



CANADIAN
NURSES
ASSOCIATION

**INVITATIONAL ROUND TABLE
NURSING CARE DELIVERY MODELS
AND STAFF MIX:
Using Evidence in Decision-making**

**OTTAWA
October 13-14, 2010**

This report was produced by CNA to provide information on a particular topic or topics. The views and opinions expressed in this report do not necessarily reflect the views of the CNA board of directors.

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“If we continue to work with current policies and delivery models, the gap between health-care needs and our ability to address them will grow.”

– *The Next Decade*, CNA (2009)

“Nursing: it’s the service nurses provide to individuals, groups and nations in many different care delivery models. Our desire is to nurse in environments and within care delivery models that offer the maximum benefit for individuals to achieve optimal healthy, productive and meaningful lives.”

– Judith Shamian, President, Canadian Nurses Association

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Introduction

On October 13-14, 2010, the Canadian Nurses Association (CNA) convened in Ottawa an invitational round table on the topic “Nursing Care Delivery Models and Staff Mix: Using Evidence in Decision-making.” The event was part of a national dialogue that the CNA Task Force on Evidence-Informed Nursing Care Delivery Models across the Continuum of Care led throughout 2010.

The round table’s overarching goal was to develop recommendations for decision-makers, health-care administrators and providers across the continuum of care aimed at accelerating the transfer into practice of knowledge related to the following:

- selection, adaptation and design of nursing care delivery models; and¹
- optimal mix and deployment of registered nurses (RNs), licensed practical nurses (LPNs)² and registered psychiatric nurses (RPNs).³

Over the course of the two-day meeting, participants heard presentations from experts in nursing research, practice, policy and administration. The meeting also included opportunities for small-group issue-focused discussions, larger question-and-answer sessions and face-to-face networking. Varying and conflicting perspectives were put forward on both the strength of the evidence presented and the relative absence of some evidence related to emerging practices.

This report is not intended to be a verbatim account of all that was presented and discussed. Rather, it summarizes the event’s objectives, contexts, participants and formal presentations, then outlines the main points of discussion, including a set of guiding principles for nursing care delivery models that participants created, as well as topics for further investigation that arose from participants’ deliberations.

¹ A model of care “describes the delivery of health care within the broader context of the health system” (Davidson, Halcomb, Hickman, Phillips and Graham, 2006, p. 49). Nursing care delivery models are a structured approach, informed by values and beliefs, for organizing and providing nursing care to clients (e.g., functional nursing, primary nursing) (adapted from Jost, Bonnell, Chacko and Parkinson, 2010: 209).

² In Ontario, LPNs are called “registered practical nurses;” in Quebec, they are known as “infirmières et infirmiers auxiliaires” in French and “nursing assistants (NA)” in English. In the rest of Canada (and this report), “licensed practical nurse” is used.

³ Registered psychiatric nurses are regulated in Alberta, British Columbia, Manitoba, Saskatchewan and Yukon. In this report, RPN is used to identify this category of nurse.

Objectives

Nursing care delivery model design and staff mix decision-making are complex tasks. As organizations undertake this important work, nurse⁴ leaders, health-care administrators and policy-makers require – and are calling for – reliable evidence relating to the impact on client, staff and system/organization outcomes of nursing care delivery model design and staff mix configurations.

In response to these concerns, the CNA task force set four objectives for the round table:

1. to share current research and evidence regarding nursing care delivery model design and staff mix decision-making;
2. to share relevant evidence aimed at informing nursing care delivery model design;
3. to discuss trends, challenges and solutions that affect the implementation into practice of different nursing care delivery models and staff mix configurations; and
4. to review and examine the latest draft of a Canadian framework currently under development to support the assessment and evaluation of staff mix decisions for nurses working together and/or with unregulated care providers (UCPs).

⁴ In this report, the term “nurse” signifies registered nurses (RNs), licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs).

Contexts

The goals of nursing care delivery models at all levels are to:

- provide safe, competent, quality care that meets client needs and maximizes client outcomes across the continuum of care;
- utilize health-care providers effectively; and
- ensure meaningful work for health-care providers, thereby instilling in them a sense that their contributions are important.

Nursing care delivery model design and staff mix decision-making are now at the forefront of deliberations pertaining to the future of nursing and health care in Canada. The following list summarizes the major issues and concerns that informed the round table participants' deliberations:

- Ongoing funding pressures have led many regional, provincial and territorial health-care systems to redesign models of care, including their nursing care delivery models, which are often not guided by evidence-based decisions. Establishing effective delivery models involves understanding the many elements that affect client care, including staff mix, consumerism, human developmental stage and diverse populations, economics, politics, technology and client acuity.
- Nursing care delivery models could maximize nurses' contributions to the models of care that are being developed and deployed across Canada.
- Canada needs multi-faceted evaluations of nursing care delivery models and [other?] models of care in order to determine the models' effects on the quality of client care, client safety, nurse well-being and organizational efficiencies.
- There is a limited amount of research and clinical evidence on the effectiveness of nursing care delivery models across the continuum of care. Well-targeted, national research funding is needed to collect nurse-sensitive data that can support the monitoring and improvement of care delivery processes and the measurement of performance outcomes.
- System inefficiencies need to be better understood. To this end, additional research is required that focuses on client-centred needs analysis across the continuum of care.
- Health-care policy-makers, the media and the public need to be aware that the redesign of care models across the continuum of health delivery should not be confined to cost.
- Nurses need to occupy leadership positions at all decision-making tables to ensure consistent consideration is given to the evidence during decision-making related to nursing care delivery models and staff mix.
- Respectful intraprofessional nurse collaboration among RNs, LPNs and/or RPNs should be a main feature of nursing education and practice.
- There is a large body of research regarding clinical and staff outcomes relating to RN deployment, primarily in acute care settings. This evidence is not being used consistently by policy-makers, funders and decision-makers.
- There is insufficient research regarding the effectiveness of RNs, RPNs and LPNs outside of the acute care setting.

Participants

Chaired by Rachel Bard, CNA's chief executive officer, the invitational round table brought together 65 nurses from across Canada, including many of the country's knowledgeable and influential nursing researchers, policy-makers, clinicians and administrators. Round table participants represented a wide variety of regulatory and professional nursing organizations, unions, health-service providers, universities and government agencies.

Presentation Summaries

Keynote address

Ginette Lemire Rodger – “Nursing Needs its Models”

Ginette Lemire Rodger articulated the difference between “organizational” and “nursing care” delivery models. She cautioned the audience to be clear about the distinctions and use of terminology. She called for well-developed nursing care delivery models within the current era of interprofessional collaboration. In this context, one of her main messages was that management models are needed whenever different categories of nurses work together. Drawing on the results of a longitudinal study of the nurse- and organization-related effects of adopting a common nursing practice model across a recently merged multi-site hospital, Rodger shed light on many recent positive outcomes such as decreased turnover rate, increased nurse satisfaction and increased leadership-building. She concluded her address with a discussion of The Ottawa Hospital's Inter-Professional Model of Patient Care[®] (IPMPC), which is a guide for organizing patient-care delivery among health professionals from different disciplines. The IPMPC takes into account all health professionals' competencies, as well as collaborative patient-centred practice and The Ottawa Hospital's strategic directions. It is grounded in guiding principles, against which all concerned staff members must measure themselves and their actions.

Panel 1: What's happening in research?

Linda McGillis Hall: “What's Happening in Nurse Staffing Research in Canada?”

Linda McGillis Hall outlined some of the research evidence on the effects of nurse staffing and care delivery models. The data are clear, she noted, regarding the benefits of RN staffing in acute care (e.g., decreased pressure ulcers, post-operative wound infection, restraint use). She said that researchers are now looking beyond staffing and focusing on larger organizational, system and environmental factors that impact patient, nurse (e.g., retention) and system outcomes. Evidence shows, for instance, that nursing care delivery models that do not use total patient care contribute to job stress among nurses. McGillis Hall also urged the need to consider the barriers to the uptake of nursing health services research (e.g., nurse staffing and outcomes) as a way to overcome those challenges through, for example, more effective communication.

Ann Tourangeau: “Nurse Staffing and Hospital Mortality Rates”

Ann Tourangeau presented her research, which examined the impact of hospital nursing structures and processes of care on 30-day mortality rates for acute medical patients in Ontario hospitals. After highlighting the findings of two studies, Tourangeau concluded that, for acute medical patients, the higher the percentage of RNs and of baccalaureate-prepared RNs providing patient care, the fewer unnecessary patient deaths will result. Other influencing factors that result in lower mortality rates include routine use of care maps/algorithms to guide patient care, and having adequate staffing and resources to provide care. Her key message: The educational preparation of those providing nursing care makes a big difference in mortality outcomes – a higher proportion of RNs and baccalaureate-prepared RNs is associated with far fewer unnecessary deaths in hospitals.

Barbara Davies: “Evidence-Informed Models of Nursing Service: Spreading Best Practices in Nursing”

Focusing on the findings of five studies under the umbrella of the Research, Exchange and Impact for System Support (REISS) program, Barbara Davies discussed nine key implications for decision-makers:

1. Best-practice nursing innovations require far-reaching change with networks of individuals and organizations.
2. Champions from every level (front lines to leaders) are required.
3. Using evidence must be made a normal part of structures and processes.
4. Interprofessional teams must recognize the benefits of best-practice guidelines, and resources (e.g., money, staff, policies) must be available to support them.
5. A willingness to test, adapt, modify and discard innovations is important.
6. Timing is crucial when bringing stakeholders together.
7. It is vital to track, measure and give timely feedback to adjust and improve innovations.
8. Innovation efforts should always be evaluated from diverse angles.
9. Both successes and failures offer insights into future efforts.

Irmajean Bajnok: “Staff Mix Framework: Overview, Update, and Next Steps”

In February 2010, CNA organized the Staff Mix: Regulated Nurses and Unregulated Care Providers Working Group, which was tasked with leading the revision of *Evaluation Framework to Determine the Impact of Nursing Staff Mix Decisions* (Canadian Nurses Association (CNA), Canadian Practical Nurses Association, Canadian Council for Practical Nurse Regulators and Registered Psychiatric Nurses of Canada (2005), as well as creating policy and educational documents based on current literature and expert opinion. A member of the working group, Irmajean Bajnok, gave an overview of the project’s contexts, elements and background research on the subject. In particular, she focused on selected feedback obtained during the summer of 2010 consultation process on a draft of the revised framework. Bajnok noted, for instance, that respondents asked for additional definitions; discussion of collaboration, consultation, and leadership; more explanation of how different care providers can work together; and additional tools to support the framework’s application. Bajnok explained that the framework will be revised and finalized in the fall of 2010, with anticipated approval and publication/dissemination

in the first half of 2011. Among the questions Bajnok left participants to consider was how the framework can be effectively connected to and support nursing care delivery models and healthy work environments.

Panel 2: What's happening in practice and why?

Laurie Leith: "Collaborative Nursing Practice – Acute Model"

Laurie Leith discussed Vancouver Coastal Health Authority's collaborative nursing practice (CNP) acute model. Noting evidence of substituting RNs with LPNs and UCPs without simultaneously implementing a CNP model, Leith explained Vancouver Acute's CNP planning and implementation. Preliminary results show this initiative has resulted in reduced vacancy rates, reduced overtime rates, no increase in reported "unwanted events," and no changes identified using the baseline global trigger tool on pilot units. In order to succeed, CNP implementation requires, among other elements, commitment and communication at all levels, standardized education, and demonstration of trust and respect for all roles within a health-care team. Above all, Leith counselled, be sure to get the nursing care delivery model right before moving on to collaborative care models.

Susan VanDeVelde-Coke: "Nursing Demonstration Project: Building Better Nursing Care Delivery Models"

Focusing on a demonstration project undertaken at Sunnybrook Health Sciences Centre, Susan VanDeVelde-Coke explained the development and implementation of a toolkit comprising a patient care needs assessment tool and a unit environment profile. These tools were shown to provide a sound method of assessing client predictability, stability, complexity and risk, and can be adapted to other nursing sectors such as pediatrics, mental health and, perhaps, community health. Assessment levels were decided by front-line nurses, which added to staff, understanding, confidence and participation. An additional benefit of such wide participation was that staff understood and supported the transition to new staff mix configurations.

Cindy Cruickshank & Mary Ellen Gurnham: "Model of Care Initiative in Nova Scotia"

The mandate of the Model of Care Initiative in Nova Scotia (MOCINS) was to design, implement, and evaluate a viable provincial model of care for acute care in-patient delivery that is patient-centred, high quality, safe, and cost-effective. Cindy Cruickshank and Mary Ellen Gurnham reported on MOCINS' collaborative care model, which is a partnership among the district health authorities, the IWK Health Centre and the department of health, aimed at improving patient outcomes; optimizing providers' scopes of practice; engaging patients, families and communities in their care; and facilitating interprofessional-team communication and collaboration. Results from the research-based evaluation show that MOCINS is making a positive difference for patients, health-care providers and the health system.

Jane Underwood: "Community Health Nursing Practice Models"

Jane Underwood explored the use of evidence in the design and implementation of community health nursing care delivery (or practice) models. She reported that Community Health Nurses of Canada is currently developing an updated professional practice model. The major challenges to

using evidence are that research results are not necessarily delivered on time in order to provide all the information required, and policy-makers and financial managers sometimes have difficulty accepting the long-term benefits of evidence-based policy (e.g., nurse-family partnership). Front-line managers, Underwood noted, know what is needed in terms of staff mix; however, they do not have enough evidence to fully inform and support their decision-making. Community health requires far more published research on the connection between nursing care delivery models and client outcomes.

Panel 3: Change drivers and how best to respond to the drivers of change

Doris Grinspun: “Evidence-Informed Nursing Care Delivery Models and Staff Mix”

Nursing care delivery models and staff mix applications are changing, Doris Grinspun observed, because of predicted staff shortages and the perception that changed scopes of practice justify these changes. Grinspun explained, however, that shorter lengths of hospital stay result in higher complexity of patients’ care needs, thus requiring a richer skill mix than ever before. She also shared research regarding the cost-effectiveness of RN utilization, and observed that this information is either not reaching decision-makers or is being ignored. She observed a trend across Canada where cost-cutting experiments designed by consultants are being introduced at great expense to tax payers, patients and nursing. Grinspun urged the importance of care and caregiver continuity when redesigning nursing care delivery models, and she advocated for primary nursing. She also stressed that skill mix applications must be based on patients’ needs, complexity, predictability, acuity and stability. Lastly, Grinspun urged round table participants to use evidence, politics and the media to make the case for implementing best-practice models and to shape healthy public policy driven by nurses’ knowledge and courage.

Jeanne Besner: “Evidence-Informed Nursing Care Delivery Models across the Continuum”

Excessive workloads, low job satisfaction, challenges to recruitment and retention, lack of role clarity, underutilization of nurses’ knowledge and skills, and ineffective and inefficient service-delivery models: these are the challenges, Jeanne Besner observed, that necessitate the redesign of nursing care delivery models. In that process, evidence is critical for informing what needs to change. We must support efforts to introduce and evaluate new models, which requires using evidence about collaborative care and the impact of optimized roles, as well as engaging in shared visioning and decision-making. At the same time as she noted the importance of using evidence, Besner identified the barriers facing the uptake of research: difficulty letting go of “sacred cows” (e.g., around patient and care assignment), politics (including inconsistent definitions of terms), differing views about what constitutes “evidence,” and leadership issues (e.g., spans of control of first-line managers, diminished voice for nursing at executive levels, lack of common vision and joint planning).

Panel 4: Practice, policy and research perspective about recommendations

The fourth panel consisted of commentaries by Sandra MacDonald-Rencz, Gail Tomblin-Murphy and Judith Shamian on the round table's core themes, as well as discussion and development of the themes over the course of the event.

In her remarks, MacDonald-Rencz noted that the current emphasis on nursing care delivery model redesign and staff mix must be understood within a movement happening across Canada's health-care system to be more patient-focused and in step with efforts to ensure interprofessional teams work effectively. For nurses, one of the major challenges is that different types of nurses do not necessarily know what each brings to the care process and how to work collaboratively. RNs, LPNs and RPNs need supports (e.g., organizational, educational) so that they can collaborate and consult with one another. Developing and sharing knowledge – among nurses, but also with other health-care professionals – about how to collaborate is essential.

Tomblin-Murphy began by stressing that nursing care delivery model redesign should begin by answering four important questions:

1. What are patients' and clients' needs?
2. Based on those needs, what kinds of health services delivery do they require?
3. How do we ensure they get those services?
4. How does nurses' unique knowledge enter into the teams that care for patients/clients?

Among the factors that one must consider in the design of nursing care delivery models, Tomblin-Murphy noted social determinants and inequities, political factors within and around the profession of nursing, economic drivers, health human resources and their budgets, and health-system technology. A strong proponent of knowledge sharing, Tomblin-Murphy concluded by emphasizing the importance of information-sharing (including of evidence that is not yet published in journals or grey literature), stakeholder engagement from the creation of indicators to the evaluation stage, and the creation of partnerships that support dialogues among nurses and between nurses and researchers.

Judith Shamian spoke as the president of CNA and emphasized the importance of making use of the available evidence as we deal with both skill mix and care delivery models. Within the context of evidenced-based decisions, she indicated that it is essential for the different nursing groups to work together respectfully. Furthermore, Shamian told delegates that she wants to advance *engagement* within the nursing profession; on this account, "relationships are vital, because they allow us to trust one another. We must continue to look for opportunities for relationship- and trust-building, as these will enable us individually and as a profession to take risks." Speaking also from an employer perspective (as the president and chief executive officer of VON Canada), Shamian noted the importance of aligning the health system with evidence-informed data; nurses and nursing researchers must share information with employers. More generally, Shamian pointed out the value of understanding the barriers – policy and system – that must be removed in order to optimize client care; in this regard, she noted, "It's also about knowing what you *can* and what you *cannot* do." Shamian concluded her remarks by returning to

the theme of engagement, which, she said, also includes engaging with the public: “We all talk about being patient-centred, but we need to do much more thinking and planning to really understand this, and get the public to have this conversation, too.”

Summary of evidence arising from the presentations

While additional research is required – specifically related to LPN and RPN practice and their respective impact on patient outcomes – the keynote speaker and panellists offered evidence for certain conclusions on which to base nursing care delivery model design and staff mix decision-making:

- Client condition and stability, nursing experience, and system support are each separately and interactively vital in staffing decisions.
- Client outcomes are positively affected when all practitioners work to their full scopes of practice and according to their full competencies.
- Using RNs is cost-effective: the cost of RN staffing is likely to be offset by improved patient outcomes and lower lengths of stay in health-care organizations and settings (e.g., hospital, home care).
- There are associations between the following:
 - improved client survival rates and higher levels of RN hours in long-term care facilities and community services;
 - richer RN staffing levels and positive client outcomes in acute care and long-term care settings;
 - positive client outcomes and higher RNs’ levels of education (e.g., baccalaureate level) and experience; and
 - LPN staffing levels and positive client outcomes in long-term care settings.
- System sustainability is supported by having nursing care delivery models that support knowledgeable workers.
- We cannot assume that quality care and best practices are costly; the evidence shows otherwise.
- There is a strong need for mutual respect and respectful collaboration between and among different nursing groups.

Main Discussion Points

The round table afforded extensive opportunities for collegial, multi-perspective idea-sharing and debate: formal presentations, small- and large-group discussions (see Appendix A for small-group discussion questions and responses) and informal networking. Taken together, these forums led to discussion on directions to help steer the course of future efforts in the areas of nursing care delivery model design and staff mix decision-making. This list of discussion points does not represent agreement among all participants but rather highlights areas for further collaborative work:

- Develop guiding principles to support the selection, adaptation, and design of nursing care delivery models, starting with concepts emerging from the round table.
- Engage and empower staff and clients in the selection, adaptation and design of nursing care delivery models.
- Clarify nurses' roles and scopes of practice.
- There is a dearth of research about LPN and RPN practice and their respective impact on patient outcomes.
- Promote the use of transparent, precise and consistent terminology.
- Develop and support leaders who are able to consider evidence arising from research and experience.
- Build capacity for knowledge exchange and translation among both nurses and the public; this includes demonstrating connections between research and practice.
- Link nursing education, research and practice through ongoing collaboration nationally, provincially/territorially and locally.
- Ensure the development and adoption of evidence-informed models of care that provide quality, safe care based on population health needs (e.g., by addressing interprofessional collaboration, determinants of health, efficient access, funding and chronic disease management).

Guiding Principles for Nursing Care Delivery Models

Invitational round table participants concurred on the urgent need to develop guiding principles to support the selection, adaptation and design of nursing care delivery models. Drawing on small-group and plenary discussions, a provisional list of principles was developed. While they will require further deliberation and refinement, the following guiding principles represent widespread discussion among event participants:

- Care must be client-centred.
- Care must be responsive to clients, families and communities.
- Staff mix decision-making must be based on client needs, which include complexity, predictability, acuity and stability.
- Support inter- and intraprofessional respect and collaboration; this includes teaching how to work together.
- Support direct care.
- Ensure continuity of care.
- Ensure consistency of care and caregiver.
- Engage and empower care providers, clients and their families.
- Engage and empower care providers, clients and their families in the development of nursing care models.
- Foster strong nursing leadership/management.

- Support ongoing learning.
- Foster a supportive and healthy organizational culture and structure.
- Conduct ongoing monitoring and evaluation.
- Ensure evidence-based clinical and management decision-making.
- Incorporate multiple levels of staff experience and expertise.
- Ensure accountability.
- Clarify roles and scopes of practice.
- Deploy staff to the full extent of their scopes of practice, taking into consideration relative strengths of novices and experts.
- Protect the long-term sustainability – human resource and financial – of the health-care system.
- Make decisions based on the fact that safe, quality care is cost-effective care.
- Align with strategies for building nursing workforces.
- Ensure cultural safety.
- Build in flexibility.
- Reflect geographical context.
- Take into consideration health human resources issues (e.g., improving organizational climate, decreasing nurse fatigue, reducing absenteeism).
- Consider and account for environmental factors.

Issues for Further Investigations

Round table participants acknowledged that there remain important gaps that must be addressed in order to ensure the transfer into practice of evidence that will support high-quality nursing care delivery model design and staff mix decision-making. The following presents issues that require further investigation.

Guiding principles

- What existing evidence supports the guiding principles for nursing care delivery models? (See draft principles outlined above.)
- How can the guiding principles be made sufficiently flexible to ensure use across the country and in many different practice settings?
- How can we translate guiding principles and nursing care delivery models into messages that resonate with front-line staff?
 - How can those efforts assist change management and leadership?
 - What environmental factors must be considered?
 - What precisely is meant by “continuity” (e.g., of care and caregivers)?

Further research

- What outcomes-related research regarding RNs, LPNs, RPNs and collaborative models remains to be conducted in order to support optimal nursing care delivery model design and staff-mix decision-making?
- What further longitudinal studies as well as qualitative and quantitative research are required to support the development of nursing care delivery models and staff mix decision-making?

Uptake of research evidence

- What is the role of CNA, working independently and with other organizations,⁵ in ensuring the development of clear key messages that support the work of RNs, LPNs and RPNs, and in advancing evidence-based policy- and decision-making as they pertain to the design of nursing care delivery models and staff mix?
 - What are the most effective ways to engage the public, governments, employers and other stakeholders outside the nursing community?
- What are the roles of change management and leadership in promoting research uptake by front-line staff?
- How can nurses identify and overcome the barriers (e.g., policy, system, historical) to the use of evidence?
- What roles do nursing care delivery models and staff mix decision-making play in health-care system sustainability?
 - How can nurses and the profession of nursing be promoted as having valuable solutions to overall health-care system sustainability?

⁵ Other organizations could include the Canadian Council for Practical Nurse Regulators, the Registered Psychiatric Nurses of Canada, the Canadian Federation of Nurses Unions, the Canadian Nurses Foundation, Health Canada's Office of Nursing Policy, the Canadian Institutes of Health Research, and the Canadian Health Services Research Foundation.

Conclusion

While the round table did not meet its overall purpose of developing recommendations, it succeeded in [addressing?] the three objectives set for it. Specifically, the gathering enabled the following:

- sharing of current research and evidence that affect nursing care delivery model design and staff mix decision-making;
- discussion of trends, challenges and solutions that affect the implementation into practice of nursing care delivery models and staff mix configurations; and
- review and examination of the latest draft of a framework being developed to support the assessment and evaluation of staff mix decisions for nurses working together and/or with unregulated care providers. *Note:* Event organizers forwarded that advice directly to the working group members responsible for the framework's development.

Next Steps

In light of the CNA invitational round table proceedings, CNA committed to undertake several initiatives:

- Organize and facilitate a Delphi survey process that will bring together a group of experts – practice, policy, research and education – to develop guiding principles for nursing care delivery models.
- Support the completion and publication of a revised staff mix framework.
- Publish the staff mix literature review that was created as part of the staff mix framework revision process.
- Post CNA invitational round table presentations and other related material on the CNA website.

Appendix A: Small-Group Session Questions and Responses

Note: The responses given in this appendix are not a complete transcript of all the comments made in every group. Instead, they are a compilation of the responses put forward most often across all seven small-group discussion groups.

How do we influence the implementation of nursing care delivery models?

- Draft guiding principles for the development of nursing care delivery models.
- Ensure continuity of care and caregiver/right provider, right patient.
- Empower nurses; those who are key to implementation should be part of the planning process from the start and across the continuum of care.
- Assume that there will be tensions because scope of practice is dynamic. We need respectful processes to deal with the tensions.
- Foster a sense of inclusiveness.
- Develop/ensure common, transparent and precise terminology.
- Complement scientific research with experiential evidence. Accept that there is a variety of types of valuable evidence.
- Support education and communication: educate communities, populations, decision-makers, politicians and nursing students. Develop various vehicles for communicating with different constituencies.
- Develop and support quality practice environments, including making time for ongoing education and work-life balance.
- Incorporate new quality frameworks and agreements: connect nursing to the big picture across the care continuum. Take a system-level perspective and include a long-range view; build on quality improvement.
- Use existing research and build research capacity (there is a need for financial support for pilot projects and implementation efforts).
- Create an inventory of widely shared tools and care delivery models (e.g., tools to assess acuties, case studies, best practices).
- Clarify scopes of practice and roles.
- Support leaders: courageous leaders who can consider objectively the whole body of science and context, not just research that supports their own views.

What recommendations or modifications would you make to the framework?

- Create tools (e.g., case studies, guidelines).
- Build an interactive technology application.
- Contextualize the framework in terms of practice model, service delivery model and context of care.

- Expand the glossary (e.g., framework, nursing care delivery model).
- Address the fact that care is provided by teams that include staff other than nurses and unregulated care providers.
- Clarify the target audience.
- Reinforce the message that the table is not exhaustive.
- Ensure that guiding principles encourage any nurse to pick up and read the framework.
- Ensure the framework remains dynamic (it is not a tool).
- Use questions as triggers.
- Discuss assignment and delegation in the Working Together section of the framework.
- Clarify assumptions.
- Remove “regulated” from the title.
- Add references to money/cost.
- Add a new core principle: Client assessment must be based on acuity, complexity, predictability and stability.

How do we move research into practice?

- Acknowledge what we know and what we do not know.
- Develop and support leaders/champions. They are the knowledge brokers and they can use the media to further public engagement.
- Increase research capacity.
- Link education, research and practice cyclically.
- Present research in context, and describe clinical applications in relevant, logical terms.
- Build and support relationships and communities of practice.
- Create incentives and support.
- Become a partner at interprofessional board and budget-setting tables. In such win-win forums, nurses will be able to identify the issues for which nursing research can provide evidence and solutions.
- Since nursing operates in a broad context, advocate for an interprofessional lens.
- Involve the people who are themselves involved in moving research into practice.
- Involve care recipients; listen to what they say about care delivery processes.
- Clarify roles.
- Build capacity for knowledge translation, which includes demonstrating connections between research and practice, and developing forms/templates for sharing knowledge and other applicable research.
- Create healthy work environments that give nurses time to reflect on their actions and to access/review research. Create safe places in which nurses can discuss challenges they are facing.

- Tie outcomes evidence to cost: demonstrate cost savings and cost avoidance.
- Explain clinical applications in relevant, logical terms.
- Market to the public and bring them on board. The public will then pressure organizations to implement research-based approaches.
- Move quickly from pilot projects to implementation.
- Include sustainability measures and evaluation.
- Change management is key. Incorporate change management and research into clinical practice and tools.
- Ensure core principles: continuity of care and caregiver, full scope of practice, team work, accountability.
- Create a mechanism for bringing problems to research in order to solve those problems.

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