Full-Time/Part-Time Employment of Nurses in Small Hospitals in Rural and Northern Ontario:

Current Status, Issues and Options

Cater Sloan, MA
Raymond Pong, PhD
Ellen Rukholm, RN, PhD
Sylvie Larocque, RN, PhD
Roger Pitblado, PhD

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Centre for Rural and Northern Health Research
Laurentian University

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EXECUTIVE SUMMARY

While the late 1990s saw a decline in both the number of nurses and the proportion of nurses employed full time in nursing, there has been growth in nursing since 2000, and growth in full-time employment as well. In 2005, 88,345 RNs and 24,430 RPNs were working in Ontario. This study found that 47,429 RNs and 6,766 RPNs were working in Ontario's hospitals, based on an analysis of 2004 data from the Canadian Institute for Health Information. Fifty-two percent of RNs and 41% of RPNs employed in hospitals in 2004 worked full time; recent changes in reporting employment status suggest these figures underestimate full-time employment. In 2005, the College of Nurses of Ontario mandated that all nurses report their employment status when they register; prior to this about 13% of nurses did not report on their work status. The proportion of full-time nurses showed the greatest increase when all nurse reported their employment status. Overall, 60% of RNs and 55% of RPNs worked full time in 2005.

What about nurses working in small hospitals? Is the rate of full-time employment in rural and remote hospitals the same as for the province overall? This study and others have found that nurses employed in small hospitals in rural and small towns in Ontario are less likely to have full-time employment than urban nurses employed in larger hospitals. Findings from this study suggest that there were a substantial number of part-time nurses working in small hospitals who would preferr full-time employment should it become available. The survey findings (on involuntary part-time workers) suggest that between 10% and 38% of part-time RNs and between 20% and 50% of part-time RPNs working in small hospitals want full-time employment.

Chief Nursing Officers indicated that small hospitals do face barriers to increasing full-time employment; some barriers are intractable, others could be lowered. The high level of responsibility that a nurse assumes when working in a rural or remote hospital is a given; rural and remote communities are small and so are the hospitals that serve them. There are limits on the availability of nurses in more rural and remote parts of the province. There are rural and northern municipalities where very few or no nurses are looking for work; they may or may not prefer full-time employment. Most of these barriers can't be lowered by means of public policy.

But policies could be modified to take size and location of hospitals into account. The implementation of the 70% full-time employment target for the first two-year planning cycle of the Hospital Accountability Agreements can be further modified for small hospitals by widening the performance corridor (JPPC 2005b). Funding streams tied to efficient staffing can be harmonized with improved full-time employment opportunities. There should be training sessions on how collective bargaining agreements can be used to increase the number of full-time positions. The goals of efficiency, safety, and more full-time employment could be made to work together to improve patient care and nurses' work environments. Funding and other types of support for employing new nursing graduates full time can be implemented.

HIGHLIGHTS

During the mid to late 1990s, part-time and casual employment for nurses rose in Ontario while the federal and provincial governments restructured health and hospital care. There were reports that working conditions and a decline in full-time nursing positions were causing nurses to leave Ontario to work in other jurisdictions or to leave nursing altogether. Nursing stakeholders called for an increase in full-time employment as part of a strategy to increase the supply of nurses available to work in Ontario. In 2004, the Ministry of Health and Long-Term Care (MOHLTC) implemented a full-time employment target for hospitals. Seventy percent of annual nursing hours were to be worked by full-time nurses. During that year, some senior administrators began to voice concerns that there were too many barriers for small hospitals to meet the 70% full-time employment target. This 5-part study used a mixed methods approach and several sources of data to examine the issue of increasing full-time employment for nurses employed in small hospitals in rural and remote municipalities in Ontario. The following pages highlight findings from the study.

Small Hospitals in Rural and Remote Ontario *(Definition of small hospitals used for this study; see Appendix 3 for more details.)*

- There were 93 communities with fewer than 50,000 residents that had hospitals with 100 or fewer beds.
- Hospitals were more likely to have fewer than 50 beds (72%) and to be located in smaller more rural communities rather than in larger, less rural communities.
- Communities with small hospitals were most likely to be located in the North (41%), followed by the Southwest (25%), and East (22%). Only 12% were located in the Central regions that broadly encircle Toronto, Kitchener-Waterloo, and Hamilton.

Small Hospitals' Degree of Success in Meeting the 70% Full-Time Employment Target *(Data provided from the Nursing Secretariat, MOHLTC; see Appendix 3 for more details.)*

- The 2004-05 classification of full-time nurses restricted full-time status to nurses providing direct care to patients; nurses employed in full-time job share or temporary positions were not counted as full-time. The 2005-06 classification of full-time nurses included nurses in direct care, support, and managerial positions. Nurses employed in full-time job shares and temporary full-time positions were considered full-time.
- As of July 2005, only 9% of small hospitals had met the 70% full-time employment target using MOHLTC's 2004-05 classification of full-time nurse. All 8 of these small hospitals were located in the North region.
- Based on the 2004-05 definition, 74% of small hospitals had between 46% and 70% of annual nursing hours worked by full-time nurses and 15% of small hospitals had fewer than 46% of annual nursing hours worked by full-time nurses.
- A handful of the CNOs who participated in the study suggested that their hospital had met or exceeded the 70% full-time target using the 2005-06 classification of full-time nurses; their hospitals were located outside the North.

Challenges and Opportunities Faced by Chief Nursing Officers in the First Year of Implementing the 70% Full-Time Employment Target *(Based on interviews with 23 Chief Nursing Officers; see Appendix 3 for more details.)*

- No single factor or barrier was related to decisions concerning a hospital's full-time to part-time ratio of nurses; rather it was a combination of factors and barriers that created a particular context within which hospital administrators made decisions about full-time and part-time employment for nurses.
- Barriers to implementing the 70% full-time employment target included the availability of nurses interested in working for small hospitals, limits on the number of nurses needed to staff a small hospital, and scheduling and hiring conditions set by government policy and collective bargaining agreements.
- Factors associated with these barriers included the eclectic nature of nursing practice in small hospitals, the overall small numbers of patients cared for and rapid changes in the number of patients being cared for at any given time, community location and attributes such as economic health and growth or loss of population, the average age of full-time nurses in small hospitals and vacation benefits they received, the need for part-time nurses to replace absent nurses, low turnover, and nurses' preferences for full-time or part-time work.
- Opportunities to increase full-time nursing positions came about through funding from the Nursing Enhancement Funds, workload analysis, and supports for nursing. Strategies used to increase full-time work included combining part-time positions into full-time positions, combining a new part-time position with an existing part-time position, combining part-time positions left open through retirement or attrition, bundled positions, cross-training positions, and cross-site positions.

Supply of Hospital-Employed Nurses *(Based on an analysis of the CIHI RN and RPN databases; see Appendix 2 for more details.)*

- Nursing in Ontario is one profession with two categories of care providers: Registered Nurse (RN) and Registered Practical Nurse (RPN).
- 47,429 RNs and 6,766 RPNs worked in Ontario hospitals in 2004.
- 12% of the RNs and 23% of RPNs lived in rural municipalities where 13% of Ontario's population lived.
- The majority of hospital nurses lived within a 30-km radius of where they worked in 2004. These 30-km commuting sheds overlapped with at least one other community with a small hospital for 73 of the rural and remote communities included in the study; 20 of the small communities with small hospitals required a commuting shed of 80 km to create overlap.

Employment Status of Hospital Nurses *(Based on an analysis of the CIHI RN and RPN databases; see Appendix 2 for more details.)*

- 52% of RNs and 41% of RPNs worked full time in 2004; 30% of RNs and 36% of RPNs worked part time. It should be noted that in 2004, a substantial number of nurses did not report their employment status (12% of RNs and 15% of RPNs).
- Rural hospital nurses were less likely to be employed full time in 2005 than were nurses overall.
- Nurses were most likely to be employed full time in the largest cities and in more rural municipalities.
- Full-time nurses were older; the largest proportion of full-time nurses were 45 to 54 years of age.
- Male nurses (4% of the hospital nursing workforce) were somewhat more likely to be employed full time than were female nurses.

- Full-time employment varied by as much as 35 percentage points across census divisions. Self-reported full-time employment for RNs ranged from 26% in Haliburton to 61% in Toronto; for RPNs, full-time employment ranged from a low of 27% in Haliburton to a high of 52% in Prince Edward.

Rural Hospital Nurses Interest in Full-Time Work *(Based on a mail survey of nurses living in and around communities with small hospitals; see Appendix 4 for details.)*

- 16% of rural hospital RNs and 17% of rural hospital RPNs held two or more nursing positions.
- 30% of part-time and casual rural hospital RNs held two or more nursing positions compared to 6% of full-time RNs; 25% of part-time and causal RPNs held two or more positions compared to about 7% of full-time RPNs.
- Nurses were asked what employment status (i.e., full-time, part-time or casual) they would prefer to work in nursing. If all RNs had their preferred employment status, the proportion of full-time RNs would increase 10 percentage points, from 58% to 68%. Similarly, if all RPNs had their preferred employment status, the proportion of full-time RPNs would increase from 46% to 67%. These estimates take into account the 4% of full-time nurses who preferred part-time work.
- Part-time and casual RNs and RPNs said they preferred to work more hours than they actually worked.
- 38% of RNs and 50% of RPNs said they would like to work in a full-time position at the time they responded to the survey.
- A lack of full-time positions was the most often mentioned reason for not working full time by nurses who could be considered "involuntary part-time workers". Lack of seniority was the second most commonly mentioned reason for those who indicated they would choose full-time employment if they could.
- Nurses who were considered "voluntary part-time workers" were most likely to say they worked part time to meet family responsibilities such as child care, spending time with a retired spouse, caring for an aging parent, or working in a family business. Other reasons for choosing part-time or casual work in nursing included personal preferences, health conditions that did not allow them to handle the stress of a full-time nursing position, increased income (part-time nurses receive 13% of their salary in lieu of the benefit packages received by full-time nurses), the enjoyment of nursing, avoidance of work politics, and an increase or decrease in variety in their work. Attending school and long commutes were mentioned by a handful of nurses as reasons for working part time.

Number and Characteristics of Nurses Seeking Employment *(Based on an analysis of the CIHI RN and RPN databases; see Appendix 2 for more details.)*

- 1,420 or 1.4% of all RNs registered in Ontario were seeking employment in nursing in 2004; 588 or 1.9% of all RPNs registered in Ontario were seeking employment in nursing in 2004.
- The average age of nurses seeking employment ranged from 44.3 to 46.9; between 8% and 17% were younger than 35 years of age.
- Whether these nurses wanted to work in the hospital sector was unknown.
- Unemployed nurses were more likely to seek nursing employment than nurses employed outside of nursing.
- Nurses seeking employment were not evenly distributed across the province. When analyzed by census district, the number of RNs seeking employment varied from 184 in Toronto to 0 in several more rural or remote census districts; for RPNs the number ranged from 36 in Toronto to less than 5 or 0 in many rural or northern census divisions.

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TABLE OF CONTENTS

1.0 INTRODUCTION

Throughout the 1990s the overall proportion of full-time RNs and RPNs declined in Ontario and the percentage of nurses working in part-time positions increased. In addition, the number of nurses employed in nursing dropped in Ontario. The decrease in full-time nurses was the result of long term changes in staffing patterns in service industries, such as hospitals. It was also the result of health care and hospital restructuring undertaken at the provincial and federal levels during the 1990s.

In 1998, the Ontario Government established the Nursing Task Force (NTF) to "examine the impact of health care reform on both the delivery of nursing services and the nursing profession in Ontario and to recommend strategies to ensure and enhance quality of care through effective use of nursing human resources" (Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee, 2001). The NTF delivered its report in January 1999, and its first recommendation was an investment in "additional permanent front-line nursing positions across all sectors of the health care system" (Nursing Task Force, 1999). In 2000, the Registered Nurses Association of Ontario (RNAO) began advocating for 70% full-time employment for RNs in Ontario. The 70 percent full-time employment target was also endorsed by the Joint Provincial Nursing Committee, the Canadian Nursing Association, and the Canadian Nursing Advisory Committee (Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee, 2001).

The RNAO and others have argued that continuity of care and continuity of care providers cannot be achieved with low levels of full-time employment and the reliance on part-time, casual, and agency employment (RNAO, 2000; RNAO, 2003). There is concern about the working conditions of nurses who are currently in the system, and fears that poor working conditions will deter individuals from choosing nursing as a career.

The Ministry of Health and Long-Term Care (MOHLTC) supports the 70% full-time employment policy. In an announcement in July 2004, the Hounourable George Smitherman, Minister of Health, said that the MOHLTC intended to create 2,400 new full-time nursing positions, with a view to helping "the government meet its goal of having at least 70 percent of the province's nurses working full-time" (MOHLTC, 2004). The target has been included in the Hospital Accountability Agreements (HAAs), which will extend funding to hospitals to support two-year planning cycles. The first HAA will cover fiscal years 2005-06 and 2006-07.

Some of those in charge of small hospitals in rural and northern Ontario have voiced their concerns that the barriers they faced in meeting the 70% full-time employment target were too large to overcome. They indicated that small hospitals tended to have less flexibility in nursing staff deployment because of the small size of their programs and the small numbers of nurses employed. Others mentioned that their hospitals would find it difficult to reach the 70% full-time employment target if the limited number of qualified nurses in their communities did not want full-time work.

These concerns raised a number of questions. What sorts of challenges and opportunities have Chief Nursing Officers in small hospitals faced in the first year of implementing the 70% full-time employment target for hospital nurses? Who works in full-time, part-time and casual

nursing positions in Ontario's hospitals and are there differences between rural and urban locations? What proportion of part-time and casual nurses in small hospitals are interested in working full-time? Does the 70% full-time employment policy make sense for small hospitals? What could be done to assist senior administrators in raising the proportion of full-time nurses in small hospitals?

To address those questions, the Nursing Secretariat of the MOHLTC commissioned the Centre for Rural and Northern Health Research (CRaNHR) at Laurentian University to conduct a study on the implications of the 70% full-time employment policy for small hospitals in rural and northern Ontario. This report presents a literature review of research pertaining to the supply of nurses in Ontario and their employment status, the methods used for each of the five components of the study, findings from each component, and recommendations from Chief Nursing Officers and nursing leaders concerning the 70% full-time employment policy and increasing full-time employment in small hospitals.

2.0 LITERATURE REVIEW

Challenges to implementing the 70% full-time employment policy reside in the nature of rural nursing practice, the stability of employment in the nursing workforce, and the aging of the workforce. Understanding the workforce trends and factors that draw and keep nurses working in rural and northern communities will assist policy makers to better support small hospital administrators implement the 70% full-time employment policy.

What is Rural?

Researchers define "rural" and "northern" in a multitude of ways (Pong and Pitblado 2001). Approaches to defining rural fall into two categories; technical definitions based on identifying geographic locations and social definitions that identify cultural and social features of rural life (du Plessis et al. 2002; Pitblado 2006). "Northern" in this context refers to Northern Ontario, which is administratively defined as extending north and west from Parry Sound, Muskoka, and Nippising (JPPC 2005a). Northern cities are considered similar to rural areas because they are geographically isolated and have difficulties in accessing services (Pong 2000). This study used Rural and small towns (RST) and Metropolitan Influence Zones (MIZ), two geographic methodologies that are increasingly used by Canadian researchers because they are useful for planning local or community issues. RST refers to towns or municipalities outside the commuting zone of larger urban centres (with 10,000 or more residents). The MIZ methodology further divides RST municipalities into zones according to how much influence larger urban centres have on the municipalities. The degree of urban influence is measured by how many individuals in a municipality commute to larger urban centres (du Plessis et al. 2002).

Workforce Trends: Number and Employment Status of Nurses

While the supply of RNs increased from 1996 to 2005, the percentage of those living in rural communities decreased (O'Brien-Pallas et al. 2003; Pitblado, et al. 2002). The growth of RNs was not steady: the number of RNs employed in nursing in Ontario dropped by about 4% from 1996 to 1999, then rose by 14% from 1999 to 2005 (CNO 2005). From 1987 to 2003, Ontario experienced a decrease of 65% in its supply of RPNs, the largest decline of any province or territory (Pyper 2004).

The proportion of full-time RNs and RPNs also declined in Ontario during the 1990s (CNO 2005). This was a continuation of changes that began in the 1970s (Hiscott 1997). Growth in part-time work for nurses in Ontario has been attributed to long term changes in the way employers have chosen to staff service industries, an economic downturn, and short-term pressures caused by restructuring of healthcare at the federal and provincial levels (Baumann et al. 2006; Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee 2003; Keddy et al. 1999; Woodward et al. 1999; Tilly 1991).

Increased part-time work has been described as either voluntary and involuntary Voluntary part-time workers choose part-time work; involuntary part-time workers would prefer full-time work (Feldman 1990). Grinspun argued that the 17-percentage point increase in nurses' part-time employment from the 1970s and 80s to 1997 represented involuntary part-time employment for Ontario's nurses (Grinspun 2003). An analysis using the Survey of Labour and Income Dynamics (SLID) that asked workers if they worked part-time by choice revealed that 37% of RNs were involuntary part-time workers. By 2003, overall involuntary part-time employment dropped to 23%, which was still more than one fifth of Canada's RNs. Data on involuntary part-time employment for RPNs was only available for 1997: 46% of RPNs were involuntary part-time workers and 54% were voluntary part-time workers (Pyper 2004). Blyth, et al.(2005) reported that some full-time nurses maintained their full-time status for job security reasons, but actually preferred part-time work. In a study of nurses working in medical, surgical, and obstetrical units in Ontario teaching hospitals, McGillis Hall et al. (2002) found that 11% of hospital employed nurses wanted a different employment status, and about half (6%) said they wanted to work more hours.

Studies of nurses have found that voluntary part-time employment is associated with family responsibilities such as child care and elder care, being over 55, the desire to maintain skills or have a flexible schedule, and the desire for increased income (Blythe et al. 2005; Hiscott 1997; RNAO 2003). Sometimes, part-time work is the only way RNs could work in their field of interest (Blythe et al. 2005).

Casualization refers to the increase in part-time workers who do not have regularly scheduled employment. The SARS (Severe Acute Respiratory Syndrome) epidemic revealed that high rates of casual nurses and nurses working for more than one health care provider could threaten public health during an epidemic (Baumann et al. 2004). Casual employment for nurses is now at about 9%, down from 14% or 15% in the late 1990s (CNO 2006; CNO 2005).

The decline in the number of nurses from 1996 to 1999, and the decrease in full-time employment for nurses, caused concern amongst nursing leaders and government that a shortage in the supply of nurses was developing (CNAC 2002; Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee 2001). The recommended changes by the Nursing Task Force (NTF 1999) appear to have had some positive results. The number of nurses employed in nursing has increased and the overall proportion of full-time RNs has risen from a low of about 50% in 1997 to almost 60% in 2005 (CNO 2005). The rise in full-time employment for RPNs began two years later: about 47% of RPNs were full-time in 1999 compared to 55% in 2005 (CNO 2005). The proportion of full-time nurses remains lower today

than it was in the past. During the 1960s 70% to 80% of nurses were employed full-time (Hiscott 1997).

The Importance of Full-Time Work

O'Brien-Pallas et al. (2003) reported that the reduction of full-time nurses in the 1990s created a decrease in the actual supply of nurses because available nurses who wanted full-time work were not fully employed, and suggested that the strategy negatively affected continuity of care, recruitment and retention, and increased overtime costs.

Full-time work is important to the retention and recruitment of nurses and nursing students. In the past, younger RNs and middle aged RNs were most likely to be employed full-time (Hiscott 1997); by 2003 full-time employment was more likely for RNs and RPNs over 40 as compared with those younger than 40 (O'Brien-Pallas et al. 2003). A number of reports indicated that younger nurses left Ontario in the last half of the 1990s because they could not obtain full-time work (RNAO 2000; RNAO 2001; McGillis Hall & Kiesners 2004). New nursing graduates wanted full-time employment in the region where they were trained and preferred work in the hospital sector; in 2004 nursing graduates were about 4 times more likely to obtain full-time employment in and around Toronto as compared to nursing graduates in other regions (Baumann et al. 2006). Nursing students and nurses stated that the lack of full-time positions made it difficult for them to stay in Northeastern Ontario (Rukholm 2006). Casually employed RNs in Canada were about twice as likely to be lost of the profession because they did not renew their licenses than were full-time or part-time nurses (CIHI 2006).

Burke & Greenglass found higher rates of job satisfaction and psychological well-being in nurses whose actual employment status matched their preferred employment status than in nurses whose employment status was involuntary (Burke and Greenglass 1999). A decrease in full-time nursing positions was associated with increased work and financial insecurity for nurses in Nova Scotia, and these changes negatively affected nurses' close relationships, especially with their children (Keddy et al. 1999).

Has the reduction of full-time nurses had had a negative effect on continuity of care? Laschinger et al. (2001) reported that nurses were concerned about increased workload after hospital restructuring, and perceived the quality of care had decreased due to an increase in part-time nurses whom they viewed as less qualified. O'Brien-Pallas et al. (2004) reported that patient knowledge about their condition at discharge improved as the percentage of full-time nurses employed on the hospital unit increased. Improved patient knowledge might be viewed an indirect measure of continuity of care. It seems likely that full-time nurses, who saw patients more often, were more likely to ensure they knew about their condition prior to discharge. McGillis Hall (2005) conducted a comprehensive literature review on indicators of nurse staffing and found that "[t]o date, no empirical literature exists that links the number or percent of full-time, part-time, and casual nursing staff" to patient, nurse or organizational outcomes.

A recent study on hiring practices in three Ontario teaching hospitals nurse managers seldom advertised externally for full-time nurses (Blythe et al. 2005). Instead, they filled full-time vacancies according to union guidelines by promoting the most senior internal candidates. Nurse mangers stated that it was difficult to fill part-time positions. Recent graduates or migrating

nurses were reported as most likely to be hired part-time and young nurses had a high rate of turnover. Although human resources managers agreed that full-time staff saved costs, nurse managers were restricted to hiring into existing full-time positions. Nurse managers attempted to increase full-time positions using innovative strategies such as packaging weekend shifts with a weekday shift, creating a float pool of full-time nurses to cover unfilled shifts in three specialty areas, and job sharing. The authors report that these strategies created a limited number of jobs and created only a small change in the ratio of full-time to part-time nurses (Blythe et al. 2005)

Nurse managers also thought "that hiring more full-time nurses would decrease their ability to cover sick leave and other absences" and that hiring more full-time worker would cause them to overspend their budgets. Managers reported that union conditions limited how they deployed their staff and made part-time nurses a necessity (Blythe et al. 2005). These hiring practices and beliefs about full-time and part-time nurses were similar to those reported in this study of small hospital administrators.

Supply of Nurses in Rural and Small Towns in Ontario

In 2004, about 11% of Ontario RNs employed in nursing lived in rural and small towns. Of the roughly 10% living in rural areas, 3.7% commuted to work in the largest cities, 3.3% worked in mid-sized cities, and 3.3% stayed to work in rural areas (CIHI 2005b). If the 2004 percentage of RNs who worked in rural areas is applied to the total number of RNs (89,054) working in Ontario in 2005, then about 3,145 RNs live and work in Ontario's rural and small towns (CNO 2005). A sister report found that about 14% of Ontario's RPNs lived in rural areas: 3.3% commuted to work in the largest cities, 4.4% worked in mid-sized cities, and 6.6% worked in rural areas (CIHI 2005a). When the 2004 percentage of RPNs who worked in rural areas is applied to 2005 figures for RPNs (24,482) employed in nursing in Ontario, there are an estimated 1,629 RPNs working in rural and small towns (CNO 2005). This analysis did not take into account nurses who lived in urban areas and worked in rural areas, and so may underestimate the number of nurses who worked in rural municipalities.

Demographic and Employment Characteristics of Rural Nurses

Previous research found that Ontario's rural RNs were overwhelmingly female (98%) and older. Almost two-thirds were between 35 to 54 years old (CIHI 2002) and 15% were over 55, the age at which many RNs are more likely to choose part-time employment or retirement (CIHI 2002; Hiscott 1997; O'Brien-Pallas et al. 2003; Stewart et al. 2005). Most were married and 60% lived with a dependent child or relative (Stewart et al. 2005).

Information about rural RPNs could not be located. Almost all RPNs were female (94%) and most were employed in urban areas (CIHI 2005a). The majority of RPNs were older; 61% were between 35 and 54 years old, and 20% were over 55 (CNO 2005).

The largest proportion of rural RNs worked in acute care settings (56%) in Ontario, though this proportion was lower than for urban RNs (62%). About 88% provided direct care and 6% were in administration (CIHI 2002). They were experienced, with an average of 20 years in nursing. About 90% indicated their work was regular and steady, while 10% said their work was seasonal. About 85% of Ontario's rural RNs reported a diploma in nursing as their highest level of nursing education (CIHI 2002; Stewart 2005).

Ontario's RPNs were most likely to work in the hospital sector, though the proportion of hospital employed RPNs declined from about 60% in 1992 to 46% in 2005 (CNO 2005; Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee, 2003). Hospitals in the North and Toronto regions were most likely to employ RPNs (50%) followed by the Southwest and Central regions. Almost 80% were staff RPNs, and about 2% were in managerial positions (CIHI 2005a).

Nursing in Rural Communities

Nurses working in rural and remote settings were very likely to have a rural background prior to becoming a nurse (Bushy and Leipert 2005; Huntley 1995), prefer a country lifestyle (Bushy and Leipert 2005; Huntley 1995) and autonomous nursing practice (Andrews et al. 2005). Nursing in small hospitals involves caring for a wide variety of patients with limited resources (Hegney 1998; Kenny and Duckett, 2003; MacLeod 1998). Rural nurses were less likely to work full-time than urban nurses (Pitblado et al. 2002). MacLeod reported that part-time and casual work diminished nurses' confidence in their ability to provide care because of the high levels of responsibility they assumed, and the difficulty of maintaining skills with fewer hours of employment. Nurses in the study used the phrase "We're it" to describe the high levels of responsibility and accountability they assumed in health care delivery. Nurses were on-site day and night; physicians were not (MacLeod 1998).

Rural nursing has typically been learned on the job (Kenny and Duckett 2003; Squires 2005; Hegney 1998) and experienced nurses have recognized that it is difficult for new nurses to learn that way (MacLeod 1998). Hospital administrators, nursing researchers and rural nurses have suggested that rural nurses require advanced assessment skills and that their formal education may be inadequate because it is often based on urban models of care and given in urban centres (Kulig, 2005; Hegney 1998; MacLeod et al. 2004).

As a result of all these factors (personal background and preferences, increase likelihood of working part-time instead of full-time, and the high level of responsibility), recruitment of health professionals from outside rural communities is difficult (Strasser 2003; Tepper et al. 2005). Financial constraints have also limited rural hospitals in competing with urban hospitals to recruit nurses. Urban hospitals have been better able to offer higher salaries, flexible work hours, specialty areas of practice, and educational benefits (Bushy and Leipert 2005; Huntley 1995) as well as full-time work (Baumann et al. 2006).

Organizational factors associated with retention of rural nurses included employer support for continuing education (Huntley, 95), and hospital orientation programs for new nursing graduates (Squires 2005). Other professional and organizational factors that helped retain rural nurses included adequacy of staffing, and respect from administrators and physicians; isolation and security were a concern, especially for younger nurses working in hospitals (Huntley 1995; Kenny and Duckett 2003).

Although continuing education was positively related to job satisfaction and retention for rural nurses, nurses and small hospital administrators were sometimes unsupportive of continuing education because of costs, lack of interest, fears of university based education, and family

commitments (Gibb et al. 2004; Gibb et al. 2006; Kenny and Duckett 2003; Rosenberg and Canning 2004). The opportunity to mentor created a more positive response to education amongst administrators, learners, and co-workers (Gibb et al. 2006).

Conclusion

There is a limited amount of research on rural nurses and their work. Findings from this study will provide more information on the characteristics of small hospitals in rural and remote Ontario, the nurses who practice in them, and the community and policy environments that surround them. Some of the gaps in information this study will help fill include:

- The demographic and employment characteristics of nurses who work in small hospitals;
- The average distance that nurses commute to work in Ontario;
- The number, sex, and age of nurses seeking employment in nursing by the census division in which they live;
- The employment preferences of nurses who work in small hospitals in rural and remote Ontario;
- The opportunities and barriers that senior hospital administrators experienced in their first year of implementing the employment policy mandating 70% of annual nursing hours be worked by full-time nurses;
- Recommendations from senior hospital administrators and nursing stakeholders concerning the 70% full-time employment policy and issues that pertain to it.

3.0 OBJECTIVES

The main objectives of the study were to describe the current situation with respect to full-time and part-time employment status of nurses (both RNs and RPNs) in small hospitals in rural and northern Ontario and to examine the challenges and opportunities hospital administrators encountered during their first year of implementing the 70% full-time employment policy. A related objective was to discuss alternative strategies or approaches to facilitate optimal employment status of nurses in small hospitals.

The question of whether the 70% full-time employment contributes to high-quality patient care or better patient outcomes is beyond the scope of this study.

4.0 METHODOLOGY

This five-part study used a mixed methods approach and several sources of data to examine the issues from a variety of perspectives. The study received ethical approval from the Laurentian University Research Ethics Board. More detailed results for each component are reported in individual appendices at the end of this report.

- Part 1: Qualitative exploratory research was conducted with a small number of hospital administrators to identify the issues they perceived as barriers to implementing the 70% full-time employment goal for nurses and the definitions of full-time, part-time, and casual work. The information gathered was used to develop the interview protocol for Part 3 and the questionnaire for the mail survey of Part 4. Results are reported in Appendix 1.
- Part 2: Secondary analyses using the latest available data (2004) from the Canadian Institute for Health Information (CIHI) provided an empirical overview of the employment status of

Registered Practical Nurses (RPNs) and Registered Nurses (RNs) in Ontario. Results are reported in Appendix 2.

- Part 3: A qualitative exploratory study of the challenges and opportunities that 23 Chief Nursing Officers experienced in their first year of implementing the 70% full-time employment target. The interview protocol also asked about the strategies Chief Nursing Officers used to implement the 70% full-time policy, the recommendations they made regarding it and regarding complementary or alternative strategies to facilitate optimal employment status of nurses in small hospitals. Results are reported in Appendix 3.
- Part 4: A mail survey that explored nurses' perspectives on their employment preferences for work in small rural or remote hospitals in Ontario. Results are reported in Appendix 4.
- Part 5: Two focus group sessions were held to assess results from Parts 1-4 and to suggest policy recommendations regarding the 70% employment policy in small rural and remote hospitals. The assessments were made by senior hospital administrators and nursing leaders and nursing interest groups, two groups expected to make use of the study: Members lived experiences in small and rural hospitals, and their knowledge of nursing issues and concerns, assisted them in determining the relevance and utility of the research findings. Results are reported in Appendix 5.

4.1 Small Hospitals and Chief Nursing Officers

Small hospitals were defined as having 100 or fewer beds. The study included small hospitals as defined by the Joint Policy and Planning Committee (JPPC) and some that are termed community hospitals by that organization.

Hospitals' rural location was classified using Statistics Canada's Metropolitan Influence Zones (MIZ), a method that categorizes rural and small towns (fewer than 10,000 residents) by the percentage of residents who commute to work in larger urban centres. Generally, the larger the percentage of commuters, the closer a community is to one or more urban centres. Urban centres are divided into Census Metropolitan Areas and Census Agglomerations. Rural areas are divided into Strong, Moderate, Weak, and No MIZ.

- Census Metropolitan Areas (CMAs) are large urban centres (100,000+)
- Census agglomerations (CAs) are smaller urban communities (10,000 to 99,999). They are split into larger CAs (50,000 – 99,999) and smaller CAs (10,000-49,999).
- Strong MIZ municipalities have 30% or more of residents commuting to an urban centre (10,000+).
- Moderate MIZ municipalities have 5% to 30% of residents commuting to an urban centre.
- Weak MIZ municipalities have 0.1% to 5% of residents commuting to an urban centre.
- No MIZ municipalities have fewer than 40 or none of the residents commuting to an urban centre. There were no hospitals located in a No MIZ municipality in Ontario.

Communities were included in the study if they were in a region outside of Toronto, if they were located in a municipality with 50,000 or fewer people (non tracted CAs and Strong, Moderate, and Weak MIZ), and had a hospital with 100 or fewer beds. There were 93 communities in Ontario that fit this definition. Each community had one small acute care hospital.

A sample of communities was drawn to represent Ontario's population of small hospitals in terms of number of beds, region, rural-remote location (MIZ), and degree of success in meeting the 70% employment target. Hospitals from the north region (northeast and northwest) were overrepresented, as were hospitals that had met the 70% full-time policy and those that had less than 46% of annual nursing hours worked by full-time nurses.

Chief Nursing Officers from the sample hospitals were invited to participate in the study. Twenty three out of 25 eligible Chief Nursing Officers agreed to participate, a 92% response rate. The 23 Chief Nursing Officers represented 24 hospitals. Interviews lasted from 30 minutes to over an hour. All Chief Nursing Officers granted permission for their interviews to be audio taped. The audio taped interviews were transcribed and analyzed for themes.

4.2 Nurses

A secondary analysis of administrative data was conducted to learn more about demographic, geographic, and work place characteristics of full-time, part-time and casual hospital nurses and to learn more about the nurses seeking nursing employment. A survey of nurses residing in rural communities was carried out to learn more about their employment status preferences.

The secondary analysis was conducted using the most recently available data from the Registered Practical Nurses Database (RPNDB) and Registered Nurses Database (RNDB). The analysis was restricted to nurses who lived in Ontario and worked in hospitals as their primary place of employment and nurses who were seeking employment in nursing. Nurses working in hospitals and nurses seeking employment were analyzed separately. SPSS was used to cross-tabulate RNs and RPNs by four demographic characteristics: sex, multiple employment status, nursing positions, and age. These results were further categorized by two geographical measures: census divisions and rural-urban residence using the MIZ methodology. An analysis of the average commuting distance for nurses was conducted using postal codes for nurses' residences and primary places of work.

The study population for the mail survey consisted of nurses who lived in and around the 93 communities with small hospitals. A randomized systematic sample of 1600 RNs and RPNs was drawn from by the College of Nurses of Ontario using employment and residence specifications identified by the research team. A questionnaire was developed using findings from a literature review and exploratory research conducted at the start of the study. The mail survey used a modified Dillman approach. The analysis was restricted to nurses who indicated they worked in hospitals with 100 beds or less. Responses were analyzed using SPSS version 12. Survey findings on demographic and employment characteristics of the responding RNs and RPNs compared favorably with what is known about rural nurses.

5.0 FINDINGS

5.1 What do we know about small hospitals in rural and remote Ontario?

There were a total of 93 communities with fewer than 50,000 residents that had hospitals with 100 or fewer beds. Most of the hospitals could be considered smaller and more rural: 72% had

fewer than 50 beds and about the same proportion were located in Weak or Moderate MIZ communities where less than 30% of residents commuted to an urban centre. Fourteen percent were in Strong MIZ communities where 30% or more of residents commuted to urban centres for work; 13% were located in communities with between 10,000 and 50,000 residents.

Small hospitals in rural and remote Ontario were concentrated in the North (41%), Southwest (25%) and East (22%) regions. Only 12% were located in the central regions that broadly encircle Toronto, Kitchener-Waterloo, and Hamilton. (See Appendix 3 for more details.)

How is full-time, part-time and casual work defined for nurses working in small hospitals? Full-time work for RNs and RPNs was described by all Chief Nursing Officers as consisting of 1950 hours per year, which was divided into 75 hours per two week pay period or 37.5 hours per week. Definitions for part-time work varied, but all Chief Nursing Officers agreed that part-time nurses had pre-scheduled shifts and that casual nurses were employed on an call-in basis. Part-time nurses typically committed to work a certain number of shifts during a pay period, but there was no guarantee that nurses would receive the full number of hours that they had committed to. On the other hand, they might be asked to work more than the number of shifts they had committed to.

How successful were small hospitals in meeting the employment target of 70% annual hours worked by full-time nurses? Nine percent of the 93 hospitals identified as small by this study had met the 70% employment target using the 2004-05 definition provided by MOHLTC. Another 74% of small hospitals had 46% to less than 70% of their annual nursing hours worked by full-time nurses and 15% had fewer than 46% of annual nursing hours worked by full-time nurses. All of the hospitals that had met the employment policy were in the North region. During the interviews, some Chief Nursing Officers outside the North region indicated their hospital had met or exceeded the 70% goal after they had recalculated their annual nursing hours using the 2005-06 definition. The 2004-05 definition restricted who could be counted as a full-time nurse to nurses who provided direct care to patients; hours worked by nurses in full-time job shares and temporary positions were classified as part-time. The 2005-06 definition allowed hospitals to count hours worked by full-time nurses (RNs and RPNs) in direct care and managerial positions; job shares and temporary full-time positions were considered full-time as well.

Chief Nursing Officers from the sample of small hospitals that had met the 70% employment policy (n=3) differed from other sample Chief Nursing Officers in that they did not express concern about fiscal constraints or policy mandating they staff their hospitals efficiently, nor did they express much concern about the availability of nurses to work in their hospitals. These findings suggest that region, fiscal constraints, and the perceived difficulty in staffing efficiently *and* increasing full-time nurses had the strongest relationship to a hospital's degree of success in meeting the 70% employment target. The fact that some small hospitals in the North are funded differently suggests that fiscal constraints may be most strongly related to a small hospital's degree of success in meeting the 70% target as defined in 2004-05.

These findings are taken from interviews with Chief Nursing Officers. See Appendix 3 for more details.

5.2 Who works in full-time, part-time and casual nursing positions in Ontario?

The secondary analysis of the RN and RPN databases were aimed at answering three questions:

- How many nurses in Ontario worked full time or part time and what were the geographic, demographic, and work profile characteristics of these nurses?
- How many nurses were there within the commuter-sheds of Ontario's small rural and remote hospitals?
- How many nurses were seeking work in nursing and what were their geographic and demographic characteristics?

The secondary analysis was restricted to nurses employed in hospitals and nurses seeking employment. Findings revealed a great deal of variation in the proportion of RNs and RPNs who worked full-time and amongst nurses who were seeking employment in nursing by where they lived. See Appendix 2 for more details.

How many nurses worked full-time and part-time in hospitals in Ontario and what were the geographic, demographic and work profile characteristics of these nurses? There were 47,429 RNs and 6,766 RPNs working in hospitals in 2004. Across the province, 40.9% of RPNs and 52.0% of RNs worked full-time in 2004, and 36% of RPNs and 30% of RNs worked part-time. About 15% of RPNs and 12% of RNs did not report their employment status in 2004; in 2005, nurses were required to report their employment status to the College of Nurses of Ontario when they registered. The proportion of full-time nurses increased the most from the change in reporting: overall full-time employment for RNs in Ontario increased from 52% in 2004 to 60% in 2005.

The proportion of full-time hospital nurses varied with age, gender, license type, rural-urban location, and census division.

- Full-time nurses were older; the largest proportion were within 5 years of turning 55, an age when nurses often change to part-time work or retire.
- Male nurses were a small part of the hospital nursing workforce in Ontario: 3.7% of all RPNs and 4.0% of all RNs were male.
- Male nurses were somewhat more likely to be employed full-time than were female nurses.
- Nurses were most likely to be employed full-time in the largest cities (CMAs – 100,000+) and in municipalities in Weak MIZ areas.
- The proportion of nurses employed full-time in different census divisions varied by as much as 35 percentage points. Full-time employment for RPNs ranged from 26.7% in Haliburton to 52.4% in Prince Edward in 2004. Haliburton also had the lowest proportion (25.6%) of full-time RNs while Toronto had the highest (60.8%).
- RPNs were more likely to live in rural and small towns in Ontario than were RNs. Thirteen percent of Ontario's general population lived in rural and small towns; 12% of RNs and 23% of RPNs lived in rural and small towns as well.
- RNs were more likely to be employed full-time than were RPNs, regardless of urban-rural location.

- When hospital commuter sheds were used as the geographic unit of analysis, RNs were not always more likely to be employed full-time than were RPNs.

How many nurses lived within the commuter-sheds of Ontario's rural hospitals in 2004? The majority of hospital employed nurses in Ontario lived within 30 km of their place of work. In more remote areas, the estimate of commuting nurses was extended to 80 kilometres. These commuting sheds are referred to by the name of the community at the centre of each commuting shed. The commuting sheds were purposely designed to overlap, however, and ***it is not possible to determine which small hospital a nurse worked for by examining the map or tables in Appendix 2.***

- In some overlapping commuting sheds more RPNs were employed full-time time than were RNs. In some commuting shed, full-time proportions for RNs and RPNs were similar, in others there was large variation in full-time employment for RNs and RPNs.
- The existing supply of hospital employed nurses who lived within 30 km and 80 km commuting sheds of small hospitals varied considerably.
    1. For RPNs who lived within 30 km of small hospital communities, the number of RPNs ranged from 0 in Mattawa (North region) to 504 in Grimsby (South Central region). Fifteen of the 73 small hospital 30 km commuting sheds had fewer than 5 RPNs. This may indicate that hospitals in these areas prefer employing RNs, although RNs were not as concentrated in rural and small towns in Ontario as RPNs were. Full-time employment for RPNs who lived within 30 km of small hospitals ranged from 0.0% to 100.0%. Findings were similar for RPNs who lived within 80 km commuting sheds, although the range of full-time RPNs was slightly narrower: 18% to 83%.
    2. The number of RNs who lived within 30 km of small hospitals ranged from a low of 11 for Smooth Rock Falls (North region) to a high of 3,354 for Grimsby (South Central region). Four communities had fewer than 5 RNs within their 30 km commuting shed. Full-time employment ranged from 25% in the Barry's Bay commuting shed (East region) to 75% in the Thessalon commuting shed (North region). Results were similar for communities with 80 km commuting sheds.

How many nurses were seeking nursing employment in 2004, and what were their characteristics? Nurses seeking employment in nursing were analyzed by number, age, sex, and geographic distribution using census division.

- The number of nurses seeking work was small. A total of 588 or 1.9% of all RPNs registered in Ontario, were seeking employment in nursing in 2004; 1,420 or 1.4% of all RNs were seeking employment in nursing.
- Male RNs and RPNs were slightly more likely to be seeking employment in nursing than females.
- The age distribution of nurses seeking employment in nursing was similar to that of all hospital employed nurses. Their average age was in the middle 40s and most were over 35; 15% of RNs and 17% of RPNs were younger than 35.
- Whether these nurses wanted to work in the hospital sector was unknown.
- Unemployed nurses were more likely to seek nursing employment than were nurses employed outside nursing. Unemployed RNs were 4.5 times more likely to seek nursing employment than were RNs employed outside of nursing; unemployed RPNs were 2.5 times more likely to seek nursing employment than RPNs not employed in nursing.

- Nurses seeking employment were not evenly spread across the province. When census division (n=49) was used as the geographic unit of analysis, the number of RPNs seeking employment in nursing varied from 0 to 36; the number of RNs ranged from 0 to 184. 53% of nurses seeking employment were located in 11 urban census divisions.

5.3 Are part-time and casual nurses in small hospitals interested in full-time work?

The survey asked nurses a series of questions about their employment status and preferences, and collected information on demographic and employment characteristics related to employment status and employment preferences. See Appendix 4 for more details of the surveys' findings.

Full-time employment amongst nurses working in small hospitals. About 58% of responding RNs and 46% of RPNs were employed full-time; 35% of RNs and 47% of RPNs were employed part-time, and 7% of RNs and RPNs were employed casually. The proportion of full-time RNs and RPNs was higher for the survey than findings from the secondary analysis; this may reflect more complete reporting of employment status by survey respondents.

RNs and RPNs employed in small hospitals in rural and small towns in Ontario were less likely to have full-time employment than nurses overall in Ontario. In 2005, CNO reported that 60% of RNs and 55% of RPNs were employed full-time, a higher proportion than the full-time proportion for rural nurses. This is consistent with findings from previous research on rural RNs.

What is the level of interest in full-time work? There was evidence that a proportion of part-time nurses would like to work full-time. Nurses were asked a series of questions to assess whether they had chosen to work part-time or worked part-time because they could not find full-time work. Two kinds of questions were used: closed questions that provided nurses with a pre-determined set of responses and open questions that provided space for nurses to comment freely.

Nurses whose responses indicated they chose part-time or casual employment were considered voluntary part-time employees; nurses whose responses indicated they worked part-time because they could not obtain full-time work were considered involuntary part-time workers. The difficulty in pin-pointing estimates of involuntary part-time employment lie in the difference between what people say they want and what they would actually do if they had a choice. For example, a full-time nurse might prefer part-time work and say so, but would not accept a part-time position if offered one because she could not afford the loss of income, benefits, or both. Nevertheless, these measures do help clarify the level of interest in full-time work amongst part-time and casual nurses. A summary of responses for the closed-ended questions will be presented first, followed by responses to the open questions.

Closed-ended questions: All nurses were asked if they worked more than one position in nursing, what their actual and preferred work status was, and what their actual and preferred work hours were. Part-time and casual nurses were asked "Would you like to work in a full-time position at this time?"

Working more than one nursing position may indicate interest in a full-time job. About 16% of RNs and RPNs worked two or more positions. Not unexpectedly, full-time nurses were less likely to have more than one job than were part-time and casual nurses; almost 30% of part-time and casual RNs and 26% of part-time and casual RPNs worked in more than one nursing position compared to 6% of full-time RNs and RPNs.

If RNs all had their preferred employment status, the proportion of full-time hospital RNs would increase 10 percentage points from 58% to 68%; similarly, full-time employment for RPNs would increase about 20 percentage points from 46% to 67% if all RPNs had their preferred work status. These estimates account for the fact that 4% of full-time RNs and RPNs wanted part-time work. The size of the estimated increase in full-time employment for RNs is consistent with previous research on RNs in Ontario (RNAO 2003).

Part-time RNs and RPNs said they preferred to work more hours than they actually worked while 70% to 75% of full-time RPNs and RNs indicated their actual hours equaled their preferred hours. About 21% of part-time RNs and 24% of part-time RPNs wanted 36-40 hours of work a week, which is generally considered full-time employment. About 8% of RPNs wanted 41 to 45 hours of work per week. Half of RPNs and 38% of RNs who worked part-time and casual said they would like to work in a full-time position at the time they responded to the survey.

Taken together, these finding indicate there is interest in obtaining full-time work amongst part-time and casual nurses. Findings suggest that the level of interest may range in size from 10% to 38% of RNs and from 20% to 50% of RPNs. Some of the findings are based on relatively small numbers, and caution in generalizing them is advised. Nevertheless, the strength of the response from part-time and casual nurses when asked directly, "Would like to work in a full-time position at this time?" suggests that involuntary part-time employment was fairly sizeable for nurses that worked in small hospitals. These findings indicate a higher level of involuntary part-time employment than found in three Ontario teaching hospitals (6%) by McGillis Hall and in all Canadian RNs (23%) by Pyper in 2003. They also indicate that a small number of nurses were involuntarily employed full-time.

Open-ended Questions: If a nurse's actual employment status did not match that nurse's preferred status, the nurse was asked "What could your employer do to help you achieve your preferred employment status?" This question allowed full-time as well as part-time and casual nurses the opportunity to indicate what changes would help them achieve their work preferences. Part-time and casual nurses were asked two additional questions: "What are the three main reasons why you work as a part-time or casual nurse?" and "What needs to be done at your hospital to encourage you to work full-time?" The first and third questions were very much alike, and some themes were common to both. Some new themes emerged from the responses of part-time and casual nurses, and some themes that were more important in the responses to the first question became less important in the responses the third question.

Reasons for involuntary employment

The most often mentioned reason given by RNs and RPNs who were considered involuntary part-time or casual workers was that a full-time position was not available. A few RNs and a large minority of RPNs said that turnover was low in the small hospitals where they worked.

One nurse said she "started as part-time 17 years ago and [I am] still waiting to get a full-time position." A second said that "management prefers to have more part-time employees so they don't have to pay benefits and they have less rules to bind them in regards to scheduling."

A few nurses said that they had lost their seniority due to hospital closings or because of hospital amalgamations, and that they were limited to part-time work as a result. One nurse's comment indicated seniority was not a guarantee of a full-time position, "[There are] no permanent positions available [because] most of the full-time [nurses] and myself are the same age, 40-50."

A few nurses said that they did not have the training required to obtain a full-time position in their hospitals. One RPN said she wanted to return to school to become an RN because "there are more RN positions. If it was easier to upgrade, I would." A few others said that they could not obtain full-time work in the unit they preferred to work in.

Reasons for voluntary part-time or casual nursing employment: RNs and RPNs had similar reasons for choosing part-time and casual work in nursing. The most common reason was that the flexibility of part-time work allowed them to meet family responsibilities such as providing child care, sharing child care with their spouse, spending time with a retired spouse, caring for an aging parent, or working in a family business including farming.

Other reasons given by RNs and RPNs for working part-time or casual included personal preferences, because their health did not allow them to handle the stress of full-time nursing work, for the enjoyment of nursing, avoiding work politics, and increasing or decreasing variety in their work. A handful said that they worked part-time while attending school, and one mentioned that the stress of a two or more return trip to work was a deterrent to working full-time.

Both RNs and RPNs mentioned that they chose to work part-time to increase their income. This is possible in nursing because full-time nurses are offered benefits, while part-time nurses are offered 13% extra income in lieu of benefits. This 'either-or' relationship of benefits to full-time and part-time employment was mentioned as a deterrent for part-time work by some full-time nurses who could be considered involuntarily employed full-time. It could also be considered a deterrent to full-time work for some part-time nurses.

Suggestions from nurses on how small hospitals could assist nurses to achieve their preferred employment status

Suggestions from casual nurses on how hospitals could help them achieve their desired employment status included cross-training nurses to work in more than one unit to increase full-time job positions, increasing staffing for the entire hospital by adding one nurse to the day and night shifts, allowing job share positions, creating weekend worker positions, and providing guaranteed hours of work. One RPN said that "considering budget restrictions and union protocols, there really is nothing the employer can do to increase hours or change status to part time."

Suggestions from part-time RNs on what their employers could do to help them find full-time work fell into 4 themes: creating more full-time positions, changing scheduling practices,

providing part-time nurses with the option of having benefits rather than payments in lieu of benefits, and changing collective agreement contracts. The most common mentioned suggestion for RPNs was that their employers could create more full-time positions.

Many part-time RNs indicated that their hospitals had low turnover and full-time positions did not become available very often. A number of part-time RNs and RPNs said they would be content with their employment status if they had benefits. Others suggested that more government funding was needed to support their employers' creation of full-time positions or that their employer should allow senior nurses who were interested in partial retirement the opportunity to work in a casual or job share position. Some suggested methods of creating more full-time positions: weekend worker positions, cross-training to allow nurses to work in several nursing departments, and increasing the number of full-time positions by decreasing the number of hours part-time nurses were expected to work. Some RPNs also suggested that full-time positions could be increased if their employers stopped employing unregulated health care workers.

Some RPNs gave reasons for why they wanted the number of full-time positions increased and these fell into two broad themes: high workload and the desire to work their full scope of practice. This suggests that for a group of RPNs, working a full-scope of practice was an important employment preference.

A few RNs indicated that a change in their collective bargaining agreement would help them achieve their preferred employment status. Mentioned changes included awarding full-time jobs by a combination of experience within a unit and seniority rather than by seniority alone, and harmonizing the collective bargaining agreements in nearby hospitals. Harmonized collective bargaining agreements could permit part-time nurses to work full-time hours in two separate hospitals, or assist with the creation of a full-time position if hospitals created a shared full-time position. Neither of these last two solutions, however, would create a full-time position that might contribute increased continuity of care in a unit or hospital.

Full-time nurses suggested that their employers could help them achieve their preferred employment status by providing part-time nurses with benefit packages or creating more job share positions.

What do part-time and casual nurses think small hospital employers need to do to encourage them to work full-time? Part-time and causal nurses were also asked what their hospital could do to encourage them to work full-time. Both RNs and RPNs suggested that employers needed to offer improved working conditions, improved schedules, as well as increase the number of full-time positions. A number of RNs wanted benefit packages changed while RPNs suggested a range of incentives that could interest them in working full-time. A few RNs and RPNs said that they were not interested in full-time work at the present time.

Suggestions for improving work conditions included comments about workload and management. RNs suggested that workload could be improved if their employer created a better staffing ratio, decreased the work load, clearly defined the workload, asked them to work less overtime, and allowed vacation requests. RPNs also asked for more staff, especially when the workload was heavy, and an increased number of volunteer workers. Some nurses said they

wanted management to show more respect and appreciation for nurses, especially when the workload was heavy. Others mentioned a desire for greater job security. A couple of responses were related to multi-site hospitals: a few RPNs said they wanted to be able to maintain their seniority when hospitals were amalgamated.

New suggestions for increasing full-time positions included an analysis of overtime by employers because the "number of hours paid out in overtime to cover shifts… would probably pay for full-time positions." A number of nurses thought the availability of full-time positions would improve if hospitals offered early retirement packages based on years of service or age. Some nurses thought that a reduced number of job share positions would increase full-time while other thought that increasing "job sharing positions would be a fiscally wise move."

Some nurses wanted changes in the benefits packages; the most common suggestion was that full-time nurses be allowed to have increased income in lieu of benefit packages. Other suggestions included improved benefits packages or a better pension package.

Improved scheduling was mentioned more often by RNs than RPNs. The most commonly mentioned change for RNs was to be allowed to work in a 0.9 or 0.8 FTE position and still receive benefits. Other changes included self-scheduling, regularly scheduled rotations, and fewer weekends. RNs and RPNs wanted fewer night shifts or the ability to work their preferred shifts. Some preferred 12 hour shifts while others preferred 8 hours shifts.

Other suggestions from RPNs on what could be done to encourage them to work full-time included: utilizing RPNs in day surgery, ambulatory care units and emergency departments, and increasing training opportunities to allow this to occur, ending the use of unregulated health care workers, and on-site child care.

5.4 What challenges and opportunities did Chief Nursing Officers face while implementing the 70% full-time employment target?

In-depth interviews were conducted with a convenience sample of Chief Nursing Officers to understand the range of challenges and opportunities they faced when implementing the 70% full-time employment target. The sample was selected to represent the distribution of small hospitals by size, region, and success rate with the 70% full-time target. See Appendix 3 for more details on the findings.

Very few small hospitals in Ontario have met the employment goal of having of 70% of their annual nursing hours worked by full-time nurses. The handful (8) of successful small hospitals were located in Northern Ontario and may be funded differently due to their location.

Chief Nursing Officers reported a variety of barriers to meeting the 70% full-time employment target including: the small number of nurses needed to staff a small hospital, the availability of nurses interested in working in small hospitals, and scheduling and hiring conditions set by unions and government. No single barrier was related to Chief Nursing Officers' decisions concerning a hospital's full-time/part-time ratio of nurses. Rather it was the **combination** of

barriers and associated factors that created a particular context within which hospital administrators made decisions about full-time and part-time employment.

For example, the supply of nurses was discussed in terms of nurses availability for work, but the meaning of "availability" varied according to the location of the hospitals and the characteristics of the community. Chief Nursing Officers of remotely located small hospitals were more likely to discuss the supply of nurses in terms of a small number of nurses in the community, while Chief Nursing Officers of small hospitals located close to an urban centre might say that the availability of nurses in their community was limited because of competition with larger hospitals that could offer more specialized positions and were more likely to have full-time positions available.

Availability was also said to be related to the preferences of nurses for one employment status over another. It might be possible that a full-time position in a small hospital could not be filled because nurses in the community preferred part-time work and the location of the hospital made recruitment of nurses to the area challenging. Under such a scenario, it would be difficult for a small hospital to achieve the goal of 70% annual nursing hours provided by full-time nurses. On the other hand, if there were a sufficient supply of nurses in the community, and enough were interested in full-time work should it be available, then those two factors would contribute to reaching the 70% employment goal.

Rural nursing was described as qualitatively different from urban nursing, and these differences were said to negatively impact the availability of nurses. Many Chief Nursing Officers said that rural nurses were generalists who often worked alone or in a number of different units. This increased level of responsibility for patient care diminished their willingness to be recruited to work in small hospitals. Distance was another often mentioned barrier to recruitment and retention.

Many of the collective agreements set conditions on scheduling nurses that varied by full-time or part-time employment status. For example, a local contract might place conditions on the number of day and night shifts a full-time nurse was expected to work during a two-week pay period. When the total number of staff was small, say for a 20 or 25 bed hospital, then a two week schedule might only have 3 or 4 sets of shifts that met the conditions specified for full-time nurses. As a result, the rest of the shifts had to be filled by part-time or casual nurses.

Funding agreements with MOHLTC also limited the number of full-time nurses for small hospitals. Chief Nursing Officers wanted to add or drop nurses quickly in order to fulfill funding agreements with MOHLTC to staff their hospitals efficiently. Efficient staffing might limit the number of nurses on a night shift to two or three in a very small hospital, and there might not be many more during the day. Collective bargaining agreements made it easier to send part-time nurses home during dips in a hospital's patient census. Therefore, increasing the number of full-time nurses made efficient staffing more difficult. Some Chief Nursing Officers viewed the baseline staffing requirements for efficient staffing as potentially detrimental to patient and staff safety; hospitals that regularly staffed their units with higher nurse-to-patient ratios, however, were deemed inefficient. Over half of Chief Nursing Officers indicated that they viewed staffing efficiently and increasing the proportion of full-time staff as contradictory policy goals.

Chief Nursing Officers reported that having extra nurses at work during periods with few patients was very helpful in getting support tasks completed, such as chart reviews, infection control or help in the pharmacy. Allowing hospitals to include support activities in calculating the full-time percentage of nurses might encourage the creation of full-time positions that included direct care and nursing support work.

Chief Nursing Officers reported age as a factor that limited the number of full-time positions in their hospitals. Full-time positions were most likely to be held by nurses ages 45 to 55. Collective agreements restricted access to full-time positions by seniority, which limited Chief Nursing Officers ability to recruit new nursing graduates since they prefer full-time employment. Chief Nursing Officers also said they needed a plentiful pool of part-time nurses to fill shifts left open by vacations, sickness, and leaves of absence (LOAs). The overall small size of their staff meant that when Chief Nursing Officers converted the number of part-time nurses they felt were necessary into a percentage, the percentage was higher than 30%.

Scope of practice was another factor that was sometimes reported as a barrier to meeting the 70% target. Findings in Appendix 2 show that 22% of RPNs live in rural and small towns with populations of 10,000 or less, as compared to about 13% of the general population and about 12% of RNs. A hospital in a rural area might employ more RPNs because of their greater availability compared to RNs. If the hospital had an emergency department, however, RNs were necessary because they were better able to meet that scope of practice. Therefore, a relatively small number of RNs might have full-time work, while a large percentage of the RPNs might have part-time work so that the hospital had nurses to call to fill in for vacation or sick time.

Chief Nursing Officers reported a number of concerns about developing full-time positions. Many expressed frustration with funding. The two chief complaints about the Nursing Enhancement Funds were that they did not cover the total cost of hiring a full-time nurse and that they were not permanent. This meant that positions recently created with Nursing Enhancement Funds were often expanded part-time positions that were vulnerable to being cut should overall funding change.

And hospital funding *is* changing: at present there are a variety of funding streams to hospitals, including a new two year funding agreement known as the Hospital Accountability Agreements (HAAs). Chief Nursing Officers were unclear if the current measure of efficiency will continue to be used to fund hospital nurse staffing, or if it will be replaced by HAA performance indicators. Chief Nursing Officers wondered how the HAA balanced budget performance standard would effect implementation of the 70% full-time employment policy at their hospitals. The Hospital Funding Committee, which advices the Joint Policy and Planning Committee on issues related to hospital funding, has stated that the "development of strategies to enhance harmonization across various Ministry funding streams" is necessary (Joint Policy and Planning Committee 2006)

Finally, all Chief Nursing Officers mentioned that at present they have low turnover in their workforce of full-time senior nurses in their late 40s and early 50s; these nurses, however, are expected to start retiring in about 5 years. Several Chief Nursing Officers were concerned that

they would soon face a nursing shortage of experienced nurses because they could not presently recruit and train new graduates without full-time positions. New graduates want full time work, yet lack the necessary seniority to obtain in unionized workplaces with low turnover. Other Chief Nursing Officers said that while they did not have difficulty recruiting or retaining nurses at present, they expected to have difficulties when more senior nurses began to retire, because they would not have senior nurses to mentor and train new graduates in rural nursing practice.

Chief Nursing Officers reported using a number of strategies to increase the number of full-time positions in their hospitals including temporary full-time, job-shares, and bundled positions. Bundled positions combined a number of different part-time positions in different areas into a single full-time position, such as occupational health and infection control or a position in the medical surgical unit with a float position in the Emergency Department. Bundled positions required experienced, versatile nurses. A job share was a position where two or more nurses shared a single full-time position. Some Chief Nursing Officers conducted workload and overtime analyses to determine if adding a full-time position would be financially advantageous to a unit. Chief Nursing Officers reported they created one or two new full-time positions for their small hospitals using these strategies.

This section presented some of the factors inherent in being a small hospital in rural and remote Ontario, and described how those factors created local conditions that influenced Chief Nursing Officers decisions about full-time and part-time employment in their hospitals. It also highlighted strategies used to create new full-time positions.

5.5 What did the focus groups think about the results of the study?

Two focus groups met to assess the findings from the secondary analyses, Chief Nursing Officer interviews and the survey of rural nurses working in small hospitals.

First Focus Group: The focus group of senior hospital administrators felt that two aspects of scheduling were most important in understanding the challenges Chief Nursing Officers faced in increasing the proportion of full-time nurses. The first was the need for enough part-time nurses to cover shifts not worked by full-time nurses and to cover shifts left open by nurses on vacation, sick leaves, or LOAs. The second aspect was the need for flexibility in scheduling nurses. Focus group members agreed that the different conditions that union contracts placed on scheduling full-time and part-time nurses made it more difficult to staff small hospitals with more full-time nurses because of large changes in the number of in-patients that might require adding or dropping a nurse on short notice. Members did not focus on how funding regulations concerning efficient staffing interacted with collective bargaining agreements to make hiring part-time nurses more attractive. They did agree that staffing for efficiency and patient safety was a challenge.

This focus group spent much of the discussion time on the lack of full-time positions hindered their ability to recruit and retain new nursing graduates in their small hospitals. There was concern that a lack of new nursing graduates will create a nursing shortage for small hospitals when the present cohort of full-time nurses begins to retire in the next 5 to 10 years. Some Chief Nursing Officers indicated interest in full-time cross-site positions, though the barriers to using

these positions seem high. Key difficulties to cross-site positions were how full-time hours would be counted between hospitals, how weekend shifts would be coordinated between hospitals, and how issues surrounding infection control of contagious illness made these positions less desirable.

Second Focus Group: The second focus group of nursing stakeholders concentrated their discussions on how size and rural location affected the supply of nurses for small hospitals, the need for part-time nurses in small hospitals to cover vacations, sick time, and LOAs, and how provisions in collective agreements could be used to enable the creation of more full-time positions in small hospitals.

There was general consensus from both focus groups that the findings accurately portrayed the challenges and opportunities of implementing the 70% employment policy in small hospitals. Recommendations from the focus groups have been added to the Chief Nursing Officers recommendations.

6.0 DISCUSSION

Findings from the study indicated that the availability of nurses looking for work in small hospitals is limited and that rural nurses do not have access to as many full-time positions as urban nurses do. There were not many nurses seeking employment overall, and many census divisions surrounding small hospitals had very few or no nurses seeking employment. Those that were seeking employment were older. Other studies have found that younger nurses are seeking employment in urban centres where they can obtain full-time work (Baumann et al. 2006).

Nevertheless, findings also suggested that there were a substantial number of part-time nurses working in small hospitals who preferred full-time employment should it become available. The survey findings implied that between 10% and 38% of part-time RNs and between 20% and 50% of part-time RPNs working in small hospitals wanted full-time employment.

Chief Nursing Officers indicated that small hospitals did face barriers to increasing full-time employment; some barriers were intractable, others could be lowered. The high level of responsibility that a nurse assumes when working in a rural or remote hospital is a fact of life; rural and northern communities are small and so are the hospitals that serve them. Nursing staff turnover is low. There are limits on the availability of nurses in more rural and remote parts of the province. There are very few or no nurses looking for work in some rural municipalities. Most of these barriers can't be lowered by means of public policy.

But policies could be modified to take size and location of hospitals into account. The implementation of the 70% full-time employment target for the first two-year planning cycle of the Hospital Accountability Agreements can be further modified for small hospitals by lowering the performance corridor (JPPC 2005b). Funding streams tied to efficiency can be harmonized with improved full-time employment opportunities. There should be training sessions on how collective bargaining agreements can be used to increase full-time positions. The goals of efficiency, safety, and more full-time employment could be made to work together to improve

patient care and nurses' work environments. Funding and other types of support for employing new nursing graduates full-time can be implemented.

7.0 RECOMMENDATIONS

On the basis of discussions with some Chief Nursing Officers and in focus groups, the following recommendations are made concerning the implementation of the 70% full-time employment policy. Fifteen of the recommendations are directed to government, five to hospitals and nurses, and two to unions.

RECOMMENDATIONS TO GOVERNMENT

Policies for Rural and Northern Hospitals

1. **Policy makers need to consider size and location of hospitals when making policies.** Small hospital size and low nursing staff turnover may necessitate different or more flexible policies for rural hospitals. Different strategies may be necessary to assist rural hospitals to meet the same policy goals as urban hospitals.

2. **The target of 70% annual nursing hours worked by full-time nurses should be lowered for small hospitals.**
   Suggestions for a realistic target for small hospitals ranged from 50% to 67%. One of the consequences of having a small staff was the fact that the percentage of full-time nurses could be affected by very small changes in staff employment.

3. **Make the time frames for implementing new policies more flexible.**
   Measuring positive changes in the percentage of full-time nursing hours over an extended time line is more realistic than setting a firm deadline.

4. **Create a provincial network of small hospital Chief Nursing Officers, using teleconferences or web portals to facilitate sharing of innovative ideas to discuss and solve common problems.**

Funding

5. **Reconcile the definition of efficient staffing with the 70% full-time employment policy.**
   Staffing small hospitals efficiently and increasing the percentage of full-time nurses could be contradictory goals given the small number of patients their hospitals served and the small nursing staff.

6. **Increase Nursing Enhancement Fund allotments to hospitals so that they cover the entire cost of a full-time position for an RN or RPN.**
   The Nursing Enhancement Funds are most useful when used to expand existing part-time positions into full-time positions, but the funding allocations for small hospitals are not sufficient to create entirely new full-time positions, nor do they address long-term funding

for maintaining newly created full-time positions. More government funding may be required to increase full-time positions for nurses, as well as to maintain a balanced budget to fulfill agreements with MOHLTC to staff small hospitals efficiently and to be able to cancel staff on short term notice because of variability in the number of inpatients.

Funding for Future Needs

7. **Use the Nursing Strategy to establish a funding program to support full-time leadership positions for nurses.**
   Rural nursing practice requires generalists: experienced versatile nurses able to work in a number of areas. There is a need to develop clinical nursing leadership for mid-career nurses working in small hospitals so that they can precept, mentor and coach existing nursing staff, new graduates, and nursing students. Full-time leadership positions will help retain experienced mid-career nurses already working in small hospitals, increase the percentage of full-time nurses overall, and recruit and develop the supply of younger nurses that will be required as more senior nurses begin retiring in the next 2 to 10 years.

8. **Establish a funding program to create long-term full-time positions for new nursing graduates to work in small hospitals.**
   Rural nursing practice is mostly learned on the job. New graduates who want full-time work are most likely to find full-time work in urban hospitals. Low turnover in unionized workplaces means that full-time positions in small hospitals go to senior nurses. Long-term full-time positions are required to recruit new nursing graduates to small hospitals and to train them as nurse generalists.

9. **Establish a funding program in the Nursing Strategy to support full-time summer internship positions for nursing students to work in small hospitals.**

10. **Establish a funding program to create full-time nursing positions for work that isn't direct patient care.**

11. **Include continuing education for nurses as a budget item for hospitals to support development of nurses for full-time clinical and managerial positions.**
    The high average age of full-time nurses suggests that many may wish to retire or move to part-time positions in the next five years, yet their experience is vital to mentoring younger nurses. Likewise, continuing education for nurses between the ages of 35 and 50 will allow them to develop clinical and managerial skills necessary to provide full-time leadership as the 'Boomer' cohort of nurses begin to retire.

Safety

12. **Reconcile patient and staff safety with efficiency by increasing baseline nurse-patient staffing ratios in funding agreements.**
    When baseline staffing is set at an absolute minimum to guarantee efficiency, any surge in the number of patients requiring care, or violent behaviour from patients, patient families or

staff, can create an unsafe environment for patients and nursing staff. A standardized nurse-patient ratio would be beneficial in justifying the 70 full-time employment policy.

Sharing Full-Time Nurses in Rural and Remote Healthcare Organizations

13. **Allocate funding to create a centralized replacement call centre for a region or the province to assist with filling open shifts, thereby allowing small hospitals to create more full-time positions.**
    A pool of part-time nurses is considered vital in small hospitals to fill shifts left open by sickness, vacations, and leaves of absence. More full-time positions might be created in individual hospitals if nurse managers could rely on a centralized call centre to fill open shifts rather than maintaining a large pool of part-time nurses. Nurses could registered with the call centre to work in specific hospitals. Nurse managers could call their vacancies in and the call centre could match nurses with the hospital's need.

14. **Increase the percentage of full-time nurses by creating full-time positions that serve more than one health care sector.**
    Some part-time nurses in small hospitals work in more than one sector (e.g., community care, long-term care, public health) to have full-time hours. Full-time nursing positions that span health care sectors could "bridge" patients' movement between sectors, such as between hospitals and home care or long-term care (Arundel and Glouberman 2001; Alcock et al. 2002).

Broaden the Definition of Who is Counted as a Full-Time Nurse for Small Hospitals

15. **Change the definition of full-time to include: nurses in full-time management positions, full-time job-shares, full-time temporary positions, or count full-time nurses differently in small hospitals.**
    Allow hours worked by full-time nurses in management, temporary full-time positions, job shares, and support positions such as infection control, occupational health, and telehealth, to be counted in calculating the percentage of full-time nurses.

RECOMMENDATIONS TO HOSPITALS AND NURSES

Many of the recommendations to government also applied to hospitals and nurses. Strategies and recommendations to government that were also appropriate for hospitals and nurses are listed below.

Hospitals

1. **Develop dialogue around staffing for patient safety and not just for efficiency.**
   Some Chief Nursing Officers felt that variability in the numbers of patients, coupled with a very small staff at night, presented safety issues for patients and staff at times.

2. **Open discussions between administration and unions about creating flexible full-time positions.**
   Chief Nursing Officers said that meeting scheduling obligations for full-time staff made it difficult to staff efficiently, which could affect their funding from the government. A number of Chief Nursing Officers recommended on-going discussions between hospital administration and collective bargaining units on the subject.

3. **Work with other hospitals to create full-time cross-site positions.**
   Shared full-time positions could assist small hospitals in finding replacement nurses for vacation and sick-time. Concerns to be addressed include infection control, harmonizing collective bargaining contract, costs for travel time, and burn-out due to traveling distances. Retainment of nurses may be improved by hiring nurses into in cross-site positions rather than moving currently employed nurses into them, and by covering travel costs.

4. **Work with other hospitals to create an integrated call system to create and coordinate a shared pool of nurses that could provide on-call staff with required expertise.**
   Full-time positions could be increased if nurse managers in small hospitals had a reliable way to fill vacant positions.

Staff Nurses

5. **Be supportive of flexible, bundled full-time roles.**

RECOMMENDATIONS TO UNIONS

1. **Provide training for senior administrators, local bargaining units, and nurses in small hospitals about how collective agreements could be used to enable more full-time positions.**
   There are provisions in collective bargaining agreements that could support development of full-time positions in small hospitals. Training sessions about these provisions could assist in the implementation of the 70% full-time employment target.

2. **Improve partnerships with hospitals to enable the creation of more full-time positions by addressing variability in acuity and in patient flow in collective bargaining agreements.**

8.0 REFERENCES

Alcock, D, E Gallagher, E Diem, D Angus, J Medves. (2002). Decision-Making: Home Care or Long Term Care Facility. National Evaluation of the Cost-Effectiveness of Home Care, Substudy 6. Prepared for the Health Transition Fund, Health Canada. Retrieved December 13, 2005. http://www.coag.uvic.ca/documents/research_reports/home_care_decision-making_home_care_long_term_care.pdf

Andrews, ME, NJ Stewart, J Pitblado, DG Morgan, D Forbes, and C D'Arcy. (2005). Registered Nurses Working Alone in Rural and Remote Canada. *Canadian Journal of Nursing Research* 37(1): 15-33.

Arundel, C, S Glouberman. (2001). *An Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care.* National Evaluation of the Cost-Effectiveness of Home Care, Substudy 15. Prepared for the Health Transition Fund, Health Canada by the National Evaluation of the Cost-Effectiveness of Home, the Centre on Aging [University of Victoria] and Canadian Policy Research Networks. Retrieved December 13, 2005. http://www.cprn.org/en/doc.cfm?doc=155

Baumann, A, J Blythe, K Cleverley, and D Grinspun. (2006). *Educated and Underemployed: The Paradox for Nursing Graduands*. Hamilton, ON: Nursing Health Services Research Unit, McMaster University.

Baumann, A, J Blythe, J Underwood, and J Dzuiba. (2004). *Capacity, Casualization, and Continuity: The Impact of SARS*. Hamilton, ON: Nursing Health Services Research Unit, McMaster University.

Blythe, J, A Baumann, I Zeytinoglu, M Denton, and A Higgins. (2005). Full-time or Part-Time Work in Nursing: Preferences, Tradeoffs and Choices. *Healthcare Quarterly* 8(3): 69-76.

Burke, RJ, and ER Greenglass. (2001). Effects of hospital restructuring on full time and part time nursing staff in Ontario . *International Journal of Nursing Studies* 37(2): 163-171.

Bushy, A and A Bushy. (2001). Critical Access Hospitals. *Journal of Nursing Administration* 31(6): 301-310.

CIHI. (2001). *Supply and Distribution of Registered Nurses in Canada, 2000*. Ottawa, ON: Canadian Institute for Health Information.

CIHI. (2005a). *Workforce Trends of Licensed Practical Nurses in Canada, 2004*. Ottawa, Ontario: Canadian Institute for Health Information.

CIHI. (2005b). *Workforce Trends of Registered Nurses in Canada, 2004*. Ottawa, ON: Canadian Institute for Health Information.

CIHI. (2006). *Measuring the Retention of Registered Nurses in Canada: A study of 2000-2004 Registration Data*. Ottawa, ON: Canadian Institute for Health Information.

CNAC. (2002). O*ur Health, Our Future: Creating Quality workplaces for Canadian Nurses, Final Report of the Canadian Nursing Advisory Committee.* Advisory Committee on Health Human Resources.

College of Nurses of Ontario (CNO). (2006). Membership Statistics Data Query Tool: Work Status of RNs and RPNs from 1992-2005. Retrieved July 21, 2006. http://www.cno.org/about/stats/dqt_disclaimer.htm.

College of Nurses of Ontario (CNO). (2005). *Membership Statistics Report 2005*. Toronto, Ontario: College of Nurses of Ontario.

du Plessis, V., Beshiri, R., Bollman, R. D., and Clemenson, H. (2002). Definitions of "Rural". Rural and Small Town Canada Analysis Bulletin 3(3): Ottawa, ON: Statistics Canada Catalogue no. 21-006-XIE.

Feldman, DC. (1990). Reconceptualizing the Nature and Consequences of Part-Time Work. *Academy of Management Review* 15(1): 103-111.

Gibb, H, J Anderson, and K Forsyth. (2004). Developing support for remote nursing educating through workplace culture that values learning. *Australian Journal of Rural Health* 12: 201-205.

Gibb, H, K Forsyth, and J Anderson. (2006). Culture of Rural Nursing Practice: A Critical Theoretical Analysis of Determinants of Power in Nursing. *Australian Journal of Advanced Nursing* 23(2): 34-39.

Grinspun, D. (2003). Part-time and Casual Nursing Work: The Perils of Healthcare Restructuring. *International Journal of Sociology and Social Policy* 23(8/9): 54-70.

Hegney, D. (1998). Disciplinary power and its influence on the administration and supply of medications by nurses in rural areas of Australia. *International Journal of Nursing Practice* 4: 144-150.

Henderson-Betkus, M and M MacLeod. (2006). Retaining Public Health Nurses in Rural British Columbia. *Canadian Journal of Public Health* 95(1): 54-58.

Hiscott, RD. (1997). Changes in Employment Status: The Experiences of Ontario Registered Nurses. *Canadian Journal of Nursing Research 26*(2): 43-60.

Hoffman, A J, and LD Scott. (2005). Role Stress and Career Satisfaction Among Registered Nurses by Work Shift Patterns. *Journal of Nursing Administration* 33(6): 337-342.

Huntley, B. (1995). Factors influencing recruitment and retention: Why RNs work in rural and remote area hospitals. *Australian Journal of Advanced Nursing* 12(2): 14-19.

Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee. (2001). *Good Nursing, Good Health: A Good Investment. Progress Report on the Nursing Task Force Strategy in Ontario*. Toronto, ON: Ministry of Health and Long-Term Care.

Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee (2003). *Good Nursing, Good Health. The Return on Our Investment, Progress Report*. Toronto, ON: Ministry of Health and Long-Term Care.

JPPC. (2005a). Ontario Hospitals by Ministry of Health Planning Region. Joint Policy and Planning Committee website. Retrieved 13 April 2005. http://www.jppc.org/

JPPC. (2005b). *A Primer on Performance Indicators and Standards for Use in the 2005/06 and 2006/07 Hosital Accountability Agreement.* Toronto, ON: Joint Policy and Planning Committee.

JPPC. (2006). *Summary Report of the Hospital Funding Committee on the Use of 2004/05 Cost and Activity Data*. Toronto, ON: Joint Policy and Planning Committee.

Keddy, B, F Gregor, S Foster, and D Denney. (1999). Theorizing about nurses' work lives: the personal and professional aftermath of living with healthcare 'reform'. *Nursing Inquiry* 6 58-64.

Kenny, A and S Duckett (2003). Educating for rural nursing practice. *Journal of Advanced Nursing* 44(6): 613-622.

Kulig, J. (2005). *What educational preparation do nurses need for practice in rural and remote Canada?*

Laschinger, HKS, JA Sabiston, J Finegan, and J Shamian (2001). Voices from the trenches: Nurses' Experiences of hospital Restructuring in Ontario. *Nursing Leadership* 14(1): 1-14.

MacLeod, M. (1998). *"We're It": The Nature of Nursing Practice in Very Small Rural and Remote Hospitals in Northern British Columbia*. Prince George, BC: UNBC.

MacLeod, ML, JC Kulig, NJ Stewart, and JR Pitblado. (2004). *The Nature of Nursing Practice in Rural and Remote Canada*: Final Report Canadian Health Services Research Foundation. Retrieved September 3, 2005. http://www.ruralnursing.unbc.ca/reports/study/RRNFinalReport.pdf

McGillis Hall, L, D Kiesner. (2004a) *We hear, but do we listen? Nurses Voices from Ontario.* Retrieved 2 August 2006. http://www.nursing.utoronto.ca/lmcgillishall/research/QWENFinal%20Report%20dec2004.pdf

McGillis Hall, L, D Doran, S Sidani, L Pink. (2004b). Development and Testing of Quality Work Environments for Nurses. Retrieved 2 August 2006.
http://www.nursing.utoronto.ca/lmcgillishall/research/QWENFinal%20Report%20dec2004.pdf

McGillis Hall, L, DI Irvine, GR Baker, GH Pink, S Sidani, L O'Brien-Pallas, GJ Donner. (2002). Nurse Staffing and Work Status in Medical, Surgical and Obstetrical Units in Ontario Teaching Hospitals. *Hospital Quarterly* 5(4):64-69.

McGillis Hall, L. (2005). Nurse Staffing. In L. McGillis Hall (ed.) *Quality Work Environments for Nurse and Patient Safety.* Sudbury, MA: Jones and Bartlett.

Nursing Task Force. (1999). *Good Nursing, Good Health: An Investment for the 21st Century.* Retrieved July 26, 2006. http://www.health.gov.on.ca/english/public/pub/ministry_reports/nurserep99/nurse_rep.html

Ontario Ministry of Health and Long-Term Care (MOH LTC). (2004). Hospital Allocations Announcement: St. Michael's Hospital, Toronto. Speaking Notes Presented by George Smitherman, Minister of Health and Long-Term Care Retrieved May 8, 2006. http://www.health.gov.on.ca/english/media/speeches/archives/sp_04/sp_072604.html

O'Brien-Pallas, L, C Alksnis, S Wang, GT Murphy, and R Meyer. (2003). Trouble on the horizon: nursing human resources in Ontario, Canada. *International Nursing Perspectives* 3(2): 85-94.

O'Brien-Pallas, L, D Thomson, C Alksnis, M Luba, A Pagniello, KL Ray, R Meyer. (2003). *Stepping to success and sustainability: An analysis of Ontario's Nursing Workforce.* University of Toronto: Nursing Effectiveness, Utilization, and Outcomes Research Unit.

O'Brien-Pallas, L, D Thomson, L McGillis Hall, G Pink, M Kerr, S Wang, X Li, and R Meyer. (2004). *Evidenced-based Standards for Measuring Nurse Staffing and Performance*. Ottawa, ON: Canadian Health Services Research Foundation.

Pitblado, JR. (2006). "So what do we mean by 'rural,' 'remote,' and 'northern'?" *Canadian Journal of Nursing Research* 37(1): 163-168.

Pitblado, JR, JM Medves, and NJ Stewart. (2005). For Work and For School: Internal Migration of Canada's Rural Nurses. *Canadian Journal of Nursing Research* (37): 102-121.

Pitblado, RJ, J Medves, M MacLeod, N Stewart, J Kulig. (2002). *Supply and Distribution of Registered Nurses in Rural and Small Town Canada, 2000*. Ottawa, ON: Canadian Institute for Health Information.

Pong, RW. (2000). Rural Health Research in Canada: At the Crossroads. *Australian Journal of Rural Health* 8 261-265.

Pong, RW and JR Pitblado. (2001). Don't take "geography" for granted! Some methodological issues in measuring geographic distribution of physicians. *Canadian Journal of Rural Medicine* 6(2): 103-112.

Pyper, W. (2004). "Employment trends in nursing." *Perspectives on Labour and Income, November 2004*; catalogue no. 75-001-XIE. Ottawa, ON: Statistics Canada.

Registered Nurses' Association of Ontario (RNAO). (2000). *Ensuring the Care Will Be There: Report on Nursing Recruitment and Retention in Ontario*. Toronto, ON: Registered Nurses Association of Ontario.

Registered Nurses' Association of Ontario (RNAO). (2001). Earning Their Return: When & Why Ontario RNs Left Canada, and What Will Bring Them Back. Toronto, ON: Registered Nurses Association of Ontario.

Registered Nurses' Association of Ontario (RNAO). (2003). *Survey of Casual and Part-time Registered Nurses in Ontario*. Toronto, ON: Registered Nurses Association of Ontario.

Rosenberg, JP and DF Canning. (2004). Palliative care by nurses in rural and remote practice. *Australian Journal of Rural Health* 12 166-177.

Rukholm E. (2006). Northeastern Nursing Recruitment and Retention Study. Toronto, ON: Ministry of Health and Long-Term Care.

Squires, A. (2005). New Graduate Orientation in the Rural Community Hospital. *Journal of Continuing Education in Nursing* 33(5): 203-209.

Stewart, N, C D'Arcy, R Pitblado, D Forbes, D Morgan, G Remus, B Smith, and J Kosteniuk. (2005). *Report of the National Survey of Nursing Practice in Rural and Remote Canada*. Saskatoon, SK: University of Saskatchewan, Applied Research/Psychiatry and College of Nursing.

Stewart, NJ, C D'Arcy, R Pitblado, DG Morgan, D Forbes, G Remus, B Smith, ME Andrews, J Kosteniuk, JC Kulig, and MLP MacLeod. (2005). A Profile of Registered Nurses in Rural and Remote Canada. *Canadian Journal of Nursing Research* 37(1): 122-145.

Strasser, R. (2003). Rural health around the world: Challenges and solutions. *Family Practice* 20(457): 463-

Tepper, J. D., Schultz, S. E., Rothwell, D. M., and Chan, B. T. B (2005). *Physician Services in Rural and Northern Ontario: ICES Investigative Report*. Toronto, ON: Institute for Clinical Evaluative Sciences.

Tilly, C. (1991). Reasons for the continuing growth of part-time employment. *Monthly Labor Review* 114(3): 10-1