermore, it concluded that if the circumstances that caused RNs to go part-time or casual were fixed, up to 78.4 per cent of the RN workforce could be full-time. Also as noted previously, CNO (2014) reported that 72.0 per cent of RNs in the general class preferred full-time employment, while only 66.6 per cent actually had it. The figures for RPNs were 76.8 per cent and 55.9 per cent respectively.¹⁷³

And of course, creating full-time positions can meet other objectives, such as increasing the number of FTEs (Maier and Afentakis (2013)).¹⁷⁴ This in turn would promote nursing workforce sustainability by reducing workloads and by allowing nurses to address more of their clients' needs.

Progress towards 70 per cent Full-Time Employment

Targeted creation of full-time employment for new nursing graduates via the Nursing Graduate Guarantee clearly works at keeping new graduate nurses employed in Ontario. In 2012, Daniels, et al.,¹⁷⁵ examined the effect of Ontario's commitment to 70 per cent full-time on nurse retention and concluded it had more impact on recruiting younger nurses than it has on retaining mid or late-career nurses. Nevertheless, it did find that after the start of the 70 per cent initiative that 13.6 per cent of part-timers and 8.6 per cent of casuals switched to full-time, vs. 3.2 per cent of part-timers and 7.1 per cent of casuals leaving. Daniels (2011)¹⁷⁶ found that after the implementation of the 70 per cent commitment, more casual nurses switched to part-time, while younger part-time and casual nurses shifted to full-time. In 2008, Baumann, Hunsberger, Idriss, Alameddine, and Grinspun,¹⁷⁷ studied employment of Ontario nursing graduates and found that between 2004/5 and 2007, higher percentages of RN and RPN new grads had full-time employment and a large majority (81.3 per cent of RN grads and 63.9 per cent of RPN grads) preferred full-time employment. The portion of RNs interested in working outside of Ontario dropped while the share of RPNs interested rose. The Nursing Graduate Guarantee (NGG) is a government program that pays employment costs for new nursing graduates for up to 26 weeks of full-time employment, to promote entry of these graduates into the nursing workforce.¹⁷⁸ Subsequent work by Baumann, Hunsberger, and Crea-Arsenio confirmed the positive effect of the NGG program on new nursing graduate employment.¹⁷⁹ The response to the NGG was positive, but LTC employers, in particular, found it difficult to offer full-time positions and to keep the new graduates after the NGG was completed. The report recommended keeping the

NGG, focusing on RPN employment, focusing on rural full-time strategies, and assisting LTC employers with recruitment and retention. A subsequent Ontario nurse employer survey by Baumann, Hunsberger, and Crea-Arsenio (2013) found that only 20 per cent of potential employers participated in NGG, with obstacles including a lack of full-time positions and budget constraints. It concluded that employers saw flexible employment as a way of controlling costs.¹⁸⁰

Recent evidence however, suggests a decline in gains due to the NGG. While Baumann et al.¹⁸¹ found impressive rates of new graduate nurses' absorption into the workforce prior to 2008, data from the College of Nurses' of Ontario (CNO) now show declining figures. Reduced commitments to creating full-time RN positions are taking a toll. According to the 2013 CNO report, *New Members in the General Class 2013*,¹⁸² new Ontario RNs' full-time share of employment peaked in 2009 at 79.3 per cent and had fallen to 53.6 per cent by 2014. 2014 part-time and casual employment shares are disturbingly high at 39.0 per cent and 7.3 per cent respectively. New RPNs saw their share of full-time employment rise modestly over the same time period, from 46.1 per cent to 50.8 per cent.¹⁸³

Reaching the goal of 70 per cent full-time is complex. Smaller hospitals and smaller nursing employers, in particular, face unique challenges. Sloan et al.¹⁸⁴ found that as of 2005, small hospitals in rural areas or small towns had lower full-time shares of employment for nurses. If all nurses in these hospitals had their preferred employment status, the RN share would have risen from 58 per cent to 68 per cent and the RPN share would have risen from 46 per cent to 67 per cent. Among involuntary part-time staff, lack of full-time employment and lack of seniority were the most commonly mentioned reasons for not working full-time. Employer barriers to 70 per cent full-time included availability of nurses willing to work in small hospitals, total staff size, government policies on staffing and scheduling, and collective agreements. Recommendations included targeting policies according to the size and location of hospitals, lowering the 70 per cent target for small hospitals, funding long-term full-time positions for new grads in small hospitals, increasing baseline nurse-patient staffing, funding a centralized replacement call centre to allow more full-time positions, and training all concerned in using collective agreements to create more full-time positions.

Ontario nursing union representatives point out that Ontario employers may need education to make use of flexibility options in their collective agreements to promote full-time (Haslam-Stroud).¹⁸⁵ These options include innovative unit scheduling¹⁸⁶ and unit weekend scheduling.¹⁸⁷ Furthermore, the Ontario Hospital Central Agreement between the Ontario Nurses' Association and participating hospitals mandates the creation of Hospital-Association Committees, one of whose stated purposes is to: "promote the creation of full-time positions for nurses, and discuss the effect of such changes on the employment status of the nurses. This may include the impact, if any, on part-time and full-time, job sharing and retention and recruitment."¹⁸⁸

Norwegian research suggests that perceptions about the feasibility of increasing full-time have normalized part-time employment, and that these perceptions are standing in the way of organizing nursing work in a way that accommodates more full-time employment (Ingstad, and Kvande (2011)).¹⁸⁹

Baumann, Hunsberger, Blythe, and Crea (2008)¹⁹⁰ studied the rural nursing workforce and found that the sample's full-time share at 46 per cent was lower than the provincial average of 53 per cent and lower than the 70 per cent target. Respondents identified barriers such as budgetary limitations and nurse preference for part-time employment. Implementing the NGG was clearly a challenge due to a limited ability to create full-time employment.

In 2005, Blythe et al. (2005)¹⁹¹ reported that employment trends and hospital approaches to staffing influenced whether nurses had their preferred employment status. Human resource managers recognized the potential benefits from full-time employment as being cost reduction, improved coverage, greater commitment, greater employment stability and improved continuity of care. The obstacles they cited in offering more full-time employment included hospital regulations, union conditions and shortages in specialist applicants, noting a failure to achieve a higher share of full-time employment caused stress in the workplace.

Prior Surveys

A number of previous surveys of Ontario nurses on nursing employment provide relevant statistics and findings that align with the results of RNAO's 2012 survey. Appendix C contains a summary of those results.

The 70 per cent Survey

Purpose

The purpose of RNAO's 2013 70 Per Cent Full-Time Employment for Nurses Survey was to get a snapshot of the employers' experience in achieving full-time employment for nurses in terms of: their current levels of full-time employment; challenges; opportunities; and strategies. In particular this survey was targeted at nursing employers in the hospital and long-term care sectors and was initiated by the 70% Full-Time Nursing Employment Working Group (FTNEWG). The FTNEWG was commissioned by the Joint Provincial Nursing Committee (JPNC) to support collaboration between nursing stakeholders and the Ministry of Health and Long-Term Care in developing and implementing strategic policy/programmatic initiatives to achieve 70 per cent full-time nursing employment.

Methods

Pilot Survey

Sixteen nursing employers were recruited to pilot the draft survey. These included five hospitals, six LTC homes, one home health care agency, one Nurse Practitioner-Led Clinic (NPLC), one community health centre (CHC), one public health unit, and one family health team. The survey was conducted on-line using a survey tool developed by RNAO.

Based on the results and feedback from pilot participants, the team simplified the survey form and collected less detailed data, in order to enhance reliability and reduce burden on participants. In the pilot, respondents were asked to break down their nurse staffing into RNs, RPNs and NPs, and then further into four different nursing roles (providing full-time, part-time, and casual "counts" (numbers of nursing staff) as well the combined number of FTEs for each of the above categories. As a result of the pilot, the team followed a suggestion from a pilot participant to break the nurses into two groups: front-line and everyone else.

The pilot responses revealed some inconsistencies between the FTEs for each employment category, and FT/PT/Casual counts. As a result, several validation rules were inserted into the on-line survey form, which pointed respondents to correct potential problems in data entry. The survey form also performed automatic calculation of FT/PT/Casual percentages to assist the users in their calculations.

The Final Survey

Target Population

This phase of the survey was targeted with two sectors: hospitals and long-term care. There were 775 unique employer names on the list of recipients targeted to receive the final survey, which represents what was believed to be a comprehensive list of hospital and LTC employers. Invitations were sent by e-mail to the Chief Nursing Officers / Executives at 152 hospitals and 621 long-term care facilities, for a total population of 773. Since several employers sent single responses for multiple sites and one response came from a site not on the list, the adjusted population total was 149 hospitals and 613 LTC homes, for a total of 762 employers.

The Survey Implementation

As with the pilot survey, the final survey was conducted on-line.¹⁹² The survey questions may be found in Appendix A. The invitations were e-mailed out on July 5, 2012. The deadline was initially set as July 18, 2012 but later extended to July 20, 2012. On July 6, 2012, a note was sent to the 16 pilot participants explaining that they may have received an invitation to the 70 per cent survey, as all hospitals and long-term care facilities had received this invitation. Pilot participants were told that they could participate in the final survey or they could simply let their pilot submissions stand instead.

An e-mailed reminder was sent July 10, 2012. A final reminder was sent July 20, 2012.

Data was accepted after the deadline, with 15 valid responses arriving after July 20.

Response Rate

There were 343 responses, of which 335 contained user-entered data. A further 60 were dropped:

- 49 were dropped because they did not identify the responding organization
- Seven responses were dropped after investigation because they proved to be entries that had been subsequently updated.
- Four were dropped because they were received from outside the hospital and LTC sectors

Even after excluding the above responses, the overall response rate was a respectable 36.1 per cent. If the unidentified 49 respondents had been included, the overall response rate would have been 42.5 per cent. The response rate for the hospital sector was 70.5 per cent and that for the long-term care sector was 27.7 per cent (See Table 9). Because of the larger population of LTC

facilities (LTCFs), there were still more LTCFs in the sample (170) than hospitals (105), in spite of the higher hospital response rate.

9. Response Rate to Final Survey by Sector				
Sector	Count (n)	Response (%)	Target	Response Rate
LTC	170	61.8%	613	27.7%
Hospital	105	38.2%	149	70.5%
Total	275	100.0%	762	36.1%

Even using these most restrictive counts, the 95 per cent confidence interval of survey results for the long-term care respondents would be + / -6.4 percentage points, while the hospital confidence interval would be + / - 5.2 percentage points. The overall 95 per cent confidence level for both groups combined would be +/- 4.7 percentage points.^{193 194}

Coverage of Survey

When reported employment figures from each employer are summed together over the whole sample, the total corresponds to a large percentage of all Ontario RNs being covered by the survey:¹⁹⁵

- 56.5 per cent of all RNs
 - 88.8 per cent of hospital RNs
 - 34.4 per cent of LTC RNs

These figures overstate the coverage of the survey because of double counting of nurses who happened to work for multiple employers who responded to the survey. This is immediately evident when one sums up total reported nursing headcounts over all survey employers. For example, Table 10 shows that the total headcount in the survey of full-time nurses was equal to 52 per cent of the number of full-time RNs reported by CNO. In contrast, the total survey headcount for part-time RNs was 58 per cent of all Ontario part-time RNs, and the total survey headcount for casually employed RNs equaled 85 per cent of all Ontario casually employed RNs.¹⁹⁶ The same can be said for RPNs (62.4 per cent of part-time and 91.1 per cent of casual vs. 45.9 per cent of full-time) and for NPs (36.2 per cent and 64.4 per cent vs. 44.4 per cent).

10. Working Status Counts vs. Ontario Totals for 2010										
Sector	Data Source	Full-time			Part-time			Casual		
		RN	RPN	NP	RN	RPN	NP	RN	RPN	NP
Total	Survey	32,189	8,106	546	14,196	6,427	76	6,677	2,420	29
	CNO	61,484	17,641	1,231	24,586	10,143	210	7,846	2,658	45
	Survey/ CNO	52.4%	45.9%	44.4%	57.7%	63.4%	36.2%	85.1%	91.1%	64.4%
Hospital	Survey	30,997	6,424	533	13,283	4,705	65	6,167	1,730	27
	CNO	41,030	7,544	490	15,576	4,669	48	4,352	1,168	21
	Survey/ CNO	75.5%	85.2%	108.8%	85.3%	100.8%	135.5%	141.7%	148.2%	128.6%
LTC	Survey	1,192	1,682	13	913	1,722	11	510	690	2
	CNO	4,851	6,690	35	2,201	3,597	6	552	804	*
	Survey/ CNO	24.6%	25.1%	37.1%	41.5%	47.9%	183.3%	92.4%	85.8%	*

This discrepancy could arise for a number of reasons. Self-selection bias could be a contributing factor, but it is unlikely that such a large sample is so heavily biased to part-time and casual employment that it explains all the discrepancy. The high response rate increases the probability of double counting. Certainly, double counting can help to explain the lower than anticipated full-time share of nursing employment that emerges from the survey data.

CNO data in table 11 show the nature of multiple employment in Ontario.¹⁹⁷ In all but around 3 per cent of the cases for nurses with two employers (i.e., when a nurse has two full-time positions), the double counting adds part-time or casual positions and not full-time positions. Adding up positions clearly overstates the number of part-time and casual nurses much more than the number of full-time nurses, meaning that the full-time share is underestimated.

11. CNO 2012 Working Status for Nurses with 2 Nursing Employers						
Working Status	RN		RPN		NP	
	#	%	#	%	#	%
Full-Time/Full-Time	359	2.8	209	3.7	9	2.5
Full-Time/Part-Time	1,832	14.03	1,079	18.9	86	24.2
Full-Time/Casual	5,778	45.1	1,798	31.5	184	51.7
Part-Time/Part-Time	1,490	11.6	992	17.4	48	13.5
Part-Time/Casual	2,474	19.3	1,216	21.3	24	6.7
Casual/Casual	885	6.9	414	7.3	5	1.4
Total	12,818	100	5,708	100	356	100

The possibility of double counting is particularly dramatic with the hospital survey data. A simple summation of reported casual employment for RNs, RPNs and NPs in the survey greatly exceeds reported casual employment in the province (Table 11). An analysis of the role of double-counting appears in the Discussion section of this report.

Size of Responding Facilities

Using MOHLTC data,^{198 199 200} measures of the size of responding facilities were calculated. Slightly over half the beds in the sample were in hospitals. Reporting hospitals on average were larger than reporting LTC homes, as measured by beds per respondent (236 vs. 137) and beds per site (229 vs. 130). This was consistent with overall Ontario averages per site (203 vs. 123), with facilities in the sample having a higher number of beds than the overall Ontario average for both sectors. That suggests that the sample is modestly biased towards larger facilities.

Quantitative Results

Organizational Name

Respondents were first asked to identify their organizational name (See Table 12). As noted above, all but 49 (15.1 per cent) elected to do so. 170 were from the long-term care sector (50.9 per cent) and 105 were from the hospital sector (31.2 per cent).

12. Organization Name		
Sector	Count	Percentage
LTC	170	52.5%
Hospital	105	32.4%
Not Identified	49	15.1%
Total	324	15.1%

Preference for Anonymity

Respondents were then asked whether they wanted to remain anonymous outside of the 70 per cent Full-Time Nursing Employment Working Group. The majority (64 per cent) did wish to remain anonymous, although a significant minority (30.2 per cent) didn't mind being identified. Of note, 49 other respondents did not even identify their organization. Overall, hospitals were more open to being identified than were LTCFs (41.9 per cent vs. 22.9 per cent).

Full-Time, Part-Time and Casual Shares of Employment and Full-Time Share of Hours Worked

Another important measure is the full-time share of hours worked, which is a measure of access to full-time nurses. There was some inconsistency between FTE measures submitted and full-time counts, even though the on-line software flagged these conflicts (for example, some respondents still reported have substantially more full-time positions than FTEs). To strengthen the validity of this survey, full-time share of hours worked was calculated using only data for respondents whose calculated ratio did not exceed 110 per cent, and for which data existed for both full-time counts and for FTEs.

Tables 13, 14 and 15 report the full-time, part-time and casual shares of employment for all nurses, as well as the full-time share of FTE hours. Data are broken down into the two reporting sectors, Hospitals and LTC homes, as well as all. There is a table for each of the three nursing classes (RN, RPN and NP), and another three tables for frontline nurses. The data are compared

with 2010 CNO data. 2010 data were used because the CNO stopped reporting head counts for sectors and other categories in 2011. In general, the CNO full-time shares are higher. This may be because of double-counting of nurses with multiple employers, most of whom will be working part-time or casual. It may also reflect sampling bias, although one would not expect respondents with lower full-time ratios would disproportionately self-select into the survey.

All RNs: All RNs in this sample had a lower full-time share of employment than all RNs in the CNO database (60.7 per cent vs. 65 per cent in 2010). The share of FTEs that was full-time was higher: 80.4 per cent, as one would expect because of the weighting by hours instead of by head counts. The full-time share for hospital RNs in RNAO’s survey was somewhat lower than the CNO average, while the full-time share for LTC RNs in RNAO’s survey was much lower than in the CNO data. An earlier survey of hospital and LTC employers made a similar finding (Fisher, Baumann and Blythe (2007)).²⁰¹

13. FT/ PT / Casual Employment Share of All RNs					
Survey Responses		FT%	PT%	Casual%	FT Share FTEs
	All	60.7%	26.8%	12.6%	80.1%
	Hospitals	61.4%	26.3%	12.2%	80.4%
	LTCs	45.6%	34.9%	19.5%	70.1%
Compare: CNO 2010					
	All	65.5%	26.2%	8.4%	
	Hospitals	67.3%	25.6%	7.1%	
	LTCs	63.8%	29.0%	7.3%	

All RPNs: RPNs in all sectors had lower full-time shares of employment than RNs, by head counts (47.8 per cent vs. 60.7 per cent) and by shares of hours worked (66.5 per cent vs. 80.1 per cent). This was true of the hospital and LTC sectors individually as well. Among RPNs, the full-time share of employment by count was higher for hospitals at 50 per cent vs. 41.1 per cent for LTCs. The full-time share of FTEs was virtually identical for hospital and LTC RPNs, and much lower than for RNs. If the above two conclusions are valid, then part-time and casual LTC RPNs must work more hours than their hospital counterparts. As with RNs, the sample has much lower full-time shares of employment than in the overall CNO RPN population.

14. Employment Status of All RPNs						
Survey Responses		FT%	RN FT%	PT%	Casual%	FT Share FTEs
	All	47.8%	60.7%	37.9%	14.3%	66.5%
	Hospitals	50.0%	61.4%	36.6%	13.5%	66.5%
	LTCs	41.1%	45.6%	42.1%	16.9%	66.6%
Compare: CNO 2010						
	All	57.9%	65.5%	33%	9%	
	Hospitals	56.4%	67.3%	35%	9%	
	LTCs	60.3%	63.8%	32%	7%	

NPs: NPs had the highest share of full-time employment and the highest share of full-time hours. They were marginally below the full-time shares in the CNO data. The hospital full-time share (85.3 per cent) was much higher than LTC share (50 per cent), although the small sample size in the LTC sector implies a need for cautious interpretation. NP and RN full-time shares of FTEs is similar in hospitals (over 80 per cent), but NP shares are higher than RN shares in LTC. We would normally expect full-time share of FTEs to exceed full-time share of job counts. There is a mild discrepancy in the case of hospitals for NPs. This could be due to modest inconsistencies between job counts and FTE counts.

15. All NPs					
Survey Responses		FT%	PT%	Casual%	FT Share FTEs
	All	83.9%	11.7%	4.5%	81.4%
	Hospitals	85.3%	10.4%	4.3%	81.3%
	LTCs	50.0%	42.3%	7.7%	83.0%
Compare: CNO 2010					
	All	82.8%	14.1%	3.0%	
	Hospitals	87.7%	8.6%	3.8%	
	LTCs	83.3%	*	*	

Frontline Nurses

Frontline RNs: Most reported nursing positions are frontline, meaning they directly provide care to people. Comparisons between frontline and all nursing positions must be done with caution as three hospitals and 14 LTC homes had “all data” but were missing frontline data, while one hospital had frontline data but was missing “all data”. Frontline RNs had lower shares of full-time employment than did the overall group of RNs. This is consistent with the pattern revealed by CNO data. The non-frontline RNs in both sectors enjoyed greater than 70 per cent full-time employment, while frontline RNs fell far short of 70 per cent full-time. As with “all nurses”, hospitals had higher full-time shares for RNs than did LTC homes. Tables 16, 17 and 18 compare frontline nurses with all other nurses (Other).

16. Working Status of Frontline RNs vs. Other RNs: Percentage Shares								
Survey Responses	FT%	Other FT%	PT%	Other PT%	Casual%	Other Casual %	FT Share FTEs	Other FT Share FTEs
All	58.8%	73.8%	28.1%	17.6%	13.2%	8.7%	78.4%	86.1%
Hospitals	59.7%	73.9%	27.6%	17.5%	12.7%	8.6%	78.8%	85.9%
LTCs	39.4%	71.9%	38.9%	18.3%	21.7%	9.8%	68.3%	90.3%
Compare: CNO 2010								
All	65.5%		26.2%		8.4%			
All direct practice	63.4%		27.7%		8.9%			

Frontline RPNs: As with the overall RPN group, the RPNs had lower shares of full-time employment than did RNs. Even by shares of full-time hours, they are well short of 70 per cent. Also, the pattern of CNO full-time shares being higher than those in the survey continues. Frontline RPNs had lower full-time shares than their non-frontline counterparts, as did frontline RNs.

17. Working Status of Frontline RPNs vs. Other RPNs: Percentage Shares									
Survey Responses		FT%	Other FT%	PT%	Other PT%	Casual%	Other Casual %	FT Share FTEs	Other FT Share FTEs
	All	47.5%	52.6%	38.1%	39.5%	14.4%	8.0%	67.5%	57.5%
	Hospitals	49.8%	52.7%	36.6%	45.3%	13.6%	2.0%	67.3%	53.3%
	LTCs	39.8%	52.3%	43.2%	28.6%	17.0%	19.1%	68.1%	84.7%
Compare: CNO 2010									
	All	57.9%		33.3%		8.7%			
	All direct practice	57.2%		34%		8.8%			

Frontline NPs:

There was an insignificant difference between Other and Frontline among the NP class. Both have high full-time ratios and both are close to the CNO shares. Small sample size for LTC NPs means that those results must be interpreted with caution.

18. Working Status of Frontline NPs vs. Other NPs: Percentage Shares									
Survey Responses		FT%	Other FT%	PT%	Other PT%	Casual %	Other Casual %	FT Share FTEs	Other FT Share FTEs
	All	81.9%	86.5%	13.5%	10.8%	4.6%	2.7%	78.2%	95.4%
	Hospitals	85.0%	88.1%	10.5%	9.1%	4.6%	2.7%	78.7%	95.4%
	LTCs	46.7%	0%	8.9%	100%	4.4%	0%	67.9%	
Compare: CNO 2010									
	All	82.8%		14.1%		3.0%			
	All direct practice	82.7%		14.2%		3.1%			

Intensity of Nursing Service

The survey provides two broad estimates of nursing intensity: the number of nurses per bed, and the number of nursing hours per client day (See Table 19; shown are the numbers of nursing staff divided by the number of beds). Hospitals use approximately 13 times as many nursing FTEs per bed as do LTCFs, and about 18 times as many RNs per bed. LTC homes use higher proportions of RPNs than hospitals in their staffing, but hospitals use almost three times as many RPNs per bed. Even though there are almost as many LTC beds as hospital beds in the sample, there are about 13 times as many nursing FTEs in hospitals.

19. Nurse Per Bed Ratios								
	RNs	RN FTEs	RPNs	RPN FTEs	NPs	NP FTEs	Nurses	Total FTEs
Hospitals	2.05	1.50	0.52	0.36	0.03	0.03	2.60	1.88
LTCs	0.113	0.06	0.178	0.08	0.001	0.001	0.292	0.142
All	1.12	0.81	0.36	0.23	0.01	0.01	1.50	1.05
Hospital/LTC Ratio	18.2	25.6	2.9	4.3	23.7	46.8	8.9	13.3

Consistent with their much higher nurse/bed ratio, hospitals had a much higher estimated number of nursing hours worked per client day than did LTCFs: about 25.6 times as much for RNs, about 4.3 times as much for RPNs, and about 46.8 times as much for NPs. Overall, the ratio was about 13.3 to 1 for all nurses. The total hours of nursing care per client day in LTC were 0.61 (See Table 20). Nursing hours per client day fall short of those recommended in LTC. For example, the Casa Verde Coroner's inquest recommended at least .59 hours of RN care per client day,²⁰² and the data show that total nursing care scarcely meets that target (.61 hours), while the amount RN care is less than half the recommended amount (.25 hours).

20. Estimated Nurse Hours Worked per Client Day				
	RNs	RPNs	NPs	Nurses
Hospitals	6.5	1.5	0.1	8.1
LTCs	0.25	0.36	0.003	0.61
All	3.5	1.0	0.1	4.5
Hospitals/LTC Ratio	25.6	4.3	46.8	13.3

The Correlation between Scale and Full-time Shares of Nursing Employment

When asked about challenges in achieving 70 per cent full-time employment, some respondents cited size of facility as a limiting factor. In the hospital sector, data in the survey weakly confirm a linear correlation between certain measures of scale and full-time shares of nursing employment. Correlations are very weak in the LTC sector, and generally not statistically significant. The tests were done for screening purposes only, on the strong assumption that any relationship is linear. Any correlations may be spurious and reflect the influence of other variables. Further investigation should be done before drawing policy inferences.

Beds vs. Full-Time Shares

Hospitals: There was a small positive and statistically significant linear correlation between the number of beds and full-time shares for RNs in hospitals. This relationship was stronger for frontline RNs. The positive correlation also held for frontline RPNs, but not for all RPNs. There was a small negative correlation for NPs but the sample size was smaller and the number of nurses was much smaller. Correlations were also tested between bed counts and full-time shares of nursing FTEs. There was a positive correlation for frontline RNs (but not all RNs), and a negative correlation for NPs (all and frontline). The results for NPs should be interpreted carefully due to the small number of NPs involved. See Figure 1 in Appendix B.

Long-Term Care Homes: There was no statistically significant correlation between numbers of beds per respondent and full-time shares in the LTC sector. See Figure 2 in Appendix B.

Nursing FTEs vs. Full-Time Shares:

Hospitals: In the case of hospitals, there were small positive correlations between full-time shares and nursing FTEs for all nursing categories (frontline and all RNs, frontline and all RPNs, and frontline and all NPs). When it came to full-time shares of FTEs, the small positive correlation held for both groups of RNs and NPs, but not for RPNs. See Figure 3 in Appendix B.

Long-Term Care Homes: For LTC homes, there is a small positive correlation for the small sample of NP employers. See Figure 4 in Appendix B.

The Correlation between Nursing Hours per Client Day and Full-Time Share:

Hospitals: Correlations were weak and statistically insignificant, except for the relationship between full-time share and the nursing hours per client day.

Long-Term Care Facilities: There was a weak positive relationship for NPs in the LTC sector. See Figure 5 in Appendix B.

Qualitative Results

Participants were asked to respond to a set of qualitative questions (see Appendix A) on an online survey and each question's set of responses were read through completely before conducting a thematic analysis. The following themes emerged from the responses received.

Opportunities and Innovation

When asked about what opportunities and innovation facilitate efforts to achieve 70 per cent full-time employment, there was a heavy reliance on Ministry-funded initiatives and in particular the Late Career Nurse Initiative (LCNI) and the NGG, which were mentioned by both hospitals and LTC homes. Respondents, however, expressed pessimism about meeting the 70 per cent FT target if the facility stated ministry funds were inadequate. This was particularly expressed by LTC respondents when the facility was small or if the facility commented that PT staff were required to cover FT vacation /weekends. Funding models were mentioned by over a quarter of respondents; most in a positive light, although a smaller percentage pointed to limitations in the models or the levels of funding. Several resources were identified as capacity building by participants. For example, the "nursing resource teams" were frequently mentioned by larger organizations as an effective health human resource strategy. When unions were mentioned, they largely played a facilitative role in keeping or increasing FT lines. Furthermore, a quantitative analysis of the themes that emerged (See Table 21) shows two-thirds mentioned their use of a health human resources (HHR) solution and 32 per cent of respondents mentioned the importance of supporting healthy work environments as an opportunity and / or innovation.

21. Themes Coded from “Opportunities and Innovation” Qualitative Responses						
Theme	Hospitals n=105 Missing=15		LTCFs n=170 Missing=44		All n=275 Missing=59	
	Count	%	Count	%	Count	%
HHR Solution proposed	63	70.0%	81	64.3%	144	66.7%
HWE (evidence-based staffing and retention efforts)	28	31.1%	41	32.5%	69	31.9%
Recruitment as concern or strategy	6	6.7%	20	15.9%	26	12.0%
Work with unions	4	4.4%	7	5.6%	11	5.1%
Small/rural/ remote challenges	5	5.6%	4	3.2%	9	4.2%
Job share	1	1.1%	4	3.2%	5	2.3%
Use IENs	0	0%	2	1.6%	2	0.9%
Funding Models help / are inadequate	25	27.8%	36	28.6%	61	28.2%
Funding models help	22	24.4%	27	21.4%	61	28.2%
Funding models hurt/funding inadequate	1	1.1%	8	6.3%	9	4.2%
Small/rural/ remote challenges	5	5.6%	4	3.2%	9	4.2%
Already reaching 70%	8	8.9%	2	1.6%	10	4.6%
Not trying to reach 70%	1	1.1%	8	6.3%	9	4.2%

Challenges and Barriers to Full-Time Employment

Inadequate government funding was noted as the most frequent and influential challenge / barrier to achieving 70 per cent FT nurse staffing overall by employers. Funding was mentioned much more frequently by LTC respondents than hospital respondents. Respondents also cited inflexible scheduling, often due to union contracts that prevented closure of PT lines, and the need for PT lines to cover time off for FT lines. Paying overtime to FT staff in order to cover the time off for FT staff was not viewed as efficient by several participants. Staff preferences were given as a constraint, with some participants suggesting many nurses are not interested in FT hours due to work-life balance, heavy workload, age, and financial incentives from working multiple PT jobs or receiving pay in lieu of benefits. A quantitative analysis (See Table 22) showed recruitment and retention emerged as a challenge in raising full-time employment. Many small, rural and northern organizations also identified their size or geography as a significant and limiting factor.

22. Themes Coded out of “Challenges and Barriers” Qualitative Responses						
Theme	Hospitals n=105 Missing=9		LTCFs n=170 Missing=11		All n=275 Missing=20	
	Count	%	Count	%	Count	%
Funding	30	31.3%	76	47.8%	106	41.6%
Retention and Recruitment	21	21.9%	52	32.5%	73	28.6%
Coverage for staff time off	45	46.9%	27	17.0%	72	28.2%
Staff preferences	18	18.8%	24	15.1%	42	16.5%
Rural/small	30	31.3%	20	12.6%	50	19.6%
Union contracts	17	17.7%	24	15.1%	41	16.1%

Mitigation Strategies to Deal with Barriers and Challenges

The two most frequent mitigation strategies employed by organizations echoed messaging in the previous sections: 1) enhance retention and recruitment efforts and 2) develop and implement a human resource strategy (e.g., nursing resource team, review of skill mix, models of nursing care delivery and composition of the inter-professional team). FT lines were created by combining PT lines as they became available, using 12 hour shifts, cross-training staff to work more than one area, and reducing the required hours to achieve FT status. Working with unions was a prominent feature of mitigating strategies, where unions were identified by several participants both as an enabler and a barrier to increasing FT lines. Training and professional development were often linked with retention and recruitment strategies. Relatively few organizations intended to maintain or increase PT lines, which, when done, was seen to address current staff preferences, enhance recruitment and / or add flexibility to the schedule. Some mentioned their lobbying for more funding, which was seen as a strong enabler of full-time employment. (See Table 23)

23. Themes Coded out of “Mitigation Strategies” Qualitative Responses						
Theme	Hospitals n=105 Missing=22		LTCFs n=170 Missing=44		All n=275 Missing=66	
	Count	%	Count	%	Count	%
Recruitment and Retention	21	25.3%	47	37.3%	68	32.5%
HHR Strategies	32	38.6%	17	13.5%	49	23.4%
Training	7	8.4%	25	19.8%	32	15.3%
Combine PT lines or 12-hr shifts or reduce FT hours	16	19.3%	13	10.3%	29	13.9%
Work with unions	11	13.3%	14	11.1%	25	12.0%
Stabilize or increase PT hours	8	9.6%	8	6.3%	16	7.7%
Lobby for funding	2	2.4%	8	6.3%	10	4.8%

Models of Care Delivery

Respondents were offered definitions of four models of nursing care delivery (see Appendix A). In the hospital sector, the dominant model was Total Patient Care, with comparatively small numbers distributed around the other three models. In contrast, over half of LTC homes reported their model as Team Nursing, with the remaining respondents evenly distributed around the remaining models. (See Table 24 for themes coded out of “Models of Care Delivery”).

Models of nursing care delivery varied significantly among survey participants. A hybrid of primary and functional or team nursing is often used, which is usually situated within a broader interprofessional team that may include RN, RPN and unregulated care providers to extend nursing roles. Models of care delivery are sometimes chosen based on the sector or unit, time of day and patient / resident characteristics. Often RNs are given the role of "charge nurse" or someone to "oversee" the home and supervise RPNs and unregulated care providers (UCPs). Some organizations are moving towards primary nursing, while others are changing to a hybrid of primary and total patient care nursing. Still others are implementing a team model of care delivery. While there are a variety of models of nursing care delivery in use, the survey did not ascertain the reasons for choice of model (See Table 25).

24. Themes Coded out of “Model of Care Delivery”						
Theme	Hospital		LTC		All	
	Count	%	Count	%	Count	%
Total Patient Care	75	68%	23	15%	98	37%
Functional Nursing	7	6%	26	17%	33	12%
Team Nursing	16	15%	80	51%	96	36%
Primary Nursing	12	11%	28	18%	40	15%
Total	110	100%	157	100%	267	100%
Number of models of care delivery per organization, by sector						
Number of Models Reported			Hospital	LTC	All	
0			7	18	25	
1			88	147	235	
2			9	5	14	
3			0	0	0	
4			1	0	1	
Total			105	170	275	

25. Other Models of Care Delivery						
Theme	Hospitals n=105 Missing=82		LTCFs n=170 Missing=144		All n=275 Missing=226	
	Count	%	Count	%	Count	%
Hybrid models	10	43.5%	5	19.2%	15	30.6%
RN-supervised team	1	4.3%	9	34.6%	10	20.4%
Varies, depending on patient	7	30.4%	1	3.8%	8	16.3%
Varies, depending upon sector	5	21.7%	1	3.8%	6	12.2%
Varies, depending upon time (e.g., of day or week)	2	8.7%	1	3.8%	3	6.1%

Use of the Nursing Graduate Guarantee (NGG)

Participant feedback suggested hospitals were much more likely to have used NGG than LTC homes for RNs (84 per cent vs. 27 per cent). For RPNs, again hospitals were more likely to use NGG (53 per cent vs. 39 per cent), but LTC homes were more likely to use NGGs for RPNs than for RNs. This is unsurprising, given the more intensive use of RPNs in LTCFs. By far the greatest single cause of not using NGG was lack of permanent FT positions (See Table 26 and 27).

26. Use of NGG for RNs						
Response	Hospital		LTC		Grand Total	
	Count	%	Count	%	Count	%
Yes - last three years or more	66	62.9%	17	10.0%	83	30.2%
Yes - last two years	6	5.7%	4	2.4%	10	3.6%
Yes - one year only out of two years	16	15.2%	24	14.1%	40	14.5%
Yes total	88	83.8%	45	26.5%	133	48.4%
No - full-time job not available	14	13.3%	65	38.2%	79	28.7%
No - budget constraints	1	1.0%	21	12.4%	22	8.0%
No - labour relations challenges	1	1.0%	12	7.1%	13	4.7%
Not applicable	0	0.0%	23	13.5%	23	8.4%
Missing	1	1.0%	4	2.4%	5	1.8%
Total	105	100%	170	100%	275	100%

27. Use of NGG for RPNs						
Response	Hospital		LTC		Grand Total	
	Count	%	Count	%	Count	%
Yes - last three years or more	31	29.5%	32	18.8%	63	22.9%
Yes - last two years	7	6.7%	9	5.3%	16	5.8%
Yes - one year only out of two years	18	17.1%	25	14.7%	43	15.6%
Yes total	56	53.3%	66	38.8%	122	44.4%
No - lack of full-time job available	29	27.6%	56	32.9%	85	30.9%
No - budget constraints	1	1.0%	17	10.0%	18	6.5%
No - labour relations challenges	7	6.7%	9	5.3%	16	5.8%
Not applicable	9	8.6%	17	10.0%	26	9.5%
Missing	3	2.9%	5	2.9%	8	2.9%
Total	105	100%	170	100%	275	100%

Most survey participants found the NGG initiative to be an overwhelming success for recruiting nurses to their organization, noting in particular the positive impact it had on professional development of new graduate nurses. It was seen as a win-win for the employer and the nursing graduate who had more confidence in their skills, and was able to practise in specialized areas of nursing that were previously not possible. Some respondents said that union contracts presented challenges in taking full advantage of this initiative. Another significant barrier was the lack of FT employment available in many organizations, particularly those smaller and rural. This created a disincentive to participate. Other themes included: 1) rural issues (e.g., smaller organizations hoped to be permitted to offer permanent part-time employment following NGG and not just full-time employment), 2) the application process was too complicated, 3) concern for retiring nurses, 4) lack of applicants, 5) the departure of new graduates for other employers, 6) cost “penalties” that might be incurred immediately following the NGG period of employment if there are no funded full-time positions available (See Table 28).

28. Themes Coded on “Comments on Nursing Graduate Guarantee (NGG)”						
Theme	Hospitals n=105 Missing=33		LTCFs n=170 Missing=90		All n=275 Missing=123	
	Count	%	Count	%	Count	%
No FT positions available	20	27.8%	17	21.3%	37	24.3%
Challenges with union contracts	13	18.1%	7	8.8%	20	13.2%
Enhanced professional development	21	29.2%	16	20.0%	37	24.3%
Positive experience	44	60.3%	42	52.5%	86	56.2%

Late Career Nursing Initiative (LCNI)

The Late Career Nursing Initiative (LCNI) provides government funding in salary replacement costs to allow nurses over 55 years of age to spend 20 per cent of their time in less physically demanding roles, such as mentoring.²⁰³ When employing RNs, hospitals were more likely to use LCNI than LTC homes were, but hospitals were not as likely to use LCNI as they were to use NGG (See Table 29). On the other hand, LTC homes were more likely to use LCNI for RNs than they were to use NGG for RNs. Both hospitals and LTCFs were less likely to use LCNI for RPNs than for RNs, but hospitals were more likely to use it than LTC homes. Very few facilities have used LCNIs for NPs. The greatest single reason was that no positions were available. Usage patterns of LCNI were similar to those for the NGG. Overall, 47 per cent reported some usage for RNs, with hospitals using the initiatives more than LTC home; with 69 per cent vs. 36 per cent for LTCs and 0 per cent for Other.

29.Use of LCNI for RNs						
Response	Hospital		LTC		Grand Total	
	Count	%	Count	%	Count	%
Yes - last three years or more	38	36.2%	33	19.4%	71	25.8%
Yes - last two years	11	10.5%	9	5.3%	20	7.3%
Yes - one year only out of two years	22	21.0%	19	11.2%	41	14.9%
Yes total	71	67.6%	61	35.9%	132	48.0%
No - Unsuccessful application	9	8.6%	20	11.8%	29	10.5%
No - Could not backfill LCNI	5	4.8%	18	10.6%	23	8.4%
No – Other	15	14.3%	47	27.6%	62	22.5%
Not applicable	4	3.8%	19	11.2%	23	8.4%
Missing	1	1.0%	5	2.9%	6	2.2%
Total	105	100%	170	100%	275	100%

Use of LCNI for RPNs and NPs

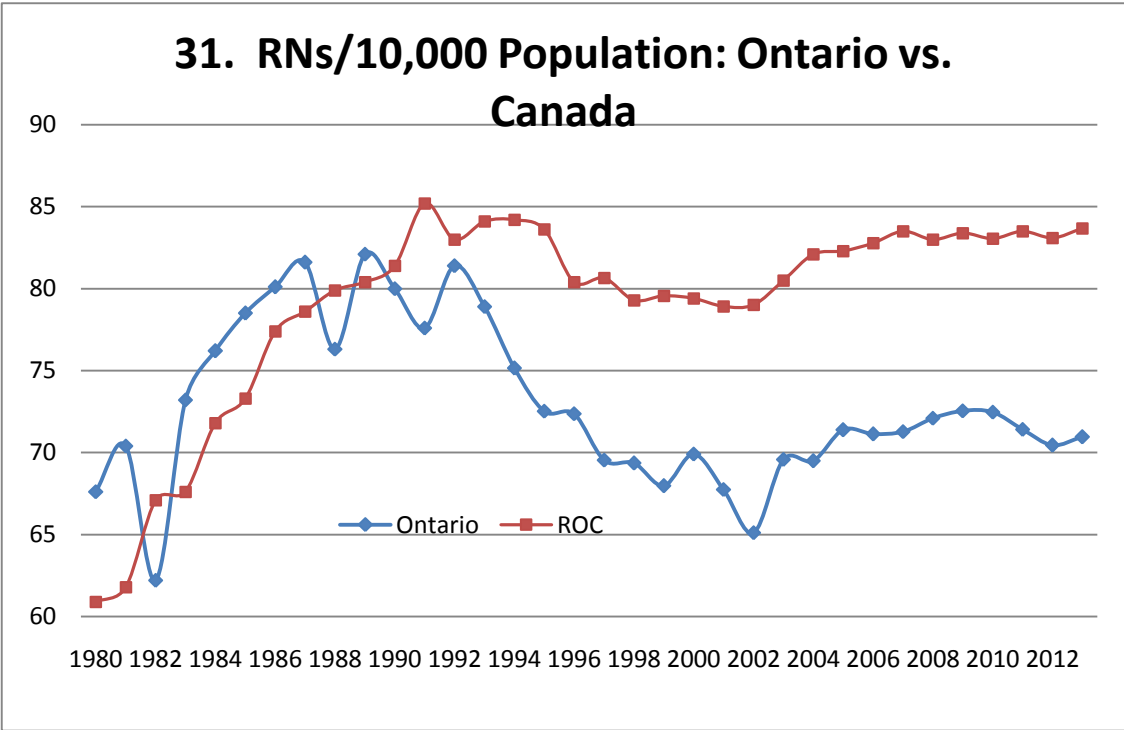
Usage of LCNI for RPNs was again less widespread (Figure 30): 40 per cent reported some usage. Hospitals (56 per cent) were more likely to use the program for RPNs than were LTCs (29 per cent). The LCNI was very little used for NPs (table not shown): 2 per cent overall, with hospitals at 4 per cent, LTCs at 2 per cent and Other at 0 per cent. Given the number of NPs in the system and the fact that most of them already have full-time positions, this is not surprising.

30.Use of LCNI for RPNs						
Response	Hospital		LTC		Grand Total	
	Count	%	Count	%	Count	%
Yes - last three years or more	29	27.6%	27	15.9%	56	20.4%
Yes - last two years	10	9.5%	5	2.9%	15	5.5%
Yes - one year only out of two years	20	19.0%	18	10.6%	38	13.8%
Yes total	59	56.2%	50	29.4%	109	39.6%
No - Unsuccessful application	7	6.7%	14	8.2%	21	7.6%
No - Could not backfill LCNI	2	1.9%	19	11.2%	21	7.6%
No – Other	25	23.8%	62	36.5%	87	31.6%
Not applicable	12	11.4%	17	10.0%	29	10.5%
Missing	0	0.0%	8	4.7%	8	2.9%
Total	105	100%	170	100%	275	100%

Discussion

Significant Progress Towards 70% Full-Time Nursing Employment in Ontario

Progress towards achieving 70 per cent full-time nursing employment in Ontario has been fairly steady overall since 1999. This progress shows a temporal correlation with government commitments to raise full-time employment of nurses and to raise the full-time share of employment. There was a marked divergence between the performance of Ontario and the rest of Canada on full-time shares for RNs after 1999. Ontario has attained higher levels than ever before, while the rest of the country lags further and further behind. For RNs, the ratio improved by increasing full-time positions and reducing part-time and casual effects. The full-time share for RNs is close to the 70 per cent goal, however the RPN experience is different. They added full-time, part-time and casual positions over most periods. Because full-time positions were added at a faster rate than part-time and casual positions, the full-time ratio for RPNs has improved. However, it still lags that of RNs, at 55.9 per cent vs. 66.9 per cent. Gains in full-time shares for RNs mask a particularly difficult employment situation. Between 2010 and 2012, Ontario RNs lost more part-time and casual positions than they gained in full-time positions, meaning that RN employment levels were falling increasingly behind population growth. That trend reversed in 2013 and 2014 according to CNO data. Using the latest national data from CIHI to 2013, Ontario would have to add over 17,000 more RNs to its workforce to catch up with the rest of Canada.²⁰⁴ That would be an increase of almost 18 per cent.



Keen Interest in the Survey

There was a good response rate from the LTC sector (28 per cent), and a very high response rate from the hospital sector (71 per cent). Considering that there were only two e-mailed reminders and that the entire process was conducted electronically, the high response rate was gratifying. If not for the 49 responses that omitted the identification step, the overall response rate would have been 43 per cent, instead of 37 per cent. Responses indicated a strong awareness and interest in the 70 per cent full-time objective, and a keen interest in explaining what employers were doing in that regard and the challenges they faced.

Double Counting

One notable finding of this survey is the obvious discrepancy in calculated full-time share of employment, which was lower in our survey than the provincial average for both sectors and for all types of nurses. Other evidence in the report helps to explain that the result is not simply a matter of sampling bias: total counts from survey respondents for part-time and particularly casual were very large relative to provincial totals (for hospitals, the casual employment count exceeded latest casual employment counts for the entire province by a large margin). This was strong evidence for a powerful double-counting effect, such that nurses with multiple employers were being counted by each employer in the survey. Higher response rates increase the double-counting effect.

Calculations were done to assess the potential for double-counting to account for the gap between CNO data and the survey results. Adjusting the hospital data by assuming that the sector has the same degree of multiple employment as the province does eliminate the gap, as can be seen in the following two tables for RNs and RPNs.²⁰⁵ Adjusting for double-counting reduces casual counts the most and reduces full-time counts the least.

32. RN Work Status Data Adjusted for Double Counting							
		Counts			Percentage Shares		
		FT	PT	Casual	FT	PT	Casual
All	Original	32,189	14,196	6,677	60.7%	26.8%	12.6%
	Adjusted	32,115	13,386	3,893	65.0%	27.1%	7.9%
	CNO	61,484	24,586	7,846	65.5%	26.2%	8.4%
Hospital	Original	30,997	13,283	6,167	61.4%	26.3%	12.2%
	Adjusted	30,870	11,985	2,704	67.8%	26.3%	5.9%
	CNO	41,030	15,576	4,352	67.3%	25.6%	7.1%
LTC	Original	1,192	913	510	45.6%	34.9%	19.5%
	Adjusted	1,190	875	338	49.5%	36.4%	14.1%
	CNO	4,851	2,201	552	63.8%	28.9%	7.3%

33. RPN Work Status Data Adjusted for Double Counting							
		Counts			Percentage Shares		
		FT	PT	Casual	FT	PT	Casual
All	Original	8,106	6,427	2,420	47.8%	37.9%	14.3%
	Adjusted	8,087	6,060	1,411	52.0%	39.0%	9.1%
	CNO	17,641	10,143	2,658	57.9%	33.3%	8.7%
Hospital	Original	6,424	4,705	1,730	50.0%	36.6%	13.5%
	Adjusted	6,398	4,245	759	56.1%	37.2%	6.7%
	CNO	7,544	4,669	1,168	56.4%	34.9%	8.7%
LTC	Original	1,682	1,722	690	45.6%	34.9%	19.5%
	Adjusted	1,679	1,651	458	44.3%	43.6%	12.1%
	CNO	6,690	3,597	804	60.3%	32.4%	7.2%

Adjusting for double-counting reduces but does not eliminate the gap for the LTC sector. This leaves several possibilities for the LTC data:

- sample bias: this may be a contributing factor, but it is difficult to imagine employers with low full-time shares disproportionately self-selecting themselves into the survey in sufficient numbers to account for the huge discrepancy;
- a very high degree of multiple job holding in the sector, well above the proportions in the nursing population overall; access to multiple job-holding data disaggregated to the sector level would answer this question;
- discrepancies between the ways that the CNO and employers report employment status.
- the age of the CNO data: it would be preferable to compare 2012 CNO data with the 2012 survey data, but that was not available at the time of writing.

Reporting methodologies of the CNO and employers may thus bear further investigation.

This suggests a different full-time target might apply at the facility level, such as, a minimum of 80 per cent of nursing FTEs being worked by full-time nursing staff. This ratio appears to be close to the level needed to get the system to 70 per cent full-time by head counts, as per RNAO estimates.²⁰⁶ In fact, Ontario hospitals currently are mandated to report full-time shares of hours worked.²⁰⁷ The issue is the appropriate target level. One source informs RNAO that the government target is 70 per cent full-time by FTEs, which would result in much less than 70 per

cent by head counts.²⁰⁸ This of course would conflict with the political commitment from the 2003 and 2007 elections to increase the share of RNs with full-time nursing employment to 70 per cent (i.e., by head counts).

Notwithstanding the double counting, we can still do useful comparisons. For RNs, the hospital sector reported higher full-time shares than the LTC sector, which is consistent with CNO data. However, the discrepancy between survey and CNO shares was greater for the LTC sector. One conjecture could be that multiple job holding is more prevalent in the LTC sector than in the hospital sector. When it came to full-time share of hours worked, hospitals were higher (at 80.4 per cent) than LTCs (70.1 per cent). By this reckoning, the hospital sector in the survey on average may have met the 70 per cent target for RNs.

CNO Data

CNO data are essential to the analysis of nursing HR policy in Ontario. They are the principle tool available to analyse progress towards 70 per cent full-time. They helped to flag the challenges in using employer-level data to assess that progress. Two changes in the way that CNO reports its data since 2010 have greatly weakened the value of the reported data. First, CNO has changed the way that it defines full-time, from "full-time as defined in the employment contract" (normally 1950 paid hours per year) to a lowered threshold of 30 hours per week. This is at odds with the definition used by the Canadian Institute of Health Information (CIHI), which retains the former information, and to which CNO reports full-time data. Secondly, CNO no longer reports head counts at any level of disaggregation below that of the province. For this report, that meant that the latest public data available to compare with July 2012 survey results was over two years old (January 2010).

Frontline Nurses Vary in FT Employment from Other RNs

Frontline nurses had significantly lower full-time shares than the rest of RNs in the survey. This is an important outcome, as continuity of care particularly refers to direct care. For RNs, non-frontline nurses enjoy over 70 per cent full-time in both sectors. Frontline RNs in the hospital sector were 58.8 per cent full-time and 39.4 per cent in the LTC sector. The situation was worse for RPNs. Non-frontline RPNs were scarcely over 50 per cent full-time, while frontline RPNs were about 50 per cent full-time in hospitals and 40 per cent in LTCFs. Frontline NPs had high levels of full-time employment. RPNs had lower full-time shares than did RNs. Again, this is consistent with CNO statistics. Their full-time share of FTEs was much lower than for RNs (66.5 per cent vs. 80.1 per cent). This confirms the lower share of full-time employment among RPNs. NPs had high full-time shares of employment and high full-time share of FTEs.

Hospitals and LTC Homes Vary Significantly in Staffing Level and Skill Mix

Hospitals used nurses much more intensively (per bed and per client day) than did LTCFs, in most cases by at least an order of magnitude. RN hours per client day in LTC were less than half of the number recommended by the Casa Verde coroner's inquest.

Some respondents pointed to size of facility limiting capacity to attain 70 per cent full-time. Various measures of scale proved to be weakly correlated to full-time shares of employment for hospitals but there was no proven correlation for LTCFs, when each sector was tested separately.

Employer's Perspectives on:

Barriers and Opportunities to Full-Time Employment: Respondents were very aware of the 70 per cent objective and there was no evident questioning of that objective, but a number of respondents were surprised that their own facilities' ratios fell well short of the goal. Respondents had a number of strategies to get there, but they were keen to point out the challenges. Irrespective of whether the question was about opportunities or mitigation or barriers, many respondents explained their difficulties in moving to 70 per cent full-time. The biggest single factor cited was funding; this was mentioned much more often by LTCFs than hospitals. Scheduling was also a commonly cited challenge, particularly around coverage for staff time off. Retention and recruitment, and staff preferences were two closely related factors, especially for LTCFs.

Opportunities and innovation: Respondents overwhelmingly identified government funding as beneficial. It was evident that many respondents made use of the Nursing Graduate Guarantee (NGG) and the Late Career Nursing Initiative (LCNI). A majority mentioned health human resource initiatives and a significant minority mentioned evidence-based staffing and retention efforts to promote healthy work environments. Very few (4.6 per cent) stated that they had attained 70 per cent full-time, and only a very few (4.2 per cent) indicated that they were not attempting to reach 70 per cent. More of these latter facilities were LTC homes (6.3 per cent) than hospitals (1.1 per cent).

Challenges and barriers: Funding was an issue for both sectors, but mentioned more often by LTC respondents. Inflexible scheduling and staff preferences were prominently mentioned. Size and geography were themes for small, rural and northern organizations.

Mitigation strategies: A number of specific strategies were mentioned, including creation of FT lines through combining PT lines as they became available, using 12 hour shifts, cross-training staff to work more than one area, and reducing the required hours for FT status. Respondents were very aware of the need to work with unions. Training and professional development were

often linked with retention and recruitment strategies and some mentioned their lobbying for more funding, which was seen as necessary to achieve 70 per cent full-time nursing employment.

Models of Care Delivery: In the hospital sector, the dominant model was Total Patient Care, with comparatively small numbers distributed around the other three models. In contrast, over half of LTC homes reported their model as Team Nursing. Some respondents reported using two or more models for various reasons (e.g., depending upon the site or client or time of day or week) and some respondents reported using other models, including hybrids of the four models suggested by the survey form.

The Nursing Graduate Guarantee: The NGG was widely used for RNs by hospitals (84 per cent) and less so by LTC homes (27 per cent). The biggest reason for not using NGG was the lack of permanent full-time positions. There was less usage for RPNs and again the leading cause of not using it was the absence of permanent full-time positions. Respondents were generally very positive about the NGG program, while some noted local disincentives or obstacles to making full use of the program.

The Late Career Initiative: Use of the LCNI for RNs was widespread (68 per cent hospitals, 36 per cent LTCFs, 48 per cent overall), but not as widespread as the use of the NGG. The use of LCNI was less widespread for RPNs (56 per cent hospitals, 29 per cent LTCFs, 40 per cent overall). It was used very little for NPs. Overall survey participants were very satisfied with both the NGG and LCNI initiatives as a retention and recruitment strategy. Many factors influenced the use of these initiatives and the achievement of 70 per cent FT employment, including sector profile, geography, size of organization, and even how statistics are calculated. Several participants noted a need to share ideas and strategies to improve their FT complement.

Survey Strengths

A pilot survey was used to hone the questions in the final survey and the final survey enjoyed a very good response rate: 36.1 per cent overall. The rate was very high in the hospital sector at 70.5 per cent, and quite respectable in the long-term care sector at 27.7 per cent. The sample is reasonably representative not only because of the response rate, but because its characteristics mirror those of the population. For example, there were 229 beds per hospital site in the survey vs. 203 in the population, and 130 vs. 123 in long-term care. Respondents on average had slightly more beds per site than the overall population. One could conjecture that smaller facilities could find responding to the survey to be relatively more burdensome due to more limited staffing. A majority of respondents preferred that their data remain anonymous (64 per cent), with the preference being stronger among LTC respondents (70.6 per cent vs. 53.3 per cent). A significant number of respondents (49) did not identify their organizational names, and because we could not verify whether they belonged in the survey, we excluded their data. To the extent that these non-identified responses belonged in the survey, the response rate would have been higher (42.5 per cent).

Survey Limitations

As this survey is a cross-sectional study that provides only a snapshot of nursing full-time employment at the time the survey was conducted, it has limited power to measure progress in full-time employment. A longitudinal design, using a subsequent survey, could facilitate further data collection and allow RNAO to measure progress over time. Also, another follow-up survey could target more sectors.

As noted above, there can be greater confidence in the representativeness of the hospital data than the long-term care data due to the higher response rate in the former sector.

Appendix A: Survey Questions

Organization Name:

I/We choose for our organization to remain anonymous outside of the 70 per cent Full-Time Nursing Employment Working Group:

Choose Yes or No.

1. Please provide counts and FTEs for your nursing team by working status for your **most recent pay period**. In the first table, please provide these data for all your nursing workforce. For the second table, please provide these data for your frontline nurses only. Once you have entered the data, you may click on the button below each table to see totals and percentages for your data.

Full-time: Employed in registered nursing on a regular basis and guaranteed a full-time number of hours per pay period, where full-time is defined in the employment contract (normally 37.5 hours per week or 1950 hours per year).

Part-time: Employed in registered nursing on a regular basis and guaranteed less than a full-time number of hours per pay period, where full-time is defined in the employment contract (normally 37.5 hours per week or 1950 hours per year).

Casual: Employed in registered nursing, but not guaranteed a fixed number of hours per pay period.

Full-time Equivalent (FTE): Number of hours worked divided by the number of hours in a normal full-time position. A full-time position would generate one FTE. Two half-time positions would also generate one FTE.

Frontline: non-management and providing direct patient care.

RN: Registered Nurse in the General Class

RPN: Registered Practical Nurse

NP: Nurse Practitioner

All Nursing Staff

Type of Nurse	Full-time counts	Part-time counts	Casual counts	FTEs
RNs				
RPNs				
NPs				

Frontline Nursing Staff Only

Nurses providing direct client care.

Type of Nurse	Full-time counts	Part-time counts	Casual counts	FTEs
RNs				
RPNs				
NPs				

Opportunities & Innovation:

2. What opportunities and innovations are being used (or can be used) in your organization to increase and/or maintain (if you have achieved 70% and greater) full-time nursing employment?

3. What challenges/barriers exist in your organization to advance full-time nursing employment?

Mitigation Strategies:

4. What mitigation strategies has your organization used to tackle these challenges/barriers?

5. Which model of care delivery is used most in your organization? Choose one from the following list:

Definitions of models of care delivery adapted from Harris, A. and McGillis Hall, L. (2011). *Evidence to Inform Staff Mix Decision-making: A Focused Literature Review*. Prepared for the Canadian Nurses Association.

Total Patient Care: one nurse assumes responsibility for the full care of a group of patients over the course of a shift, but will not necessarily deal with the same patients from shift to shift.

Functional Nursing: Specific tasks are divided among a variety of health-care staff based on their level of knowledge and complexity of the assignment, relying heavily on procedures, protocols and regulation and typically equated with production-line techniques and cost-effectiveness.

Team Nursing: Like Functional Nursing, it focuses largely on the use and integration of various staff and skill mixes, including RNs, LPNs and UCPs. A team leader oversees activities of the group, which are less prescribed by procedures, protocols and regulation than in Functional Nursing.

Primary Nursing: One RN is responsible for a patient's care and plans that care throughout their entire stay, with close coordination among the nurses on succeeding shifts to ensure continuity of care and care provider.

Other model of care delivery:

6. Has your organization utilized the Nursing Graduate Guarantee (NGG) initiative, funded by the Government of Ontario to hire RNs?

Select:

- Yes - last three years or more
- Yes - last two years
- Yes - one year only out of two years
- No - primary reason: lack of permanent full-time job available
- No - primary reason: budget constraints
- No - primary reason: labour relations challenges
- Not applicable

Has your organization utilized the Nursing Graduate Guarantee (NGG) initiative, funded by the Government of Ontario to hire RPNs?

Select:

- Yes - last three years or more
- Yes - last two years
- Yes - one year only out of two years
- No - primary reason: lack of permanent full-time job available
- No - primary reason: budget constraints
- No - primary reason: labour relations challenges
- Not applicable

Nursing Graduate Guarantee (NGG) comments:

7. Has your organization utilized the Late Career Nurse Initiative (LCNI), funded by the Government of Ontario as a workplace improvement initiative for RNs?

Select:

- Yes - last three years or more
- Yes - last two years
- Yes - one year only out of two years
- No - primary reason: lack of permanent full-time job available
- No - primary reason: budget constraints
- No - primary reason: labour relations challenges
- Not applicable

Has your organization utilized the Late Career Nurse Initiative (LCNI), funded by the Government of Ontario as a workplace improvement initiative for RPNs?

Select:

- Yes - last three years or more
- Yes - last two years
- Yes - one year only out of two years
- No - primary reason: lack of permanent full-time job available
- No - primary reason: budget constraints
- No - primary reason: labour relations challenges
- Not applicable

Has your organization utilized the Late Career Nurse Initiative (LCNI), funded by the Government of Ontario as a workplace improvement initiative for NPs?

Select:

- Yes - last three years or more
- Yes - last two years
- Yes - one year only out of two years
- No - primary reason: lack of permanent full-time job available
- No - primary reason: budget constraints
- No - primary reason: labour relations challenges

- Not applicable

Late Career Nurse Initiative (LCNI) comments:

Final Comments:

Appendix B

The following tables show correlation coefficients (R), P values (P) and valid counts (N) for each pair of linear correlations. R gives the direction and strength of relationship between the two variables (R^2 gives the fraction of variation in one variable attributable to variations in the other). Based on R values, none of the correlations are particularly strong, however, a number are statistically significant at the 5% level (italicized). The correlations were done for screening purposes only, and must be interpreted with caution, as the methodology assumes a linear relationship and may produce spurious correlations due to the effects of omitted variables. Overall, the correlations were weak and statistically insignificant for LTC homes.

1. Hospital Sector: Correlation between Number of Beds and Full-time Shares of Employment							
Values: R P N		All RNs	Frontline RNs	All RPNs	Frontline RPNs	All NPs	Frontline NPs
Full-time Share	R	<i>0.22669</i>	<i>0.29487</i>	0.18471	<i>0.20294</i>	<i>-0.30483</i>	-0.26069
	P	<i>0.0213</i>	<i>0.0028</i>	0.0658	<i>0.0439</i>	<i>0.0189</i>	0.0546
	N	<i>103</i>	<i>101</i>	100	<i>99</i>	<i>59</i>	55
Part-time Share	R	-0.18804	<i>-0.24602</i>	-0.13954	-0.14631	<i>0.45171</i>	<i>0.42548</i>
	P	0.0572	<i>0.0131</i>	0.1662	0.1484	<i>0.0003</i>	<i>0.0012</i>
	N	103	<i>101</i>	100	99	<i>59</i>	<i>55</i>
Casual Share	R	-0.09204	-0.10021	-0.04009	-0.04854	0.00344	-0.02646
	P	0.3552	0.3187	0.6921	0.6333	0.9794	0.8479
	N	103	101	100	99	59	55
Full-time Share of FTEs	R	0.20193	<i>0.22232</i>	0.09549	0.10705	<i>-0.30362</i>	<i>-0.29243</i>
	P	0.0577	<i>0.0385</i>	0.379	0.3324	<i>0.0271</i>	<i>0.0437</i>
	N	89	<i>87</i>	87	84	<i>53</i>	<i>48</i>

2. Long-Term Care Sector: Correlation between Number of Beds and Full-time Shares of Employment							
Values: R P N		All RNs	Frontline RNs	All RPNs	Frontline RPNs	All NPs	Frontline NPs
Full-time Share	R	0.00419	0.01227	-0.05072	0.0219	0.23393	0.23642
	P	0.9577	0.8819	0.5904	0.7903	0.2947	0.3022
	N	163	149	115	150	22	21
Part-time Share	R	0.04982	0.03353	0.00955	0.0474	-0.23393	-0.21263
	P	0.5277	0.6847	0.9037	0.5647	0.2947	0.3548
	N	163	149	163	150	22	21
Casual Share	R	-0.0569	-0.04816	0.05657	-0.07284	-0.0645	-0.07172
	P	0.4704	0.5597	0.4732	0.3757	0.7755	0.7574
	N	163	149	163	150	22	21
Full-time Share of FTEs	R	0.05072	-0.03895	-0.0539	-0.02266	0.22802	0.23068
	P	0.5904	0.6848	0.5724	0.8142	0.3957	0.373
	N	163	111	112	110	16	17

Nursing FTEs vs. Full-Time Shares of Employment: As with numbers of beds, there is some correlation between the number of nursing FTEs and full-time shares for hospitals, but not for LTC homes.

3. Hospital Sector: Correlation between Nursing FTEs and Full-time Shares of Employment							
Values: R P N		All RNs	Frontline RNs	All RPNs	Frontline RPNs	All NPs	Frontline NPs
Full-time Share	R	<i>0.35472</i>	<i>0.38902</i>	<i>0.32657</i>	<i>0.34594</i>	<i>-0.33939</i>	<i>-0.35727</i>
	P	<i>0.0004</i>	<i>0.0002</i>	<i>0.0016</i>	<i>0.001</i>	<i>0.0105</i>	<i>0.0101</i>
	N	<i>95</i>	<i>90</i>	<i>91</i>	<i>88</i>	<i>56</i>	<i>51</i>
Part-time Share	R	<i>-0.21465</i>	<i>-0.22479</i>	-0.1752	-0.22161	<i>0.29178</i>	<i>0.2957</i>
	P	<i>0.0367</i>	<i>0.0332</i>	0.0967	0.038	<i>0.0291</i>	<i>0.0351</i>
	N	<i>95</i>	<i>90</i>	91	88	<i>56</i>	<i>51</i>
Casual Share	R	<i>-0.21071</i>	<i>-0.23451</i>	-0.13586	-0.10391	0.2024	0.21503
	P	<i>0.0404</i>	<i>0.0261</i>	0.1991	0.3353	0.1346	0.1297
	N	<i>95</i>	<i>90</i>	91	88	56	51
Full-time Share of FTEs	R	<i>0.25551</i>	<i>0.23153</i>	0.05095	0.09283	<i>-0.51974</i>	<i>-0.63495</i>
	P	<i>0.0151</i>	<i>0.03</i>	0.6373	0.3981	<i><.0001</i>	<i><.0001</i>
	N	<i>90</i>	<i>88</i>	88	85	<i>54</i>	<i>49</i>

4. Long-Term Care Home: Correlation between Nursing FTEs and Full-time Shares of Employment							
Values: R P N		All RNs	Frontline RNs	All RPNs	Frontline RPNs	All NPs	Frontline NPs
Full-time Share	R	0.03301	0.05791	0.03035	0.0445	<i>0.79512</i>	0.0019
	P	0.706	0.5112	0.7277	0.6097	<i><.0001</i>	0.9939
	N	133	131	134	134	<i>19</i>	19
Part-time Share	R	0.01607	0.03916	0.03847	0.05088	<i>-0.59471</i>	0.08135
	P	0.8543	0.657	0.659	0.5594	<i>0.0072</i>	0.7406
	N	133	131	134	134	<i>19</i>	19
Casual Share	R	-0.05141	-0.09331	-0.06735	-0.09439	<i>-0.48506</i>	-0.15007
	P	0.5567	0.2891	0.4394	0.278	<i>0.0353</i>	0.5397
	N	133	131	134	134	<i>19</i>	19
Full-time Share of FTEs	R	-0.00711	-0.01396	-0.0254	-0.02622	<i>0.74532</i>	0.03948
	P	0.9404	0.8833	0.7913	0.7837	<i>0.0004</i>	0.8764
	N	113	113	111	112	<i>18</i>	18

5. Hospitals vs. LTC Homes: Correlation between Nursing Hours/Client Day and Full-time Shares of Employment

Values: R P N		Hospital RNs	LTC RNs	Hospital RPNs	LTC RPNs	Hospital NPs	LTC NPs
Full-time Share	R	<i>0.24856</i>	0.04448	0.13199	0.02002	-0.10671	<i>0.46882</i>
	P	<i>0.0157</i>	0.6153	0.2149	0.8204	0.4381	<i>0.0497</i>
	N	<i>94</i>	130	90	131	55	<i>18</i>
Part-time Share	R	-0.13899	-0.08698	-0.13011	-0.10502	0.06532	-0.25814
	P	0.1816	0.3251	0.2216	0.2326	0.6356	0.301
	N	94	130	90	131	55	18
Casual Share	R	-0.15969	0.03866	0.01345	0.0961	0.08954	-0.44259
	P	0.1242	0.6623	0.8999	0.2749	0.5156	0.0659
	N	94	130	90	131	55	18
Full-time Share of FTEs	R	0.12283	0.00849	-0.16141	-0.03101	-0.1863	0.3687
	P	0.2515	0.9295	0.1353	0.7489	0.1817	0.1453
	N	89	111	87	109	53	17

Appendix C

Prior Surveys

A number of previous surveys on Ontario nurses and nurse employers provide relevant statistics and findings that align with the results of this 2012 survey.

In 2003, RNAO²⁰⁹ surveyed part-time and casual RNs, and found that a majority of respondents had their preferred employment status, including 83 per cent of part-time respondents and 57 per cent of casually employed respondents. However, a significant minority of part-time and casual staff preferred full-time employment, which included 14 per cent of part-time staff and 17 per cent of casuals. In fact, RNAO found that about 11 per cent of non-full-time RNs would shift to full-time if the option were available. The preference for full-time varied by certain characteristics. Those who preferred full-time employment were younger (average age 43 vs. 46.3), had graduated more recently (18.7 vs. 23.4 years), had nursed fewer years (17.5 vs. 21.3), worked more weekly hours (27.6 vs. 22.8), and had more employers on average (1.38 vs. 1.25). There were some reasons for initially going part-time or casual that could be addressed: absence of full-time work (25.3 per cent); workload (18.2 per cent); scheduling (19.6 per cent); and stress (14 per cent) (the latter two were coded from qualitative answers and the percentages are for those who provided qualitative answers). A large percentage (42.7 per cent) indicated they would consider full-time employment under the right circumstances. In order, factors that could induce respondents to go full-time were: flexible scheduling (28 per cent), availability of any full-time work (25 per cent), reasonable workload (23 per cent), opportunities for professional development (19 per cent), availability of full-time work in geographical area of choice (14 per cent), availability of full-time work in clinical area of choice (11 per cent), childcare in the workplace (6 per cent) and assistance with eldercare (2 per cent).

In 2001, RNAO²¹⁰ found that availability of employment was a key factor in the mass departure of RNs from Ontario (as identified by 63 per cent of surveyed respondents). Included in this for many respondents was the absence of full-time employment in Ontario. Sixty-six per cent of respondents indicated that availability of full-time employment would encourage them to return to Ontario and 66 per cent further indicated that assistance with relocation would encourage their return.

In 2005, RNAO²¹¹ offered a preliminary assessment of progress towards 70 per cent full-time employment by sector based on a survey of employers and RNs. Full-time employment gains in the hospital sector exceeded expectations early-on in the 70 per cent initiative. Gains in the long-term sector fell short of government promises. Although much of the money had yet to flow evidence of any impact was unavailable. In the home care sector, FTEs rose although full-time positions lagged. RNAO noted that the comparative success of the program in hospitals was associated with strong conditionality of funding for hospitals (full-time positions were to be

created), along with clear expectations to increase the full-time share of nursing employment. Organizational commitment to full-time (for example as evidenced by the existence of a plan to raise full-time employment) was a success factor for employers in all sectors.

RNAO concluded in 2005 that if Ontario RNs had their preferred work status, 64.5 per cent would be full-time as opposed to the then 59.3 per cent. They also concluded that many other part-time and casual RNs would conditionally go full-time, assuming that workplace challenges that drove them away from full-time were fixed. If all those RNs were to go full-time, that would bring the province to 78.4 per cent full-time. The report notes that this would be an absolute ceiling, but it adds that hitting 70 per cent full-time would be feasible. The survey found that modified full-time positions (e.g., working 80 per cent full-time while maintaining full-time status) were very popular with part-time (68 per cent) and casual (45 per cent) RNs.

In 2005, RNAO tested the popularity and feasibility of a series of strategies to increase full-time RN employment. In descending order, these were work/life balance, flexible scheduling, supportive environments, salary/benefits, respect of RN's knowledge, reduced workload, lieu time/banked hours, professional development, educational opportunities, and job security. All were rated on average as important to very important. The only strategy that had neutral support was "challenging work". By contrast, employers' ranking of feasibility generally went from the least expensive strategy to the most expensive, as follows: respect for RN's knowledge, supportive environments, professional development, educational opportunities, flexible scheduling, challenging work, work/life balance, lieu time/banked hours, job security, reduced workload and salary/benefits. None of the average rankings exceeded "somewhat feasible".

RNAO's recommendations to government at that time included:

- Continued funding targeted to full-time employment
- Extension of conditionality of full-time funding to all sectors, with clear expectations of progress on full-time
- Maintenance and expansion of requirement for full-time implementation plans
- Provision to employers of tools to raise full-time shares of employment (e.g., information resources and best practices)
- Creation of sufficient numbers of full-time positions that those RNs who want it can obtain full-time employment. Particular attention should be paid to the needs of new grads who overwhelmingly want full-time employment
- Acceleration of the delivery of promised new (full-time) positions
- Work with employers and nursing organizations to implement policies in the workplace that support work/life balance.

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- ¹⁹⁴ [Notes: N1]
- ¹⁹⁵ Comparisons are made to 2010 figures from the College of Nurses of Ontario. 2010 figures are used because after 2010, CNO ceased to report headcounts at the sectoral level. We know that the share of full-time employment for RNs has grown since 2010, so the ratios calculated will tend to overstate the survey's coverage of full-time Ontario nurses. We also know that NP employment has grown rapidly, meaning that calculated ratios will overstate the survey's share of NP employment.
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²⁰⁵ An adjustment was made to RN employment counts in both sectors by discounting them for their share of the overcounts implicit in CNO's multiple employer table. The degree of capture of total double-counting by the survey is proportional to the share of total nursing employment. It was assumed that the shares of population employment of the survey were equal to the shares of total beds in each sector.

²⁰⁶ If 70% of the workforce has full-time and the remaining 30% of the workforce has part-time or casual employment, and if that 30% of the workforce works 61.6% of an FTE as per RNAO (2003), then the number of FTEs would be 0.885 times the size of the workforce ($0.7 + (0.3 \times 0.616)$). The full-time share of FTEs would then be $0.7/0.885 = 0.791$, or about 80%. If non-full-time nurses work on average 61.6% of an FTE, then the target of 70% full-time by head count is roughly equivalent to 80% full-time by FTEs.

²⁰⁷ "This indicator measures the percentage of Management & Operational Support (MOS) and Unit Producing Personnel (UPP) and Nurse Practitioner (NP) earned hours provided by full-time nurses. Nurses include RN, RPN, Nurse Manager, Clinical Nurse Specialist and Nurse Educator and Nurse Practitioner. Full-time nurses defined as those employment statuses are full-time, part time temporary full-time or job sharing, and casual temporary full time." Ontario Local Health Integration Networks. (2013). *2013/14 Hospital Service Accountability Agreement (H-SAA): Indicator Technical Specifications*. P. 72. Retrieved February 21, 2014 at <http://www.oha.com/Education/Broadcasts/Documents/HAPS%20-%20Indicator%20Technical%20Specifications.pdf>.

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