



**Pan-Canadian Quality Worklife – Quality Healthcare
Collaborative (QWQHC) Stakeholder Summit**

**December 12, 2006
Chateau Laurier Ottawa**

Summary Report

Prepared by: D. Parker-Taillon and Associates

**Pan-Canadian Quality Worklife – Quality Healthcare Collaborative
(QWQHC)
Stakeholder Summit
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Meeting Summary

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1.0 Introduction

1.1 Background:

The health and well-being of the health workforce and the quality of the healthcare work environment has a profound impact on the effectiveness and efficiency of healthcare services. In recent years, there have been numerous reports listing hundreds of recommendations for improvement; however we are not seeing enough concentrated action and outcomes.ⁱ

In June 2005, 11 national healthcare organizations partnered to form the Quality Worklife – Quality Healthcare Collaborative (QWQHC) based on a consensus that Canadian health system employers must urgently do more to retain its health human resources in healthy and supportive work environments. The specific purpose of the Collaborative is the development of a national framework and action strategy on quality of worklife to improve health system delivery and patient/client outcomes. The work of the Collaborative commenced in October 2005, and the mandate is until March 2007.ⁱ

In the fall of 2006 the QWQHC developed a draft Action Strategy for consultation. This pan-Canadian Action Strategy includes a standard set of quality of worklife indicators, priority action strategies, and a knowledge exchange framework to promote the sharing of research and leading practices in the area. The Stakeholder Summit was organized for December 12, 2006, to obtain input and feedback from a select group of key stakeholders on the specific components of the Action Strategy, as well as the overall plan for sustaining action on this issue.

1.2 Summit Goals

The specific *goals* of the Stakeholder Summit were to:

- To engage stakeholders in the pan-Canadian QWQHC Action Strategy aimed at improving the quality of worklife in Canadian healthcare workplaces in order to improve the safety and quality of patient care and facilitate the sustainability of the health system;
- To obtain feedback on the Strategy; and
- To build commitment and develop champions to sustain future action on the Strategy.

A copy of the Agenda is included in Appendix A. The list of the meeting participants is provided in Appendix B. The following report summarizes the discussions and outcomes of the Summit.

1.3 Opening Remarks

Wayne Strelloff, Chair, and Melanie Lavoie-Tremblay, Deputy Chair, QWCHC National Steering Committee, extended a warm welcome to the participants and thanked them for attending the Summit. They highlighted the importance of this topic and emphasized that the way to better healthcare is to create healthier healthcare workplaces.

Wendy Nicklin, Chair, QWQHC Partners Group, and President and CEO of the Canadian Council on Health Services Accreditation, addressed the members and provided background information on the Collaborative. She stressed the need for advocacy and support to sustain this initiative.

ⁱQWQHC Healthcare Action Strategy: Draft for Consultation Stakeholder Summit, December 2006.

Sandra MacDonald-Rencz, Executive Director, Office of Nursing Policy, Health Canada, addressed the members on behalf of the Minister of Health. She reported that Health Canada was pleased to support this important initiative. She noted that the national survey of health and the worklife of nurses had just been released following a four-year initiative. The survey addressed many issues including the nursing environment, stress, the burden of illness, and personal health habits and underscored the need to look at employment environments of health care workers. She noted that the discussions at this Summit would also provide additional information to inform the “Framework for Collaborative Pan-Canadian Health Human Resources Planning” that was recently developed by the Advisory Committee on Health Delivery and Human Resources (ACHDHR).

Dianne Parker-Taillon, the Facilitator for the meeting, welcomed everyone to the Summit and reviewed the meeting objectives, rules of engagement, role of participants/facilitators, and provided an overview of the agenda. Participants then introduced themselves indicating their name and the organization that they represented.

2.0 Setting the Stage

Wayne Strelieff, Chair QWQHC National Steering Committee, provided the participants with background information about the Collaborative. He indicated that the partners of the Collaborative consist of the following organizations:

- Canadian Council on Health Services Accreditation (CCHSA) (Coordinating Secretariat)
- Health Canada - Office of Nursing Policy (main funding partner)
- Canadian College of Health Service Executives (CCHSE)
- Canadian Nurses Association (CNA)
- Canadian Healthcare Association (CHA)
- Canadian Federation of Nurses Unions (CFNU)
- Canadian Medical Association (CMA)
- Canadian Health Services Research Foundation (CHSRF)
- Association of Canadian Academic Healthcare Organizations (ACAHO)
- Academy of Canadian Executive Nurses (ACEN)
- National Quality Institute (NQI)

These partners had brought members of the Collaborative together to develop an evidence-based Pan-Canadian framework and action strategy on Quality of Worklife to improve health system delivery and patient/client outcomes. Mr. Strelieff explained that the Collaborative’s work is guided by a National Steering Committee and four Working Groups (i.e., Awareness and Engagement; Knowledge Exchange; Indicators; and Measurement; and Priority Strategies) involving over 45 quality of worklife experts from across the country.

An underlying belief of the Collaborative is that “A fundamental way to better healthcare is through healthier healthcare workplaces; and it is unacceptable to work in, receive care in, govern, manage and fund unhealthy healthcare workplaces.” A healthy healthcare workplace is defined as “A work setting that takes a strategic and comprehensive approach to providing the physical, cultural, psychosocial and work/job design conditions that maximizes the health and well being of providers, improves the quality of care and optimizes organizational performance”.

Mr. Streliaff also provided an overview of the draft QHQC Action Strategy. He indicated that the Strategy includes the following: tools to engage leaders in taking action; a standard set of quality worklife (QWL) indicators (with common definitions); focused priority action strategies; and a leading practice knowledge exchange framework.

3.0 Healthy Workplace Experiences

To provide a context for later discussions, participants worked in self-selected table groups to discuss their own experiences with healthy workplace activities including challenges, successful/unsuccessful practices, and “lessons learned”. The following questions were presented to each group to discuss:

1. What are key *challenges* that need to be addressed when implementing healthy workplace activities?
2. What are key “*lessons learned*” to consider when implementing healthy workplace initiatives? (Hint consider both successful and less than successful practices).

A Table Host was assigned to each group to record discussions and to work with the group to identify the top two challenges and top two “lessons learned”.

The Facilitator collated the “top two” lists of challenges and lessons learned from all of the groups and several common themes were identified. A summary of the themes for challenges and lessons learned are listed in alphabetical order and presented in Table 1. The combined list of “top two” challenges and lessons learned identified by the groups is included in Appendix C.

Table 1: Healthy Workplace Experiences: Summary of Themes of Challenges and Lessons Learned Identified by Groups

<i>Challenges</i>	<i>Lessons Learned</i>
<ul style="list-style-type: none"> • Changing workforce in terms of team members, boundaries, scope • Lack of engagement/commitment from all stakeholders • Lack of public awareness for QWL issues • Need for system accountability for health work standards • Need for resources/business case • Need to change organizational culture • Shift in health care focus 	<ul style="list-style-type: none"> • Develop communication strategy • Emphasize link to patient safety • Establish clear accountability • Ensure committed/long term funding • Use change management approach • Use evidence-informed approach • Use inclusive, organization-wide approach • Use role models/champions to promote change

4.0 Providing Feedback on the QWQHC Strategy

Participants were asked to provide feedback on the three areas of the Strategy (proposed action activities, proposed indicators, and knowledge exchange framework). The process involved three tables being labeled with each of the areas of the Strategy and a Table Host assigned to each table. After 45 minutes, participants were invited to switch groups to discuss another area of the strategy. With the new group the Table Hosts briefly summarized the discussions of the previous group and invited the new group to add to this. Participants were asked to consider the following questions:

1. What aspects did you particularly *like* about this area of the QWQHC Strategy?

2. What suggestions do you have for *improvement* to this area of the QWQHC Strategy?

The Table Hosts recorded the discussions and worked with the groups to identify the top three positive aspects and top three suggestions for improvement of the Strategy. The Table Hosts for each of the three areas of the Strategy met over lunch to collate and summarize the feedback and the results are presented in Tables 2, 3 and 4. The feedback is presented in alphabetical order. The full lists of all positive aspects and suggestions for improvement identified by the groups for each of the three areas of the Strategy are included in Appendix D.

Table 2: Feedback on Proposed Standards Indicators (as summarized by Table Hosts)

Positive Aspects	Suggestions for Improvement
<ul style="list-style-type: none"> • Linking data will provide first step in determining causality • Linking together in a framework conceptually helps with engagement • Looks at organizational and system levels • Many indicators are already routinely collected (accuracy of measurement questioned) • Most do not require effort of individual providers • Moves emphasis to collecting data for management decision making (not just for information technology) • Moves towards evidence-based approach and embedding QWL in our thinking • Potential for comparability across country/organization/unit levels 	<ul style="list-style-type: none"> • Add patient safety indicator • Calculate cost of inaction • Collect at unit • Consider existing national agencies (e.g., Canadian Institute for Health Information (CIHI), Statistics Canada) and collect through Labour survey (for example) • Develop strategy for linking data to build business case for boards • Ensure consideration of leading and lagging indicators • Governments should require QWL indicators be built into agreements with organizations. • Identify return on investment (ROI) for investing in data extraction and processing • Link to overall outcomes including patient outcomes and cost (beyond satisfaction) • Need further development of indicator definitions specificity and sensitivity • Promote integration of QWL indicators in HHR plans for organizations • Question whether targeted funding at system level is appropriate

Table 3: Feedback on Proposed Priority Activities (as summarized by Table Hosts)

Positive Aspects	Suggestions for Improvement
<ul style="list-style-type: none"> • Evidence-based approach to action built on best practices • Substantive, comprehensive and flexible document • Systematic Framework, incorporates accountability (can link to accreditation) 	<ul style="list-style-type: none"> • Broaden language for application to all health professions and all health settings • Need strategy for higher “accountabilities” (government funders) • Need to be more “self serving” while attracting necessary political attention for success • Need to be seen as continuous process and sustainable • Restructure strategy document with “A strategic foundation for QWL activities” as overarching priority

Table 4: Feedback on Knowledge Exchange Framework (as summarized by Table Hosts)

Positive Aspects	Suggestions for Improvement
<ul style="list-style-type: none"> • Comprehensiveness; multi-level and practical focus of strategy and knowledge exchange (KE) will aid embedded outcomes – respect for tacit knowledge • Connectedness to whole system; multi-faceted • Global and local appeal – fit for all levels; a place for anyone to “grab hold” • Linkages (e.g., National Quality Institute (NQI), Patient Safety Institute (PSI)) • National Knowledge Exchange Network; “Knowledge Central” • Pan-Canadian perspective • Strategy conceptual framework good; KE needs to be added • Variety of KE examples • Versatile and flexible; to share “near success” stories, etc. 	<ul style="list-style-type: none"> • Action and evaluation of action • Clarify audience: public, media, government, other industry • Improve explanation on how to gather and share “stories” rather tacit knowledge • Include champions – mentors as resource • Include QWL and workplace training in Kindergarten to grade 12 and post-secondary education; use tacit knowledge as well • Need “moral imperative” to drive the initiative; opposed to taking ownership • Need a core or centerpiece document to pull it all together, e.g. “To err is human” or “quality chasm” • Need more focus on relationships; all levels and patients • Need stronger links to patient safety and NQI Framework • Need to be more explicit about KE inside organizations – top to bottom and up • Promote information/knowledge so it is able to be used in context (e.g., QWL as a policy filter for decision makers) • Strengthen existing work (e.g., with Canadian Health Services Research Foundation (CHSRF))

5.0 Building Momentum

In order to begin to move forward and build momentum for the QWQHC Action Strategy participants were asked to work in table groups to consider the following discussion question:

1. What best advice can you give about *how to bring the QWQHC Strategy to life and sustain the momentum?* Consider actions/mechanisms at:
 - The systems level
 - The organizational level.

A Table Host was assigned to each group to record discussions and to work with the group to identify the “top two” actions/mechanisms at the system and organizational level. The combined list of “top two” actions/mechanisms presented by the groups is included in Tables 5 and 6.

Table 5: Suggested Systems Actions/Mechanisms to Bring the QWQHC Action Strategy to Life and Build Momentumⁱⁱ

- Build on collaborative multi-program approach*
 - Validate with other professions and non professional workers to get on their agendas permanently and build into performance assessments
- Clarify purpose/focus**
 - Are we patient-centred or health worker-centred?
 - Articulate the cost of inaction
 - Focus
- Create and foster annual events to report and check in on QWL movement and developments*
 - Similar to “Teaming at the Queue, Safer Healthcare Now!” conference
 - Promote value of face to face meetings for relationship building
- Develop detailed targeted specific communications*****
 - Create a marketing campaign like 100,000 patients (patient safety)
 - Develop strategy, use success stories
 - Involve media; public marketing
 - Repackage document for different audiences
 - Tailor message to different groups (e.g., Auditor General Reports)
 - Take Action Strategy on the road (e.g., use “fact sheet” with 3 key messages)
 - Use networking (e.g., technology; forums) to promote
 - Use one voice advocacy (e.g., 11 partners; relentless communication)
- Engage the public/patients**
 - Promote understanding this as a patient satisfaction/patient safety issue
 - Use healthy workplace week to engage public
- Ensure required reporting and measurement are part of operations across Canada***
 - Develop QWQHC reports
 - Firm up indicators
 - Include QWL and strategic HR management in Accreditation process and in Auditor General reporting
- Get on the political agenda****
 - Engage government by linking to other key issues for government (i.e. wait times ... for every wait time strategy, what are they/we doing about quality worklife)
 - Present to the Deputy Ministers on the Advisory Committees on Health Policy and Health Human Resources
 - Tie economic issues to HHR and safety agendas
 - Use example of Auditor General to report on the status of healthcare workplaces
- Leadership**
 - Coordination* needs to be continued by partners/not ready to be handed off (partners need to promote/adopt and explore other partnerships e.g.: with CIHI, Health Canada)
 - Rely on champions
 - Seek long term funding to sustain planning, implementation, and evaluation
- Promote knowledge transfer and exchange*
 - Link to patient safety and quality
 - Connect with and share 99% of knowledge

ⁱⁱ Note: This list includes items suggested for the system, level as well as those from groups that combined both system and organizational level actions/mechanisms. Suggested items have been clustered and are presented alphabetically. An asterisk (*) indicates each time an item was mentioned by more than one group.

Table 6: Suggested *Organizational* Actions/Mechanisms to Bring the QWQHC Action Strategy to Life and Build Momentumⁱⁱⁱ

- Develop consistency in definitions of terminology for comparability
- Develop communication strategy
- Educate at Board level/regional level*
 - Know what data are, why needed, what linked to; monthly reports on workplace health
- Ensure evaluation and accountability of QWL initiatives
- Identify champions at all levels of organizations*
 - Connect them to support each other and organizational networking
 - Promote internal collaboration involving champions, partners and public
- Identify a burning platform at staff level
 - Create and train champions
 - Make concrete, observable changes
 - Provide ongoing feedback
 - Celebrate successes
- Integrate QWL into performance measurement at all levels through:
 - Accreditation*
 - Performance agreements/assessments*
 - Incentives that reward appropriate behaviours
- Focus efforts on outcomes to increase:
 - Understanding what outcome to patients and system is
 - Connection between patient safety and QWL
- Use advocacy approach for networking within organizations (specific knowledge and information needs met – Board, Executive, front line, etc.)

6.0 Committing to Action

6.1 Discussion of the Healthy Healthcare Leadership Charter

Melissa Barton, QWQCH Coordinating Secretariat, explained the Healthy Healthcare Leadership Charter. The purpose of this Charter is to visually and compellingly show healthcare providers that their leaders are committed to creating positive change in the health workplace. The Charter is to be signed by governments (i.e. Ministers and Deputy Ministers of Health), and organizational leaders (Board Chair, CEO, and other senior leaders) to indicate support for the principles of the importance of addressing QWL and also a commitment to act.

In response to a question regarding the sharing of the Quality Healthcare Action Strategy, participants were advised that the information could be widely disseminated. The document is not confidential and may be shared within healthcare organizations as a discussion paper. It was agreed that Ms. Barton would develop a Powerpoint presentation for distribution to participants to assist them in explaining the collaborative to their organizations.

ⁱⁱⁱ Suggested Items have been clustered and are presented alphabetically. An asterisk (*) indicates each time an item was mentioned by more than one group.

6.2 Commitment to Action

Ms. Barton encouraged participants to return to their organizations and discuss the Collaborative's Action Strategy at meetings with staff and other healthcare workers. She suggested that participants consider and note how they personally could help move the strategy forward in the short term (i.e., in the next month) and in the upcoming months.

7.0 Closing Keynote Speaker

After observing the discussions throughout the day, Dr. Marlene Smadu, Co-Chair, QWQHC Increasing Awareness and Engagement Working Group, provided some overall thoughts and themes that arose throughout the Summit.

She recalled the nursing shortage in the late 1990's and the studies of job satisfaction as well as recruitment/retention measures done at the time. Literature reviews showed little evidence to connect workplaces with quality outcomes. She noted the progress that has been made since to develop a highly committed and engaged workforce. We also now have a better understanding of the impact that quality workplaces have on recruitment and retention of healthcare workers.

Dr. Smadu noted the importance of having relevance and resonance with the public. She stated that Mr. Strelieff had introduced her to the concept of "political capital" which refers to when an individual or organization performs its responsibilities repeatedly in a correct, trustworthy fashion and if a mistake is made at some point, the public trust remains intact. She commented that the Canadian public highly defends healthcare workers and it is important to share information about healthy healthcare workplaces with them as we move forward.

Within the healthcare community, Dr. Smadu suggested we need to share anecdotes and experiences related to healthy workplaces to support and help form evidence. She described an example of a personal story that had been shared with her recently that underlined the importance of intangibles such as respect, value and dignity in creating healthy workplaces.

Dr. Smadu indicated she believes this Summit represents a critical moment in moving forward to develop healthier healthcare workplaces. Eleven key organizations have supported this initiative and the participants at this Summit have demonstrated their awareness and engagement in this strategy. She encouraged participants to disseminate the document for consultation throughout their organizations and to report back on areas for improvement. Awareness and engagement are key elements to moving forward with this initiative.

In closing, Dr. Smadu acknowledged the tremendous work and support of the Coordinating Secretariat, Melissa Barton. She also extended her appreciation to Wayne Strelieff and Melanie Lavoie-Tremblay, for their efforts and work in chairing this initiative. She acknowledged the support and commitment of all the participants at the meeting, many of who have already started work on QWL in their own areas.

8.0 Closing Remarks

8.1 Next Steps and Closing Remarks

Mr. Streiloff indicated that a Summary Report of this Summit would be prepared and sent to the participants. He also noted that the Steering Committee would be meeting the next day to discuss the outcomes of the Summit and next steps. He thanked the participants, Table Hosts, Health Canada, the Secretariat and the Facilitators for their time and valuable contributions to this process. Participants were reminded to complete the evaluation (see Appendix E for the results) and travel expense forms.

Appendix A: Meeting Agenda

Pan-Canadian Quality Worklife –Quality Healthcare Collaborative (QWQHC) Stakeholder Summit *December 12, 2006* *Chateau Laurier Ottawa* *Canadian Room*

The overall goals of the Summit are to:

- Engage stakeholders in the pan-Canadian QWQHC Action Strategy aimed at improving the quality of worklife in Canadian healthcare workplaces in order to improve the safety and quality of patient care and facilitate the sustainability of the health system;
- Obtain feedback on the Strategy; and
- Build commitment and develop champions to sustain future action on the Strategy.

Specific deliverables include identification by the participants of:

- Key challenges to implementing healthy workplace strategies;
- Key “lessons learned” based on successful/unsuccessful practices to improve quality worklife-quality healthcare;
- Feedback on the proposed Action Strategy;
- Priorities for action;
- Mechanisms to sustain future action; and
- Organizational and personal actions to support moving forward.

PRELIMINARY AGENDA

8:00 a.m. **Continental Breakfast**

8:30 a.m. Welcome

- Wayne Strelloff, Chair QWQHC National Steering Committee;
- Melanie Lavoie-Tremblay, Deputy Chair QWHQC National Steering Committee

Opening remarks

- Wendy Nicklin, Chair QWQHC Partners Group, President & CEO CCHSA;
- Sandra MacDonald-Rencz, Executive Director Office of Nursing Policy, Health Canada

Overview of meeting process

- Dianne Parker-Taillon, Facilitator

Introductions

9:00 a.m. **Presentation: Setting the Stage**

- Background on Collaborative and Overview of the QHQC Strategy (Wayne Strelloff)

- 9.30 a.m. **Table Discussion: Healthy Workplace Experiences**
- Participants will discuss their own experiences with healthy workplace activities including:
 - Challenges
 - Successful/unsuccessful practices
 - “Lessons learned”
- 10:30 a.m. **Health Break**
- 10:45 a.m. **Table Discussion: Providing Feedback on the QWQHC Strategy**
- Participants will provide feedback on the three areas of the Strategy (indicators, priority activities and knowledge exchange framework) considering:
 - Are key challenges addressed?
 - Are “lessons learned” supported?
 - Are there areas not addressed?
- 12:00 p.m. Networking Lunch**
- 1:00 p.m. **Plenary Discussion: Providing Feedback on the QWQHC Strategy**
- Summary of key challenges and “lessons learned” identified
 - Summary of the feedback on the Strategy
- 1:30 p.m. **Table Discussion: Building Momentum**
- Participants will discuss:
 - Priority actions for implementation of the Strategy
 - Potential mechanisms to sustain action
- 2:30 p.m. **Health Break**
- 2:45 p.m. **Plenary Discussion: Committing to Action**
- Reports of highlights of table discussions
 - Discussion of the Healthy Healthcare Leadership Charter (Melissa Barton, QWQHC Coordinating Secretariat)
 - Personal Commitment to act - QWQH Champions (Melissa Barton)
- 3:40 p.m. **Presentation: Closing Keynote Speaker**
- Marlene Smadu, (QWQHC Steering Committee & Co-Chair Awareness and Engagement Working Group, CNA President, Associate Dean of Nursing at University of Saskatchewan)
- 4:00 p.m. **Closing Remarks**
- Next steps, Evaluation, Closing Remarks (Wayne Strelieff)
- 4.15 p.m. **Adjournment**

Appendix B: Meeting Participants

Jurisdiction	Name, Title and Organization
Aboriginal	Sherri Lickers-Earle Health Services, Six Nations Council
Aboriginal	Cheryl Bomberry Six Nations Council
Aboriginal	Jocelyne Lavergne-Robenhymmer Assistant Executive Director, First Nations Inuit Health Branch, Health Canada
Aboriginal	Judy Lifshitz Senior Policy Analyst, Aboriginal Health Human Resources, First Nations Inuit Health Branch
Aboriginal	Steven Phaneuf Senior Program Officer, Primary Health Care, FNIHB, Health Canada
Alberta	Norma Woods, Employee Wellness, People and Learning, Calgary Health Region
British Columbia	Graham Lowe President, The Graham Lowe Group
British Columbia	Elizabeth Smailes Director of Healthy Workplace Initiatives, OHSAH
British Columbia	Claire Winfield Program Lead, Employee Wellness Program, Vancouver Island Health Authority
British Columbia	Tony Collins VP Human Resources, Health Employers Association of BC (HEABC)
British Columbia	Andrew Smith Board Member, Vancouver Coastal Health and HEABC
British Columbia	Roger Sharman Board Director, Interior Health Authority and HEABC
British Columbia	Jo-Ann Youmans Director, Office of the Auditor General of British Columbia
Manitoba	Carrie Solmundson COO, Seven Oaks General Hospital, Winnipeg Regional Health Authority
Manitoba	Sheila Dresen President, Manitoba Registered Nurses Association
Manitoba	Larry Hogue Board member, Brandon Health Authority
Newfoundland	David J. Tucker Vice President Human Resources & Organizational Development, Labrador Grenfell Health
Newfoundland	Regina Coady Director Human Resource Program and Policy Development, Eastern Health Authority
Newfoundland	Susan Gilliam Chief Executive Officer, Western Health
Nova Scotia	Linda Hamilton Executive Director, College of RNs of Nova Scotia
Nova Scotia	Cathy Walls Chief of Nursing, IWK Health Centre

Jurisdiction	Name, Title and Organization
Nova Scotia	Kathleen Graham VP Clinical Care, Capital Health
Nova Scotia	MaryEllen Gurnham Director Professional Practice, Capital Health
Nova Scotia	Dawn Burstall Healthy Workplace Program Leader, Capital Health
Ontario	John Amodeo Director Labour Market Strategy, Ontario Ministry of Health & Long Term Care
Ontario	Sherri Hukstep Acting Chief Nursing Officer, Ontario Ministry of Health & LTC
Ontario	Dorothy Pringle Professor Emeritus & Dean Emeritus Faculty of Nursing, UofT Executive Lead, Health Outcomes for Better Information & Care, Ontario MOHLTC
Ontario	Peggy White Project Manager, Health Outcomes for Better Information & Care, Ontario MOHLTC
Ontario	Caroline Brereton VP People, Trillium Health Centre
Ontario	Diane Hupe Senior Vice-President Patient Care, SCO Health Service, Ottawa
Ontario	Sarah Hutchison Associate Director Physician Health Program, Ontario Medical Association
Ontario	John Yardley Director, Brock University Workplace Health Research Laboratory
Ontario	Arlene Wortsman Research Associate, CPRN – Health Network
Ontario	Maureen Taylor-Greenly VP Patient Care & CNO, Queensway Carleton Hospital
Ontario	Irmajean Bajnok Best Practices Guidelines Project Lead, Registered Nurses Association of Ontario
Quebec	Serge Gagnon Assistant Professor Groupe de R & D en organisation du travail du CUSM, McGill University
Quebec	Patty O'Connor Associate Director of Nursing for Neurosciences, McGill University Health Centre
Quebec	Roxanne Coulombe Cordonnateur du secteur de planification et d'adaptation de la main-d'œuvre, Agence de Santé et Services sociaux de Montréal
Saskatchewan	Lynn Digney-Davis Chief Nursing Officer, Saskatchewan Ministry of Health
Saskatchewan	Joleen Klassen Project Manager, Saskatchewan Ministry of Health
Saskatchewan	Darren Cherwaty Director, Employee Health and Safety Services, Qu'Appelle Health Region Pasqua Hospital

Jurisdiction	Name, Title and Organization
Saskatchewan	Lisa Clatney Researcher, Saskatchewan Health Quality Council
Saskatchewan	Renée C. Torgerson Researcher, CPRN - Health Network
Saskatchewan	Alex Taylor Board member Regina Qu-Appelle Health Region, Board Chair Saskatchewan Association of Health Organizations
Saskatchewan	Rosemarie Volk Principal, Office of the Provincial Auditor of Saskatchewan
Federal	Kate Semanyk Senior Policy Analyst, Human Resource Strategies Division, Health Canada
National	Michael Hillmer Project Manager Research & Analysis, Health Council of Canada
National	Eugene Wen Manager Indicators, Canadian Institute for Health Information (CIHI)
National	Michael Kerr Scientist, Workplace Studies, Institute for Work and Health (IWH)
National	Pierrette Leonard Senior Advisor National Partners, Canadian Patient Safety Institute (CPSI)
National QWQHC Partner	Wendy Nicklin President and CEO, Canadian Council on Health Services Accreditation (CCHSA)
National QWQHC Partner	Mary Ellen Jeans Secretary General, Academy of Canadian Executive Nurses (ACEN)
National QWQHC Partner	Annette Hewitt Executive Director Policy and Research, Canadian Colleges of Health Services Executives
National QWQHC Partner	Linda Silas President, Canadian Federation of Nurses Unions (CFNU)
National QWQHC Partner	Kate Rex Researcher, CFNU
National QWQHC Partner	Jane Ellis Chief Operating Officer, Canadian Nurses Association (CNA)
National QWQHC Partner	Norma Freeman Nurse Consultant, Nursing Policy, CNA
National QWQHC Partner	Todd Watkins Director Physician Health Program, Canadian Medical Association (CMA)
National QWQHC Partner	Sandra MacDonald Rencz Executive Director – Office of Nursing Policy (ONP), Health Canada
National QWQHC Partner	Robin Buckland Senior Policy Advisor ONP, Health Canada
National QWQHC Partner	Isabelle St. Pierre Researcher – ONP, Health Canada
National QWQHC Partner	Susan Law Vice President, Canadian Health Services Research Foundation (CHSRF)
National QWQHC Partner	Brenda Clarke Manager Human Resources, CHSRF
National QWQHC Partner	Don Wilson NQi (National Quality Institute)

Jurisdiction	Name, Title and Organization
QWQHC Chair	Wayne Strelloff Former Auditor-General of British Columbia and Provincial Auditor of Saskatchewan
QWQHC Deputy Chair	Melanie Lavoie-Tremblay Assistant Professor, School of Nursing, McGill University
QWQHC Steering Committee & Chair of Engagement WG	Marlene Smadu Associate Dean of Nursing, University of Saskatchewan President CNA
QWQHC Steering Committee & Chair of Indicators WG	Jeanne Besner Director Health Systems & Workforce Research Unit, Calgary Health Region Interim Chair, Health Council of Canada
QWQHC Chair Indicators WG	Linda McGillis Hall Associate Professor, Faculty of Nursing University of Toronto
QWQHC Indicators WG	Greta Cummings Assistant Professor, Faculty of Nursing, University of Alberta
QWQHC Indicators WG	Heather Laschinger Professor and Associate Director Nursing Research, University of Western Ontario
QWQHC Chair of Priority Strategies WG	Michael Cuddihy Vice President Human Resources, The Ottawa Hospital
QWQHC Steering Committee, Priority Strategies WG	Pamela Fralick CEO Canadian Physiotherapy Association
QWQHC Partner, Chair Knowledge Exchange WG	Janet Helmer Senior Program Officer, Management of the Healthcare Workplace, CHSRF
QWQHC Knowledge Exchange WG	Gaye Hanson President Hanson and Associates, Yukon
QWQHC Partner, Knowledge Exchange WG	Andrew Taylor Policy Analyst, CHA
QWQHC Partner, Indicators WG	Emily Gruenwoldt Senior Advisor Research & Policy Development, ACAHO
QWQHC	Melissa Barton QWQHC Coordinating Secretariat, CCHSA
Summit Facilitator	Dianne Parker-Taillon Consultant, D. Parker-Taillon and Associates
Summit Facilitator Assistant	Rita Sherman RS Meeting Consultant Services
Summit Assistant	Melissa Dougherty

Appendix C: Healthy Workplace Experiences: Summary of Top Challenges and Lessons Learned Identified^{iv}

Challenges	Lessons Learned
<p><i>Changing workforce</i></p> <ul style="list-style-type: none"> • Changing workforce in terms of team members, boundaries, scope 	<p><i>Develop communication strategy</i></p> <ul style="list-style-type: none"> • Clarity in communication and a committed long term investment in respect and the structures needed for QWL development • Communication Strategy
<p><i>Lack of engagement/commitment from all stakeholders</i></p> <ul style="list-style-type: none"> • Commitment • Engagement • Lack of commitment, clear articulation of QWL goals 	<p><i>Emphasize link to patient safety</i></p> <ul style="list-style-type: none"> • Quality healthcare is linked to quality worklife – patient safety approach
<p><i>Lack of public awareness for QWL issues</i></p> <ul style="list-style-type: none"> • Public awareness of worklife issues in healthcare and making expectations known to governments 	<p><i>Establish clear accountability</i></p> <ul style="list-style-type: none"> • Accountability
<p><i>Need to change organizational culture</i></p> <ul style="list-style-type: none"> • Culture change (without new resources) • It needs to be woven into the fabric of the organization/culture • Multi-level engagement (all) employer buy-in/culture (in budget, policy) 	<p><i>Ensure committed/long term funding</i></p> <ul style="list-style-type: none"> • Ensure QWL practices are embedded into financial plans (all stakeholders including union “on the team”)
<p><i>Need for resources/business case</i></p> <ul style="list-style-type: none"> • Case for QWL has not been made sufficiently to funders, Boards, CEOs • Need to demonstrate return on investment • Human and financial resources • Lack of business model • Long term investment needed in order to make an impact • Resource allocation (recognizing there may be no new dollars) • The breadth and scope of QWL, trying to do too much, not knowing where to start or how to pull stuff together 	<p><i>Use change management approach</i></p> <ul style="list-style-type: none"> • Change can happen with clear goals, expectations, commitment at all levels and appropriate time allocation • Culture change takes time • Educate for inter-professional team competencies • QWL is a change management initiative • Role of Ministry of Health as enabler of change • To be sustainable, need engagement, continuous facilitation, ongoing action plans, performance monitoring and feedback at all levels
<p><i>Need for system accountability for health work standards</i></p> <ul style="list-style-type: none"> • System accountability for ensuring health work standards are in place 	<p><i>Use an evidence-informed approach</i></p> <ul style="list-style-type: none"> • Use outcomes evidence

^{iv} This appendix includes the combined list of “top two” challenges and “top two” lessons learned identified by the groups. Items have been clustered by themes as identified during the meeting and are presented alphabetically.

Challenges	Lessons Learned
<p><i>Shift in health care focus</i></p> <ul style="list-style-type: none"> • Shift from crisis management to health promotion/illness and injury prevention, disability management focus • Shift from funding and human resources management focus to relationship focus 	<p><i>Use inclusive, organization-wide approach</i></p> <ul style="list-style-type: none"> • Make QWL the responsibility of Boards and governments • Need to place responsibility for QWL in appropriate structure in organization • Organization-wide • QWL will be more successful if we listen, respect, and trust staff
	<p><i>Use role models/champions to promote change</i></p> <ul style="list-style-type: none"> • CEO's provide positive role modeling with meaningful follow up • Use leadership and champions to move this issue forward • Use local champions of change; culture change very difficult to do

Appendix D: Detailed Feedback on the QWQHC Strategy^v

Table D-1: Feedback on Proposed Standards Indicators

<i>Positive Aspects</i>	<i>Suggestions for Improvement</i>
<ul style="list-style-type: none"> • Accuracy of measurement (may need work) • Appreciate attempts to define these indicators • Framework itself (starts at system itself and goes right down to what organization does) • Having a national database would shift the focus of data collection toward management information for decision making • Having a set of indicators routinely traced and measured would imbed quality workplace as a way of doing business • If applied as is nationally, could first use national data sources - increased potential for success • In general, list of indicators meets the criteria set out by the Steering Committee/Working Groups • Inclusion of rationale is a good strategy – needs to be more robust, include financial figures (too qualitative) • Indicators are relatively inoffensive • Like Pulse survey but need to add all the concepts back • Linking provides first step in organization being able to use data to determine causality (not just relationships) • Linking them together helps conceptually in the engagement • Links budget to indicators (such as absenteeism) provincial funding/organizational funding ... sends a message re: importance • Looks at both system and organizational level • Many already routinely collected • Most do not require effort on part of 	<ul style="list-style-type: none"> • Add another column – impact on client outcomes • Add another core belief – that all publicly funded health organizations should be tracking progress on the development of healthy workplaces • Ask that collecting indicators/reporting be part of the privilege of signing on to the Charter • Calculate cost of inaction on managing work environments (absenteeism, overtime, etc.) • Chair of QWQHC should speak to Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR) • Challenges with indicator definitions as related to QWL (specificity and sensitivity) e.g., what do you measure re: absences, disability • Could supplement work environment health with measures of employee health • Create a model (rather than a list of indicators) that links healthy workplace indicators with patient outcomes. Need to make explicit the relationship between client, staff and system outcomes (beyond patient satisfaction) (i.e., evidence-based patient outcomes) • Has hospital bias - Not about broad HHR strategy – more about hospitals • Identify the return on investment (ROI) for data extraction and processing • Identify what data is collected in rural/remote areas - First Nations Inuit Health Branch (FNIHB) employees (note Six Nations do collect at the local level – could provide data to national database if we had common definitions) • Indicators should be framed as guidelines to encourage innovation • May need to re-examine the breakout of “failure costs such as Worker’s Compensation or long term disability data. The fundamental definitions and practices are different enough to disrupt comparability across provinces/within provinces

^v This appendix includes all suggestions for improvement identified by the groups for each of the three areas of the Strategy. Items are presented alphabetically.

<i>Positive Aspects</i>	<i>Suggestions for Improvement</i>
<p>individual provider (except patient satisfaction)</p> <ul style="list-style-type: none"> • Moves towards evidence-based • National report card approach is good as competition doesn't hurt. Needs to be public, transparent, publicly reported and have political buy-in • Potential for comparability across country/organization and eventually unit level (benchmarking) • Pulse tool and the Nursing WL index are similar – agree that it is difficult to get a consensus on one tool – need to offer a toolbox. Positive features of the Pulse are that it is quick, does not require a large infrastructure and doesn't require external analysis of data • Supports the work toward developing common definitions • Supports the work toward getting an organization to provide a data repository/data synthesis • System indicators are fine 	<ul style="list-style-type: none"> • Missing direction of organization • Need examples, case studies, accountability frameworks • Need to build into accountability • Needs to be accompanied by resources • Organizational Indicators: need increased focus on positive indicators and a connection with patient outcomes • Patient outcomes need for specificity – patient safety also patient care • “Pulse” tool is good but there may need to be a tool box for wider applicability • Recommend: national agencies should collect the data (CIHI, Stats Can) then display it publicly. Therefore organization would be able to focus on front line; use labour force survey to collect data • Report at unit level – ownership of data and measurement creates engagement • Strategy for linking the data to build a business case for the Board should be added • Strengthen leadership demands • Suggestions for System Level Indicators: One table noted systemic indicators are fine, another table noted that this is too global and could use it as an excuse to spend some unrelated program that funding is spun into • Suggested Systems Level Indicators: <ul style="list-style-type: none"> ○ Governments demonstrate that QWL indicators are built into their performance agreements with funded organizations ○ QWL indicators are integrated into HHR plans at the provincial level. • Suggested Organizational Level Indicators: <ul style="list-style-type: none"> ○ Include indicators of safety (e.g., lifting, violence against staff) ○ Ensure data are collected and analyzed at the unit program level and aggregated to organizational level ○ Add maternity leave to definition of absenteeism ○ Overtime: Number of nurse agency hours ○ Add leadership elements – make broader – explicitly made or accountability at all levels (maybe embedded in the satisfaction measures) ○ Staff perception of percentage of time

Positive Aspects	Suggestions for Improvement
	<p>on learning is directly related to healthier workplaces – trying now to create direct/quantifiable connections.</p> <ul style="list-style-type: none"> ○ Create a model in which patient outcomes/healthy workplace are linked via HR indicators – i.e. length of stay, accident/incident – could create a model which link the two worlds – find an organization to collect the data ○ Vacancy rate – why six months? <ul style="list-style-type: none"> • Training and development – clinical vs non-clinical...challenge of getting data • Supplement the focus on the environment with measures of employee health • Surveillance tool has been developed by Health Canada but does not have access to the data unless local community agrees to share – past issues have been abuse of the use of the data, politicization of data, etc. • To make standards applicable and relevant across Canada is very challenging – will take more than a year also will take longer because it is an issue that affects compensation • Too complicated for politicians – need a handout for lay persons • Too many lagging indicators • Too vague (several definitions need to be more specific) i.e. turnover, labour stability rate, vacancy rates • Worthwhile to move toward including positive indicators as well

Table D-2: Feedback on Proposed Priority Activities

Positive Aspects	Suggestions for Improvement
<ul style="list-style-type: none"> • Broadness of document (cascading level of detail; reads like primary healthcare document; something for everyone) • Building leadership capacity at all levels • Builds on best practices which is already done so can get positive outcomes more quickly • Can inform accreditation standards • Comprehensive – menu of leading practices is great • Comprehensive and flexible document • Concrete, “implementable” 	<ul style="list-style-type: none"> • Add more robust rationale so can sell to funders (business case) – too qualitative • Caution re: prescriptive solutions – applicability to all employers and environments • Charter - connect more to the action priorities? • Charter - signing at all levels of leadership and make it renewable with “evidence” • Connect to action plan in an organization • Could be restructured so that there is a strategic foundation for QWL activities as an overarching priority • Does it enable energy to be channeled - especially at the frontline?

Positive Aspects	Suggestions for Improvement
<ul style="list-style-type: none"> • Flexible for organizations – depending on their stage of development • Focuses on individual’s health and wellness, structure and their workplace • Framework systemic and incorporates accountability • Good framework (Good start to a business case) • Holistic approach • Inclusion of rationale • Liked the four main themes • Linked to research • Links well to current processes and measures • Public reporting: competition doesn’t hurt national report card • Reinforce need to demonstrate evidence-based approach to actions • Starts at a high level, but goes on to include other necessary levels • Substantive and comprehensive • System culture is key to this strategy • Systems approach 	<ul style="list-style-type: none"> • Explore applicability to broad range of healthcare professions • First priority covers all other priorities • If any strategies require significant additional resources (time, money), remove from list • Increase informed consensus, more demanding – Increase stress for health employees • Must deal with fee for service of MDs, – never collaborative practice • Need connectedness/clarity • Need organization support – time, money, culture • Needs to be seen as continuous process and sustainable • Needs to recognize that change is a continuous process – focus on integration and culture • Not focused sufficiently on health workers – need to be more “self-serving” while still attracting the necessary political attention for success • Not fully systemic where does individual fit in? • Not linked well to client outcomes • Not representative – too physician/nurse oriented, plus institutional care only • Patient-outcome data should be added • Reconsider establishment of National Secretariat – too many already • Reliance on disease management system – Ministry of Health, aging, prevention, Council on Health • Retention plan within the organizations • Strategy to engage/challenge the political level beyond the four year cycle • Strategy to get started, including how to roll out to higher “accountabilities” (governments) • Targeted funding takes away from others’ discretion (e.g. regional health authoritys) • Too complicated for many audiences; how to embed into normal part of business • Use of word “priorities” - should be three or four things • What is connection of action items to Indicators? • Who owns these priority actions?

Table D-3: Feedback on Knowledge Exchange (KE) Framework

<i>Positive Aspects</i>	<i>Suggestions for Improvement</i>
<ul style="list-style-type: none"> • A good start to system level dialogue but need to bring to unit level as well • Begins to develop a national vocabulary – further work necessary • Broad and systemic – contributes to buy-in – whole strategy relates to KE • Build in inter-professional practice – good start – strengthen • Comprehensive and inclusive of multiple mechanisms/vehicles and different kinds and forms of knowledge (may also be a downside – too many areas of focus) • Conceptual framework for strategy good but KE not in it • Connection between HR and operations – needs stronger link to resource allocation and accountability for results • Coordinating body • Development of the Knowledge Exchange • Generally having a knowledge exchange piece in the larger framework enhances the overall comprehensiveness • Global and local value/return of investment • Having a central “go to” hub for information on QWL – one stop shop, value the idea of a central repository - really needed as people need to be able to contact each other • Inclusive (for all stakeholders e.g. governments, employees, practitioners, etc.) • Like comprehensiveness/variety/versatility/flexibility to be responsive to broad range of stakeholders and the value of explicit/implicit • Link QWL to quality patient care – needs to be even stronger, • Literature and other sources • Mechanism to keep Collaborative partners together and focused on goal – maintain energy 	<ul style="list-style-type: none"> • Analysis and interrelatedness of data to build a whole picture • Assess role the media plays – TV, journalism, editorial boards ...bad news focus • Avoid positioning QWL outside fiscal accountability/patient outcomes include financial analysis – ROI tools, best practices • Better definition of explicit and tacit knowledge – more explanation of the diagram, connecting and incorporating into the document • Build in education re: change management • Celebration of success – stories, benchmarking. Publicize good news stories! • Charge QWQHC Partners to distribute goals of the Collaborative and particular strategies • Clarify terms – KE definition “collaborative problem solving” – not always • Communication strategy needs to take into account stakeholders and the need for best management practices • Connect QWL to QHC for the public – integrated, decision-makers need to make the connection – easy to blame the individual. Need a sustainable push for all • Connection to patient safety agenda • Consistency of language – apples=apples – need a lexicon – national vocabulary. Avoid inconsistency, data elements need data definitions • Create cultural shift in how we analyze and measure organizational issues re: impact on QWL • Develop more tools to support KE • Does this approach duplicate existing processes for organizations who are accountable for workplace health and QWL? • Embed QWL in operations and accountability practices – it should be a privilege to belong to the charter • Emphasize transfer of knowledge to all workers – help health workers to understand the “why” • Engage the media – share knowledge with “internet savvy” public – communicate celebration of success • Engage the public as well – bring them into the discussion – clarify responsibility – rights and

Positive Aspects	Suggestions for Improvement
<ul style="list-style-type: none"> • Network as “Knowledge Central”, networking and linking with others with similar goals • Ongoing network for partners • Pan Canadian perspective • Recognition of tacit knowledge and real experiences, tacit knowledge is honoured and respected (watch standards and quality is not compromised in transmission). The idea of being able to exchange “near misses”; “near successes” learning from what didn’t go so well, exchange around <u>action</u> piece. It makes it real with case studies and examples for cultural change, Making it real, practicable – culture change, case studies • Sharing of learning tools – valid and reliable measures, quick access • That KE has many levels and strategies, ways and means to getting into the system’s fabric (woven) “embeddedness” • This movement can’t be seen as a “one-off” – it must be integral/seminal and needs to be nurtured as a cultural change • Variety of examples of outreach • Variety of levels (e.g., CEO to front line) and knowledge from academic “experience” sources • We do not need more money for knowledge development – need to share the knowledge we have – value for money – deeper return on the investments we have already made 	<p>responsibilities of the client and the public</p> <ul style="list-style-type: none"> • Ensure the integration/efficiencies • Evidence-based vs evidence-informed (more latitude)...clarify • Expand to include more audiences (e.g. educational institutions) • Explicitly include physicians, Interprofessional learning • Focus on action and sustainability – moving from talking about it to “not needing to talk about it” Move to action and evaluation of action – focus Knowledge issues around this • Foster the Collaborative’s “political” power – who are the politicians listening to? • Highly dangerous passing along knowledge – degradation – need standards and quality • Identify how to recruit and sustain champions – missing from strategy • Identify what are they three key messages to focus on? • Increase visibility at higher levels – getting info out there – senior leaders and also front line workers • Internet - provide resources and tools to providers to deal with “internet savvy” consumers • KE needs to expand to include more audiences and groups outside of health care; need to include KE with public governments, other industries • KE of HWI with finance and funders • Know what the urgency message is – people are our greatest asset – at what cost?? Make the message compelling • Know your audience – target products from board room to frontline • Link more strongly to National Quality Indicator (NQI) framework • Link to info-generation – Stats Can and CIHI • Link to quality professional practice agendas • Look outside healthcare context for content/ideas/best practices • Make KE and quality worklife a part of the full range of the educational experience; include academic institutions, training programs, colleges, etc. (make sure tacit knowledge is part of all formal education) • Make sure that you focus on ownership and

<i>Positive Aspects</i>	<i>Suggestions for Improvement</i>
	<p>make people feel empowered and a part of the knowledge process</p> <ul style="list-style-type: none"> • Make the argument – We know what to do, know the issues – good value for money – broader and deeper return on investment of knowledge gathered to date • Need a “centerpiece” document: “To err is human”/“quality chasm” • Need more than a business case, need to make this a MORAL IMPERATIVE • Need one pager describing activity related to QWL in Canada – recognize it, share it • Need portals of communication • Need to address/propose options for how information/resources can be pulled together and how it will be kept up to date • Need to create moral imperative/urgent message to drive this/keep on radar • Need to define what quality is at unit level – opportunity for them to take ownership of quality initiatives • Need to develop capacity for organizational/team champions/mentors/coaches to support spread of leading practices • Need to drive a cultural shift in how we analyze organizational issues • Need to have more explicit discussion on how to exchange tacit knowledge • Need to make the coordinating body sustainable • Need to more explicitly discuss how to disseminate knowledge from high level to front line providers/make things practical • Need to tease out components from “happiest workplaces” • Needs to be a national priority • Problem with definition – KE is “collaborative problem solving”? • Put forward options for how particular strategies might be actualized e.g. clearinghouse • Situate within the context of quality of care • Strategies to draw providers to quality workplaces – information to encourage buy-in • Stronger link between QWL and quality healthcare – know the issues – move to action and evaluation

<i>Positive Aspects</i>	<i>Suggestions for Improvement</i>
	<ul style="list-style-type: none">• The overall conceptual framework has KE missing• Think about how we can connect pieces of the system for broader issue/higher level issues. Explain connections and interfaces between sectors within healthcare (hospital, community, team care, etc.) and learn from sectors outside of healthcare – expand inter-professional focus – include physicians• We need to strengthen existing mechanisms and avoid duplication of efforts (make sure network enhances current structures and doesn't duplicate it)• What are the roles of Statistics Canada and CIHI ? Build a project – analysis and inter-relatedness of data into the total picture (who to do this?)

Appendix E: Participant Feedback on the Summit

A total of 35 out of 80 participants (43%) completed the feedback form. The following is a summary of the feedback received.

1. How successful were we at achieving the goals for the Summit? (where 1 = unsuccessful, 5 = successful)

- Average Score = 4.5/5
- 57% indicated the Summit was successful (a ranking of 5)
- 34% gave it a ranking of 4/5
- 9% gave it a ranking of 3/5

2. What participants appreciated most about the meeting was:

- The wonderful input/participation and energy of folks
- Connecting with other people
- Gaining the energy of momentum from this group
- Access to the comprehensive strategy
- Meeting all levels involved with healthcare, at both organizational and system level
- Opportunity to network and openly discuss QWQHC issues with leaders and champions in the field from across Canada
- The opportunity to represent NQI in this process. Also, I appreciated obtaining a better understanding of the QWL activities across Canada
- Excellent dialogue
- Great sharing, very important day – glad to be part of this essential discussion
- Small group work and reporting back (synthesis of info)
- Exchange of ideas
- Meeting and interacting with participants
- Many things – facilitated discussions, opportunity to discuss issues, instrumental things – well facilitated – rich day
- The opportunity to provide meaningful feedback. The day was very well structured and each session nicely built on the previous one.
- Workgroup sessions
- Group facilitators were great, networking, excellent meeting
- The diversity of stakeholders, discussion of concrete actions and moving forward
- Ability to participate in a meaningful way
- Great opportunity to see the integration of all this work. Terrific report
- Opportunity to participate in brain-storming re: strategies to implement change that improves the health of workplaces
- Focused discussions and networking, creating synergy for QWL practices
- The conversations about the issue – hearing other perspectives – learning more about what can happen
- Collaboration of and feedback from informed key stakeholders
- Active, ordered participation
- Learning a great deal more about the QWQHC and its objectives
- Opportunity to review the strategy and provide feedback
- Small groups of discussion
- The breadth and depth of “thinking” related to QWQHC in the room – rich discussion
- The discussion groups and diversity of opinion

- Richness of exchanges – perspectives
- The variety of people and level of variety of organizations represented
- The gathering of such incredible leaders in one room
- Knowing this issue is hitting a national radar screen
- The dialogue and the summaries
- The potential for action and change
- The energy & passion & commitment of a group of people – feel like we are on our own sometimes
- Opportunity to meet and discuss this issue with people from varied backgrounds
- Information exchange
- The openness, the variety of perspectives, the level of engagement/participation and the opportunity for networking
- You've inspired me, I'm ready to fight for it!

3. What participants appreciated least about the meeting:

- All great!
- I benefited and enjoyed it all
- Nothing
- Nothing to add
- Concrete next steps (though I recognize the Steering Committee is meeting tomorrow)
- One table facilitator appeared to have own agenda
- Lack of non-nursing occupational groups
- Nothing
- As far as these types of meetings go this was much more successful than most so I don't really have anything negative to say. You felt as though your input might actually be used and that the end product would be useful.
- Less networking time
- Some of the discussions were repetitive and uncertainty of what we do post – QWQHC/March 2007
- Nothing – lots of action, variety and chance to network
- Needed two days
- No public participants
- Nothing really
- Can't think of anything
- With so many ideas and so much feedback, will you have enough time to proceed (collaborative ends too soon – too bad!)
- The facilitator
- No comment here, it was a great day
- The lack of clear messages packaged to different audiences
- Nothing, very well organized
- In one case discussion tables were too close which made it difficult to hear our own discussion. Suggestion: with such a large room we could have spread the groups out more
- Nothing
- Food (my usual complaint)

4. Only one participant said “No”, they would not like to be involved if future QWQHC activities were held.

(Note: gave an overall ranking of 4/5 for the day, although the individual appreciated the opportunity to review the strategy and provide feedback, they provided no additional comments)

5. Overall Comments:

- Great job Dianne and Melissa
- Thank you for the work of the Collaborative. Yahoo!
- Thank-you!
- Do not disband the Collaborative or the Secretariat
- Very Good Session.
- Very well organized. Great Facilitation. Thanks!
- More attention needs to be paid to the “how” of making the QWL project go and less to the “what” i.e. the actions, priorities, etc. etc.
- Well Done.
- Excellent job Melissa! Nicely run and great mix of people
- Excellent. Thank you for the invitation. Wonderful steps towards Quality Worklife
- Very worthwhile
- Great work, some nice creative work! Getting clearer all the time! A pleasure to be involved.
- Great work all!
- This is a very! Very! Important change that must be made in healthcare. We all need to be together on this change!! Let’s keep talking and taking wise action.
- Good discussion, keep up the momentum
- Very informative. The issue of patient care is one predominantly of access. Patient safety and patient satisfaction will not get much political capital, but waiting lists, cancelling surgery, etc. will.
- Nice day
- Great initiative, great work!
- I look forward to seeing this move forward
- Good start. Needs refinement to get to level of IOM To Err is Human or IHI 100,000 Lives
- Excellent value. Needs to happen more often. Do not let momentum die!
- Useful dialogue helped make the strategies real – I am going away with a better understanding of how I can move forward. Thank you
- Great work

6. Further feedback via email:

- I wanted to say that I found the Stakeholder Summit December 12th of considerable interest. It was my pleasure to meet many of the professionals who gathered together for that event. In addition, I found the interventions to be thoughtful and, I trust, helpful to the Steering Committee in putting together the final version of the Action Strategy. I have prepared a report for my colleagues at NQI and I look forward to receiving a copy of the final Strategy when it is available. I will be sure to share it with my colleagues.
- I want to thank you for the tremendous summit in Ottawa, Melissa. I have brought home some exciting new perspectives and personally, really benefited from listening and talking to so many high-caliber people who are experts in the field of healthy workplaces.
- Thanks for your encouragement. It's always great to feel that we aren't ALONE! By the way, in all of the groups I was in, we "voted" for the Collaborative to stay together and continue assisting in this important effort - I hope that it continues after March, and that you can continue to support the work so capably. It was no accident that you got two standing ovations!
- I have reviewed the material in some detail and I was surprised to see under the "Proposed Priority Activities" in the "Quality Worklife - Quality Healthcare Action Strategy" document reference to nurse/patient ratios at pages 21 and 22. I understood there was no consensus that this was an agreed "priority area". In fact two people at my discussion table spoke against it. Without getting into too much detail, there are many ways to address workload including the use of other occupations which overlap with nurse scope of practice. There is some controversy with respect to nurse/patient ratios. Since the Summit was to look at quality of work life much more broadly than nurses it is not appropriate to identify nurse/patient ratios as a "priority activity for health organizations to improve quality of worklife". Since these proposals were brought forward to "a broader stakeholder group... for consultation and validation" (page 4), and there didn't appear to be a consensus validating this point, I respectfully ask that reference to nurse/patient ratios be removed from the list of proposed activities to improve the quality of worklife in the health sector.