

Building Quality Practice Settings: An Attributes Model

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Abstract

To practice effectively nurses need an environment that supports quality professional practice. This article describes the development of a model identifying seven (7) key system attributes of a quality practice setting. The defined attributes are essential in supporting professional practice and quality care. The Quality Practice Setting Attributes Model™ developed by the College of Nurses of Ontario in Canada provides the foundational framework for the Practice Setting Consultation Program (PSCP), a unique quality improvement approach to creating quality practice environments.

This article will be of interest to nurse leaders and practitioners who strive to create quality practice settings in an environment of change, challenge and uncertainty.

The work environment is a critical influence on the ability of a competent nurse to provide quality care. In today's increasingly complex health care world it is essential that employers strengthen their organizations by building a strong foundation that supports practitioners in delivering quality care. For nurses, such an environment encourages professional practice, and is responsive to their concerns to effectively implement and communicate change (CNO, 1998). A quality practice setting can be defined as one in which client needs are met within the quality framework mandated by the organization (Villeneuve, et al., 1995) and where nurses are supported by strong organizational attributes to meet standards of practice. A key component of achieving a quality practice setting is that employers and employees work together in a collaborative process to promote and sustain the attributes in the work environment that foster quality professional practice (Attridge & Callahan, 1990; O'Brien Pallas, Baumann, & Villeneuve, 1994).

The purpose of this article is to describe the development of a Quality Practice Settings Attribute Model from a regulatory perspective. The model identifies seven key environmental attributes that support quality professional practice.

The Quality Practice Settings Attribute Model™ was developed by the College of Nurses of Ontario (CNO) as the foundation for the Practice Setting Consultation Program, a component of the Quality Assurance Program.

The College of Nurses of Ontario is the regulatory body for 138,000 Registered Nurses and Registered Practical Nurses in the Province of Ontario, Canada. It is responsible to the public for ensuring that nurses continue to practice safely and effectively throughout their careers. CNO also has a mandate to design and implement programs that "assures the quality of the practice of the profession and promotes continuing competence among members" (RHPA, 1991). With the mandate to protect the public and promote professional growth, CNO developed a comprehensive and unique Quality Assurance Program in early 1996.

CNO's Quality Assurance Program

CNO's Quality Assurance Program is based on the assumption that a competent professional nurse, in a quality setting will practice according to standards and engage in reflective practice and ongoing learning to provide appropriate effective and ethical care that contributes to the best possible health outcome for the client (CNO, 1996). The Quality Assurance Program has three components: Reflective Practice, Practice Review, and the Practice Setting Consultation Program. Reflective Practice and Practice Review focus on nurses' individual responsibility for maintaining competence throughout their careers. The Practice Setting Consultation Program (PSCP) focuses on the practice environment in which nurses deliver care. The PSCP is a unique partnership opportunity for employers and nurses to create quality practice settings where nurses can practice according to CNO standards and legislative requirements (CNO, 1996, 2000). The PSCP assists nurses and their employers, through a continuous quality improvement process, to identify and maintain attributes in the workplace that support quality professional practice and promote a quality experience for the client (CNO, 2000). A model identifying key environmental systems attributes forms the foundation for the Practice Setting Consultation Program component of the QA Program. The Quality Practice Setting Attributes Model™ emerged from a literature review exploring quality practice and focus groups with members and key stakeholders across the province.

Literature Review

The literature review examined the quality care and systems theory literature to identify components in a work environment that facilitate quality professional practice and to guide the development of the PSCP and Quality Practice Setting Attributes Model. The types of literature reviewed focused

on quality practice issues, the work environment, and the impact of change on quality (Aiken, Smith, & Lake, 1994; Flarey, 1993; Attridge & Callahan, 1990; Berwick, 1989; Bostrom, Tisnado, Zimmerman, & Lazar, 1994; Donabedian, 1982; Lucas Leveck & Bland Jones, 1996; McGillis Hall, 1997; O'Brien Pallas & Baumann, 1992; O'Brien Pallas, Baumann, & Villeneuve, 1994; Schaeffer & Moos, 1996; Tillman, Salyer, Corley, & Mark, 1997; Tumulty, Jernigan, & Kohut, 1994).

Attridge and Callahan (1990) implemented a study to identify and prioritize the characteristics of a quality work environment as defined by nurses for nurses. They described the term "Quality of Working Life" as focusing on the relationship between individual workers and their total work environment and the design of the work environment which acknowledged, utilized and developed the multiple capabilities of people. In their study, sixty-four nurses participated in four different research workshops and identified seven categories of quality of worklife characteristics. The categories were human and other resources; characteristics of the organization; nature of nursing work; work-related benefits; collegial relationships; self-career development and acknowledgment of value.

O'Brien Pallas & Baumann (1992) developed a model to examine factors that influence nursing work life based on quality of work life literature and the complexity of nursing work life. In their model, factors that influence nurse's quality of work life are categorized as being either internal to the individual or the environment in which the nurse is employed or external to these elements (O'Brien Pallas et al., 1994). Internal factors are comprised of individual factors; social, environmental, and contextual factors; operational factors; and administrative factors. The external factors include client demands on systems, health care policy, and the labour market. Both internal and external factors influence nurse and client quality outcomes and can be classified under the four categories of individual characteristics, work design, work context and work world.

The restructuring of health care delivery systems has created dramatic changes in nurses' work environments (Tumulty et al., 1994). Changes such as a reductions in nurse staffing, introduction of unregulated care personnel, increased acuity of clients and shift of care demands from the hospital to the community are affecting nurses' ability to provide quality care (Tillman et al., 1997). Tillman et al. (1997) implemented a qualitative study to explore staff nurses' perceptions of how changes in the work environment affected their ability to implement quality professional practice. Findings indicated that loss of autonomy, decreased nursing leadership, inconsistent care delivery systems, diminishing resources and reduction of staff and support systems all impacted on their ability to provide quality care. Blegen, Goode,

and Reed (1998) examined the effect of changes in nurse staffing in the restructured environment on the quality of client care. The relationship among incidence rates of adverse patient outcomes such as medication errors, client complaints, skin breakdown, urinary and respiratory tract infections, the hours of care provided by all nursing personnel, and the proportion of those hours of care given by RNs were examined. The findings indicate that as the proportion of hours of care delivery by RNs decreased the rates of decubiti, medication errors and client complaints increased.

Donabedian's (1982) model describing the determinants of quality care and General Systems Theory guided the development of the Quality Practice Settings Attribute Model. Donabedian (1982) describes assessment of quality as a judgment concerning the process of care, based on the extent to which the care contributes to valued outcomes. General Systems Theory originated from the organismic perspective in biology during the 1920s and 30s and is a philosophy and conceptual framework for understanding and analyzing systems. A system is defined as an interrelated set of subsystems that interact to optimize output (Ridge & Bland Jones, 1999).

A healthcare environment is an example of an open system in which the system interacts with the environment. Through these interactions open systems receive input from and provide output to the environment (Ridge & Bland Jones, 1999). Open systems are characterized as having *input, throughput and output*. All three components of the open system are inextricably linked to quality, with no one factor being more important than the other (Maddox, 1999). Input is defined as the complete set of resources entering into the system to provide care and the more stable arrangements under which care is produced (Donabedian, 1982; Ridge & Bland Jones, 1999). Input needs to be described in terms of its prominent attributes. In the development of the PSCP and Quality Practice Settings Attribute Model, some of the salient input attributes that were considered were the care delivery processes, communication systems, and the work environment. Throughput refers to processes within a system or subsystem that are used to transform inputs and move the system toward reaching established goals and objectives and refers to the activities that constitute implementing the care (Donabedian, 1982; Ridge & Bland Jones, 1999). Organizational attributes and leadership were considered as influencing throughputs. Output is the end product of the system. Inputs enter into the system, are transformed within the subsystems and exported to the environment as an output. Output is intended to meet the system's purpose goals and objectives (Ridge & Bland Jones, 1999). The primary output for the PSCP and the Quality Practice Settings Attribute Model was identified as an environment that supports quality professional practice and a quality client care.

Focus Groups

In 1996, focus groups were held to gather data to develop the Quality Practice Setting Attributes Model that guides the PSCP (CNO, 1996). More than 300 nurses at 16 sites across Ontario participated. Each group was asked a number of standard questions. Examples of the questions asked were: describe aspects of your work environment that presently support the ability to implement quality professional practice; and describe what barriers are present in your work environment that impede the ability to implement quality professional practice. Content analysis was used to identify common themes in the responses.

Twelve themes were identified by nurses as elements in the workplace that support or hinder their ability to meet standards of practice. The most identified theme was the presence of competent workers. The second theme related to organizational characteristics. Other themes identified in order of the number of times identified were work relations, adequate staffing, personal development, control of nursing work, other system demands, recognition, non-human support for nursing, safety, salary, and physical environment and equipment. These findings are similar to the findings by Attridge and Callahan (1990) who found that human and other resources and characteristics of the organization were the most identified themes related to quality professional practice across their four sample sites.

Quality Practice Setting Attributes Model™

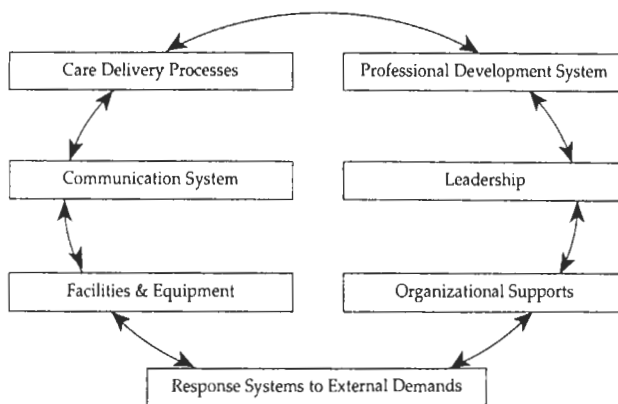
Based on the literature review and focus groups, the Quality Practice Settings Attributes Model identified seven key systems attributes (See Figure 1) in the work environment that create a quality practice setting. The seven attributes are Care Delivery Processes, Communication Systems, Facilities and Equipment, Leadership, Organizational Supports, Professional Development System, and Response Systems to External Demands. The elements and definitions for each of the attributes is provided in Table 1.

A central notion of systems theory is that changes to one part of the system impact other parts of the system. Systems are dynamic and synergistic. Mauksch and Miller in 1981 noted the interdependence of components of the health care system required in achieving quality care. Through the review of the literature and focus groups a quality practice environment was confirmed to be interactive and constantly changing. The College's Quality Practice Setting Attributes Model illustrates that the attributes are dynamic and synergistically create a quality practice setting.

1. Care Delivery Processes

The Care Delivery Processes Attribute facilitates and supports the delivery of nursing care/ programs/services to clients including planning and providing clinical care/services with other health professionals to meet client needs. Elements of the attribute are illustrated through nursing care/ program delivery models, staffing ratios, staffing mix, standards of care, professional accountability and continuous quality improvement activities. The quality of professional practice literature supports the presence of this attribute in the work environment and describes its influence on nurse satisfaction and client outcomes (Aiken, Havens, & Sloane, 2000, Aiken et al., 1994; Attridge & Callahan, 1990; Bostrom et al., 1994; Tillman et al., 1997). For example, in a study by Aiken, Havens, and Sloane (2000), the findings indicated that in "magnet" hospitals where there were higher levels of nurse staffing, nurse autonomy and control over the practice setting, nurses experienced higher levels of job satisfaction, quality of care and lower levels of burnout.

Figure 1: Quality Practice Settings Attributes Model
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Attridge and Callahan (1990) identified in their study that adequacy of staffing was the most important element of a quality practice environment as the availability of adequate staffing permitted nurses sufficient time to implement nursing interventions and provide quality care. Tumulty et al., (1994) found evidence that increases in nurse to client ratio led to staff perceptions of reduced involvement in their work and reduced support from peers and supervisors.

Bostrom et al., (1994) found a relationship between the

continuity of nurses providing care and client satisfaction. The findings suggest that care delivery systems that fragment care be modified to improve the continuity of care. In a study by Tillman et al., (1997), it was found that nurses identified a lack of control over nursing practice resulting from a changing system of care delivery based on the number and mix of staff available for a given shift. Insufficient resources to support care delivery systems may fragment care and make it less effective.

Over the past few years with the changing healthcare system, there has been a trend towards changing the client-staff mix (McGillis Hall, 1998). Traditionally, registered nurses and registered practical nurses provided care for patients. However, unregulated care providers such as health care aides and personal support workers have been introduced into the healthcare setting to provide support roles for regulated care providers (McGillis Hall, 1997). Much of staff mix research is descriptive and anecdotal, and further research is still required to evaluate the ability of regulated health care providers to effectively implement quality professional practice with new staff mix ratios (McGillis Hall, 1997).

One of the elements of the Care Delivery Process Attribute is the presence of continuous quality improvement (CQI) in an organization. CQI builds upon traditional quality assurance concepts by utilizing scientific process analysis methods to assess an organization and identify opportunities for improvement (Maddox, 1999). The focus is on system wide processes and the premise is that by understanding why, how and when a process is not being successful, the organization can take action to redesign the process and improve results (Maddox, 1999).

2. Communication Systems

The Communication Systems Attribute supports the way information and decisions related to client care and services are shared internally and externally. Elements in this attribute include communication with clients and families, professional communications, information systems and technology, documentation system, communication within and between programs/ services, and conflict resolution mechanisms. Communication is a key component of a quality professional practice setting. Salyer (1995) linked good communication skills to optimal client care, indicating that poor relationships with health care team members and blocked lines of communication may adversely affect care. Grindel, Peterson, Kinneman and Turner (1996) identified that collaboration and open communication between nurses and physicians is important in sustaining a professional practice environment and linked communication positively with improved client outcomes. Flarey (1993) also discussed communication and

quality care, observing that participants in a study to evaluate the impact of a staff support group identified poor communication amongst staff as a major problem and expressed concern that poor communication could jeopardize client care. The nurses in Attridge and Callahan's (1990) research identified the importance of feedback to staff related to matters of concern, and the positive patterns of communication among all parts of the system. Rodwell, Kienzle, and Shadur (1998) identified communication practices as integral to all management practices. Their study explored the nature of organizational communication in the context of human resource management. The findings indicated that communications enhanced teamwork, job satisfaction and organizational commitment, all of which contribute to a quality practice setting.

3. Facilities and Equipment:

The Facilities and Equipment Attribute encompasses the physical environment and access to equipment and supplies that supports and increases the efficiency and effectiveness of client care/services/programs. Elements include equipment and supplies appropriate to client needs, consistent access to reliable, regularly maintained equipment and supplies 24 hours a day/7 days a week.

Studies have identified the importance of this attribute on the ability to implement quality professional practice. Nurses who participated in the research by Attridge and Callahan (1990) identified that equipment and supplies should be available, up-to-date and in good working condition. Tumulty et al., (1994) found that the physical environment influenced nurses' job satisfaction. In a study by Tillman et al., (1997) on environmental turbulence, nurses perceived that relationships with other healthcare professionals were jeopardized by the tension created when supplies and equipment were not readily available. Nurses identified that physicians' anger and the time spent searching for supplies when equipment was not available resulted in demoralization of nursing personnel and decreased the quality of nurse-physician relationships. O'Brien Pallas et al., (1994) observed that when nurses are provided with the proper equipment and supplies required to implement quality practice care, many worklife concerns disappear.

4. Leadership

The Leadership Attribute occurs at all levels within an organization, including the level of the direct care provider (CNO, 1998). Leadership contributes to improved client care and promotes professional practice by inspiring collaboration, commitment, and achievement of mutual goals. Elements included in this attribute examine the vision of the organization, participation in decision making and management style.

Leadership styles of nurse administrators contribute to the success of an organization (Murdoch Perra, 2000). In the magnet hospital literature, leadership elements were identified as a critical component in providing a quality practice setting. In magnet hospitals, it was found that the nursing leader was influential and created a visionary culture and climate in which the central core values of the organization were supported and carried out (Kramer & Schmalenberg, 1991). O'Brien Pallas et al. (1994) found that many of the influential factors in creating a quality practice environment are within the control of the nurse manager. High visibility and accessibility to staff, as well as personifying and interpreting the organization's missions, values and strategic plans to staff are all pivotal in promoting a positive work environment.

A study by Lucas Leveck and Bland Jones (1996) found that the management style of administrators explained group cohesion. Nurses who perceived a participative management style identified higher levels of group cohesion and lower levels of job stress. Their findings also indicated that decreased job stress increased the quality of nursing care (Lucas Leveck & Bland Jones, 1996). Schaeffer and Moos (1996) had similar findings in their study examining relationships between work stressors and work climate. Their results indicated work environments with more cohesion, positive relationships with supervisors, autonomy and clarity contributed to greater job satisfaction. A positive work environment fostered by strong leadership is important since negative work environments can over time erode staff's morale and lead to increases in absenteeism, turnover and poor quality care (Schaeffer & Moos, 1996).

McNeese Smith (1997) identified a direct relationship between the leadership behaviors of managers and nurses' job satisfaction, productivity and organizational commitment. In her study, nursing manager behaviors that promoted job satisfaction included giving recognition, guiding and being supportive of the team, creating a positive work environment, establishing standards for practice, and being visionary. Behaviors that resulted in decreased job satisfaction were identified as not giving recognition, being critical of performance, and not following up on issues.

In the changing health care system, leaders require skills that motivate and promote employees to self-manage (Porter-O'Grady, 1999; Spence Laschinger, Wong, McMahon, & Kaufman, 1999). In present work environments, there are continual changes in structures, services, technology and outcomes (Porter-O'Grady, 1999). Staff members who are enabled to make decisions based on their knowledge and judgment and act without seeking unnecessary permission from higher authorities is considered important to the success of work redesign efforts in hospital settings and de-

creased occupational stress and burnout (Spence Laschinger et al., 1999). Porter-O'Grady (1999) points out that nursing leaders must shift their focus from process to outcomes, facilitate resources rather than direct work, transfer skill sets rather than make decisions for staff, develop staff self-direction rather than giving direction, and facilitate equity based partnerships rather than control individual behaviors. By doing this, leadership elements of a quality practice setting will be incorporated into the organization.

5. Organizational Supports

The Organizational Supports Attribute describes the components within an organization that support the delivery of client care, services and programs. Elements include the mission, vision and philosophy statements of the organization, standards, policies and procedures that promote client safety, and quality professional practice and accountability (CNO, 1998).

The mission, vision and philosophy statements of an organization, as well as the standards and policies are indicative of the primary interests of the organization, what it stands for and the parameters that govern performance and expectations of staff (Gaye, 1997). Health care standards must be present to assess or improve safety and quality within an organization (Smith, Armann-Hutton, Inions, & Hutton, 1999). Organizational standards usually are present in the form of policies and procedures that guide the practice of members of the organization (Smith et al., 1999). Ethical standards are derived from moral principles and affirm the obligation of health professionals to provide safe and competent care (Smith et al., 1999). An ethical culture within an organization is established through formal and informal structures where staff members are encouraged to identify ethical issues in the workplace and feel comfortable to challenge standards or practices they consider unethical (Storch, 1999).

Nurses are expected to be knowledgeable, informed and accountable for their actions (Smith et al., 1999). With increased accountability, nurses also need to identify their own learning needs and how best to meet those needs. Organizations can promote and support nurses in being accountable through professional development programs (Lepine & Ahola-Sidaway, 2000).

6. Professional Development System

The Professional Development System Attribute captures more than the annual performance appraisal. It begins with hiring and includes introducing new staff into the organization, promoting continuing education and reflective practice, position specific training and promoting professional development. Elements of this attribute include orientation

programs, preceptorship and mentorship, continuing education activities, training specific to a position or role, promoting a learning environment, and a performance management process including self-assessments, peer feedback, an annual learning plan and outcomes (CNO, 1998).

The competence of healthcare professionals critically impacts on the quality and cost to an organization (Katz, 1996). Professional development for nurses is essential in order to implement quality professional practice in the rapidly changing healthcare environment. Cervero (1985) identified variables that influence professional development and change in practice such as the individual and their motivation to change. Another important variable is the work environment in which nurses practice. If the work environment is not supportive in promoting continuing professional development then there is little possibility of it being implemented.

Goodman (1997) identifies that staff development activities and the orientation process need to be restructured to maximize resources and focus on quality outcomes. The staff development educator within the organization has the responsibility to provide education that increases knowledge and practice skills for individual nurses, and promotes the growth and development of the profession (Goodman, 1997). Orientation of new staff members should be relevant to learning needs, integrated with practice and promotes collaborative partnerships (Goodman, 1997). The use of a preceptor model can facilitate the integration of new staff members into the work environment through modeling clinical expertise and acting as a coach to new orientees (Goodman, 1997).

7. Response Systems to External Demands

The Response Systems to External Demands Attribute optimize client and labour relations and respond to legislative, regulatory, health and safety, and other requirements affecting client care/services/programs including changing consumer demands and health care needs. Elements included in this attribute examine legislative, regulatory, health and safety requirements, client satisfaction, client relation programs, outreach to local communities, employee recognition programs and accreditation (CNO, 1998).

There are powerful societal forces driving changes in the healthcare system (Decter, 2000). Decter (2000) describes them as four winds of change, which are paradigm shifts, new public expectations, technology and finances. Paradigm shifts describe new ideas that are changing the way healthcare professionals and policy makers view their work. Public expectations are changing with the evolution of the knowledgeable health care consumer who wants quality, speed, choice, and appropriateness and affordability of care. With rapidly changing technology, there are continual

changes in treatment, diagnosis, information delivery and prevention. Lastly, governmental and organizational fiscal pressures continue to force health care providers to restructure, downsize and reimagine themselves (Decter, 2000).

O'Brien Pallas et al., (1994) and Tillman et al., (1997) linked external forces to the quality of nurses' working life, specifically mentioning client demands on the system, overall health care policy and the labour market. They identified that shorter hospital stays, combined with higher acuity and changing demographics have brought about significant change in the nature of client demands on the system. Healthcare policy has also impacted the quality of nursing work life through its emphasis on cost control and the subsequent restructuring of work environments.

With these external demands on the system, organizations must be able to respond to best meet the needs and demands of the public, the government, and staff while remaining fiscally responsible. One of the key constructs of continuous quality improvement is that an organization is challenged to be "customer" driven, with external customers being stakeholders within the community, regulators and accrediting bodies and the internal customers being employees, healthcare professionals and patients and families (Maddox, 1999). Both internal and external customers become the focus of service delivery and quality is based on the ability of the healthcare organization to meet or exceed customer expectations (Maddox, 1999).

Conclusion

Nurses are best able to provide quality client care when they are in an environment that supports quality professional practice. Quality practice can be subjective, and difficult to define and measure, and mean different things to different people at different times in different circumstances (HPRAC, 1999). The College of Nurses of Ontario's Quality Practice Settings Attribute Model provides a framework of key systems attributes that are essential in supporting quality professional practice. The seven key attributes of the model are dynamic and synergistic within the organization and the health care environment. Together their presence creates a quality practice setting. Using the Quality Practice Settings Attribute Model as the foundation, CNO's Practice Setting Consultation Program offers a unique opportunity to employers, nurses and the regulatory body (CNO) to work collaboratively to create workplaces that promote and support quality professional practice.

Acknowledgement

The authors gratefully acknowledge Dr. Andrea Baumann, Associate Dean Health Sciences (Nursing), McMaster

Table 1. Quality Practice Settings Attributes Model

Attribute	Definition	Elements
1. Care delivery processes	These support the delivery of nursing care/programs/services to clients ² . They include planning and providing clinical care/services with other health professionals to meet client needs.	<ul style="list-style-type: none"> • nursing care/program delivery model • staffing ratios • staffing mix • standards of care • accountability • autonomous practice • continuous quality improvement
2. Communications systems	These systems support the way information and decisions about client care/services are shared internally and externally.	<ul style="list-style-type: none"> • communication with clients and families • professional communications • information systems technology • documentation system • communication within and between programs/ services • conflict resolution mechanisms
3. Facilities and equipment	This encompasses the physical environment, and access to equipment and supplies that support and increase the efficiency and effectiveness of client care/services/programs.	<ul style="list-style-type: none"> • equipment, supplies, and support services that meet client/staff needs • reliable and regularly maintained equipment • accessibility of equipment and supplies to staff at all times (24 hrs/7 days a week)
4. Leadership	Leadership occurs at all levels within an organization, including the level of the direct care provider. This is the process of supporting others to improve care/services to clients by promoting professional practice. It involves working together, inspiring commitment, and energizing people to achieve mutual goals.	<ul style="list-style-type: none"> • vision of the organization • staff participation in decision-making • management style
5. Organizational supports	These compromise operational norms and values that facilitate the delivery of client care/services/programs.	<ul style="list-style-type: none"> • mission, values & philosophy statements of the organization • Policies and procedures • Recruitment and retention
6. Professional development system	This process is more than an annual performance appraisal. It begins with hiring and includes introducing new staff into the organization, promoting continuing education and reflective practice, position-specific training and promoting professional development.	<ul style="list-style-type: none"> • Orientation program • Preceptorship • Promotion of continuing education activities • Training specific to the position/role • Encouraging and promoting a learning environment • Performance management process, including self-assessment, peer feedback, annual learning plan and outcome • Professional practice activities (e.g. sharing research activities)
7. Response systems to external demands	These systems provide timely means for organizations to optimize client and labour relations and respond to legislative, regulatory, health and safety, and other requirements affecting client care/services/programs, including changing consumer demands and health care trends.	<ul style="list-style-type: none"> • legislated requirements • regulatory requirements • health & safety requirements • client satisfaction • client relations program • outreach to local community • employee recognition program • accreditation

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University, School of Nursing, and Co-Director, Nursing Effectiveness, Utilization, and Outcomes Research Unit – McMaster University Site, in Hamilton, Ontario, Canada for her advice, guidance and academic support.

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