Impacting Canadian Public Health Nurses' Job Satisfaction

Karen R. Graham, RN, MScN,^{1,2} Barbara L. Davies, RN, PhD,² A. Kirsten Woodend, RN, PhD,³ Jane Simpson, RN, MSc(A),^{2,4} Shannon L. Mantha, RN, MScN¹

ABSTRACT

Objective: Workforce recruitment and retention challenges are being experienced in public health as in other Canadian health sectors. While there are many nurses working in public health, little research has been done about their job satisfaction. Job satisfaction is linked to recruitment, retention and positive client outcomes. The purpose of this research was to examine the relationships between three modifiable work environment factors (autonomy, control-over-practice, and workload) and Canadian public health nurses' (PHNs) job satisfaction.

Methods: Data were from the 2005 National Survey of the Work and Health of Nurses (response rate, 79.7%; 18,676 nurses). Bivariate and multivariate logistic regression analyses were used for this secondary analysis. Findings were discussed with practicing PHNs, policy-makers and researchers from across Canada at a knowledge translation (KT) 'Think-Tank'.

Results: Among the 271 PHNs, 53.5% reported being 'very satisfied' with their jobs. The interaction between autonomy and workload was a significant predictor of PHNs' job satisfaction, (OR 0.97, 95% CI 0.96-0.99, $p < 0.01$) as was the interaction between age and workload (OR 1.01, 95% CI 1.00-1.01, $p < 0.01$). Think-Tank participants selected priority areas for application to public health practice, management and research.

Conclusion: Despite being an important practice factor, this is the first study to reveal the negative influence of PHNs' autonomy when in interaction with an excessive workload. Significant workload findings and the presence of generational differences suggest the need for development of workload measurement tools and public health human resource strategies tailored to a multi-generational workforce.

Key words: Public health nurses; work environment; job satisfaction; autonomy; workload; control-over-practice; knowledge translation

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2011;102(6):427-31.

The public health sector is experiencing recruitment and retention issues similar to those in other areas of the Canadian health system; the current workforce is aging and replacing and retaining such expertise is challenging.¹⁻³ Job dissatisfaction has been linked to retention issues, absenteeism, increased costs, and ultimately diminished client outcomes.⁴⁻⁶ As nurses constitute the largest professional group of national public health human resources,^{1,3,7} it would be beneficial to gain a better understanding of the determinants of their job satisfaction.

Given the direction of health system reform that necessitates moving clients quickly from acute care settings into the community,⁸ some have predicted that 60% of the Canadian nursing workforce will work in the community sector by 2020.⁹ This projected increase in demand will have to be addressed in the context of an estimated shortage of 60,000 registered nurses by 2022;¹⁰ this constitutes over 25% of the current Canadian nursing workforce.¹¹

No data currently exist identifying the future demands for public health nurses (PHNs), a specialized subsector of community nurses, however Canadian public health realities – including an aging population, higher prevalence of chronic conditions, and threats from infectious disease – suggest that there will be a need to increase or, at minimum, maintain the current PHN workforce. Due to the use of varying nomenclature and the diversity of roles and responsibilities across the country, enumeration of Canadian PHNs is difficult.¹²

In their day-to-day work, PHNs identify and act on the socio-political conditions that contribute to Canadian population health inequities and are in a position to provide valuable insight to inform policy decisions.^{12,13} Recent research has identified that effective Canadian health human resource planning requires service delivery strategies ensuring that PHNs are used to their full potential.¹⁴ Positive work environments and job satisfaction would facilitate this objective.

This secondary analysis of data selected from the 2005 National Survey of the Work and Health of Nurses (NSWHN) was undertaken to determine the relationships between Canadian PHNs' job satisfaction and their autonomy, control-over-practice, and workload. Previous research has demonstrated the applicability of these

Author Affiliations

1. North Bay Parry Sound District Health Unit, North Bay, ON
2. School of Nursing, Faculty of Health Sciences, University of Ottawa, Ottawa, ON
3. Trent/Fleming University School of Nursing, Peterborough, ON
4. Public Health Nursing Consultant, Kanata, ON

Correspondence: Karen Graham, Vaccine Preventable Diseases Program, North Bay Parry Sound District Health Unit, 681 Commercial Street, North Bay, ON P1B 4E7, Tel: 705-474-1400, E-mail: karen.graham@nbpsdhu.ca

Acknowledgements: The authors gratefully acknowledge the financial support of the Health Canada Office of Nursing Policy in funding this study. The opinions, results and conclusions included are those of the authors and the end-of-study Knowledge Translation Think-Tank participants. No endorsement by the Health Canada Office of Nursing Policy is intended or should be inferred.

The authors also acknowledge with sincere appreciation the support of Kathryn Wilkins, Health Analysis Division of Statistics Canada, in the completion of this research.

Conflict of Interest: None to declare.

Figure 1. Study sample selection

Non-contact: Those nurses originally randomly selected for study who could not be contacted.
 Contact: Regulated nurses successfully reached based on information provided by regulatory authorities.
 Refusal/NR: In-scope nurses from whom a completed questionnaire was not obtained.
 Respondents: Nurses' questionnaires containing enough data to be considered complete.
 OOS: Nurses out-of-scope were not considered part of the target population – inclusion criteria not met.
 Adapted *National Survey of the Work and Health of Nurses, 2005 – Users Guide*, Statistics Canada, 2009;53.

variables to PHNs' practice;¹⁵⁻¹⁷ their modifiable nature provides organizations with tangible areas of focus for change strategies.

METHODS

Ethical approval was received from the University of Ottawa and access to these confidential data was secured from the adjudicating committee, operating under the auspices of the Social Sciences and Humanities Research Council and Statistics Canada. Analyses were conducted using the Statistical Package for the Social Sciences (SPSS) version 18.0 for Windows.

The NSWHN was a national, cross-sectional survey of regulated nurses conducted by Statistics Canada in partnership with the Canadian Institute for Health Information and Health Canada.¹⁸ It provides an overarching perspective on the work and health of nurses across the country. With an excellent response rate of 79.7% and a large national sample of 18,676 nurses, the NSWHN included extensive quality assurance evaluation and external validation

Table 1. Select Demographic and Work Characteristics of Canadian Public Health Nurses Study Sample

Characteristics	Rescaled Weighted Sample (n=271)	Non-rescaled Weighted Sample (N=4273)	Estimated %
Age Groups (years)			
<35	68	1066	24.9
35-44	84	1322	30.9
45-54	78	1236	28.9
≥55	41	649	15.2
Highest 'nursing' education*			
Diploma	75	1178	27.6
BScN	185	2924	68.4
RPN/MScN/PhD/Other	11	171	4.0
Highest 'non-nursing' education*			
None	231	3643	85.2
Bachelors	29	461	10.2
Certificate/Diploma/Masters	11	169	4.0
Year began nursing*			
1955-1967	13	211	4.9
1968-1980	91	1439	33.7
1981-1993	86	1355	31.7
1994-2004	80	1269	29.7
Year started current job*			
1969-1978	12	196	4.6
1979-1988	25	396	9.3
1989-1998	97	1526	35.7
1999-2004	137	2154	50.4
Current working status			
Permanent employee, full-time	141	2223	52.0
Permanent employee, part-time	97	1530	35.8
Non permanent employee, full-time	11	168	3.9
Non permanent employee, part-time	22	345	8.1
Immediate supervisor is a nurse	235	3699	86.6

* Recoded/collapsed data to meet Statistics Canada minimum cell count requirement for output file release.

† Rescaled weighted sample: Raw sample data weighted to represent national PHN population; rescaled to sample size.

‡ Non-rescaled weighted sample: Representative of national PHN population.

of survey items for error detection as well as comprehensive communication and structured interviewer training.¹⁸

Study variables were measured using tested reliable and valid instrumentation from the NSWHN. The reliability coefficient (as assessed by Cronbach's alpha) for each variable was satisfactory.¹⁸ Analyses were performed using weighted data to account for the multistage stratified sampling strategy used by Statistics Canada methodologists.¹⁹ Sampling strata were defined according to characteristics of interest including province of residence and type of nurse. Survey weights were derived such that when they were applied to the sample of the nearly 300 PHNs, they would be representative of all PHNs in Canada.¹⁹ The current study sample (n=271) included registered nurses who identified their main area of employment as public health, worked in Canada, and agreed to share their data (Figure 1).

Initial descriptive analyses were based on calculations of frequencies and bivariate tabulations. Rescaled sample survey weights were used because the strength of the relationships between variables was to be assessed in the representative sample, not the entire population. To explore the relationship between job satisfaction and autonomy, control-over-practice and workload, multivariate logistic regression analyses were performed.

At analyses completion, findings were interpreted with the assistance of key stakeholders (n=16) at a one-day knowledge translation (KT) Think-Tank. Participants included PHNs, managers, policy-makers, educators and researchers from across Canada including five provinces and one territory. With the assistance of a senior nursing consultant from the Canadian Nurses Association, Think-Tank participants were recruited by e-mail to voluntarily

Table 2. Public Health Nurses' Responses to Study Variable Factors: Percentage Agreement

Variable	Rescaled Weighted Sample (n)	Estimated %
Total	271	100.0
Autonomy (n=259)		
1. The supervisory staff is supportive of nurses.	220	83.2
2. Nursing controls its own practice.	206	77.5
3. I have the freedom to make important patient care and work decisions.	248	91.6
4. I am not placed in a position of having to do things that are against my nursing judgement.	247	91.4
5. I have a nurse manager or supervisor who backs up nursing staff in decision-making, even if in conflict with a physician (n=205/271).	165	80.8
Control-Over-Practice (n=234)		
1. Adequate support services allow me to spend time with my patients.	160	59.0
2. There is enough time and opportunity to discuss patient care.	189	69.7
3. There are enough nurses on staff to provide quality patient care.	172	63.5
4. I have a nurse manager or immediate supervisor who is a good manager and leader.	197	72.7
5. There is enough staff to get the work done.	185	68.3
6. I am given the opportunity to work on highly specialized patient care units (n=63/271).	35	55.6
7. I am given assignments that foster continuity of care (n=159/271).	113	71.1
Workload (n=269)		
1. I often have to arrive early or stay late to get my work done.	119	44.1
2. I often have to work through my breaks to complete my assigned workload.	156	57.6
3. It often seems like I have too much work for one person to do.	151	55.7
4. I am given enough time to do what is expected of me in my job.	116	42.8
5. I have too much to do to do everything well.	114	42.0
Job Satisfaction		
0. Other than very satisfied	126	46.5
1. Very satisfied	145	53.5

* Autonomy & Control-Over-Practice: Strongly Agree + Somewhat Agree = Agree.

† Workload: Strongly Agree + Agree = Agree.

Table 3. Logistic Regression: Job Satisfaction by Work Environment Variables

Variables	Odds Ratio	95% Confidence Interval
Autonomy	1.63	1.28-2.08
Control-Over-Practice	1.03	1.01-1.06
Workload	1.30	1.08-1.56
Autonomy x Control-Over-Practice	0.10	0.10-1.00
Autonomy x Workload	0.97	0.96-0.99
Control-Over-Practice x Workload	1.00	0.10-1.00

attend this one-day knowledge exchange event. Response was swift with all available seats secured in less than a day. Participants rated the event as 4.8 on a Likert scale of 5, highlighting the importance of including knowledge-users in research²⁰ and providing a valuable current practice perspective.

RESULTS

The mean age of NSWHN participants who reported themselves as working in public health was 42.5 years (SD=10.7). Sixty-eight percent held a bachelor of science in nursing (BScN) and 28% held a diploma. Half of the PHNs in this study had worked in public health for less than 7 years. Approximately half also identified that they held permanent, full-time positions while 36% reported permanent part-time classification (Table 1).

PHNs' autonomy scores were high with 91% reporting that they were not placed in a position of having to do things against their nursing judgement. Fewer agreed with individual control-over-practice factors. Only 59% reported that there were adequate support services in their practice, permitting them to spend time with their clients, and just 64% stated that there were enough nurses on staff to provide high-quality care. Fifty-six percent stated that they had too much work for one person to do. Forty-seven percent of PHNs reported that they were less than very satisfied with their job (Table 2).

In a main effects model, control-over-practice ($\chi^2=7.22$, $p=0.01$; OR 1.01, 95% CI 1.00-1.02) and workload ($\chi^2=15.04$, $p<0.01$;

Figure 2. Interaction of autonomy and workload (WL) on the probability of being very satisfied

OR 0.90, 95% CI 0.86-0.95) were the two study variables that reliably predicted whether or not Canadian PHNs were very satisfied with their jobs. There was an inverse relationship between workload and job satisfaction; as work overload increased, job satisfaction decreased, while increases in control-over-practice scores were positively related to increased job satisfaction. The strongest association was between workload and job satisfaction; a one-unit increase on the work overload scale decreased the odds of being very satisfied by nearly 10%, whereas a one-point increase on the control-over-practice scale increased the odds of reporting job satisfaction by only 1.4%.

The interaction between autonomy and workload was a significant predictor of job satisfaction, $\chi^2=15.87$, $p<0.01$ (Table 3). To illustrate this, Figure 2 displays five levels of workload, demonstrating the interaction of autonomy and workload on the probability of being very satisfied. There is a positive relationship between autonomy and PHNs who describe themselves as being very satisfied (p) with their jobs at low levels of work overload but

as the work overload increases, the line begins to flatten and invert, demonstrating that at excessive work overload levels, there is an inverse relationship between autonomy and satisfaction.

According to the Wald criterion, the interaction between age and workload also reliably predicted job satisfaction ($\chi^2=8.49$, $p<0.01$; OR 1.01, 95% CI 1.00-1.01) with a weak positive association of 0.07%. Within this model, both age ($\chi^2=5.08$, $p=0.02$; OR 0.93, 95% CI 0.87-0.99) and workload ($\chi^2=12.28$, $p<0.001$; OR 0.93, 95% CI 0.87-0.99) predicted Canadian PHNs' job satisfaction. The strongest association was again between workload and job satisfaction. A one-unit increase on the work overload scale decreased the odds of being very satisfied by 7%, whereas a one-unit increase in age decreased the odds of job satisfaction by only 1%.

DISCUSSION

This secondary analysis is the first study, based on nationally representative data from the 2005 NSWHN, to examine the correlates of Canadian PHNs' job satisfaction. The results of this study suggest that, although PHNs rate their autonomy above all other practice factors, this autonomy may become problematic when combined with an excessively heavy workload.

Study PHNs reported scores in the upper half of the work overload scale. Nearly 60% reported that they were not given enough time to do what was expected of them and 58% had to work outside of assigned hours to complete tasks, similar to the findings in other studies.²¹ One KT Think-Tank PHN commented, "There is no replacement if I am sick and there is nobody to cover for me if I'm gone for professional development."

No formal measures of PHN workload were found in the literature, suggesting that these nurses practice virtually unnoticed until a sudden surge in workload threatens their capacity to meet health system needs. Public health crises such as the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak and the recent H1N1 pandemic have the potential to create excessively heavy workloads. Awareness of what constitutes Canadian PHNs' workload in advance of emergency events could facilitate management of these crises, improve health system outcomes and enhance daily organizational capacity.

Workload was also a significant predictor of PHNs' job satisfaction in interaction with age; a finding that resonated with Think-Tank PHNs. One participant suggested that younger generations typically have a better work-life balance – working within assigned health unit hours, for example – reflective of recent multi-generational research.²² No studies were located that examined the phenomenon of generational differences among nurses practicing in public health, however researchers have analyzed multi-generational workforce differences in other Canadian nursing sectors.²³⁻²⁵ Public health leaders who recognize that different roles may call for different age levels and skill sets could potentially maximize the differences of the varied age groups. Strategies informed by this knowledge could support nurses to better work to the full scope of their competencies throughout their career spectrums.

Recently, 84% of nurses working in the community reported that having nurses in key leadership positions supports their practice and facilitates them working to their full scope.²⁶ A large majority of the PHNs (87%) in this study had a nurse as an immediate supervisor, similar to other research done in this sector in 2005.²⁷ Respondents claimed that nursing leaders understand their work and

uphold nursing standards. Unfortunately, a recent Canadian report has revealed that, in 2007, there were fewer nurses in senior leadership roles within the community sector than there had been since 1996.²⁸ As nurses constitute the largest professional group in the public health workforce and effective nurse leaders have been shown to facilitate optimal nursing practice, it is recommended that efforts be made by individuals, organizations and governments to appoint and support nurses in public health leadership roles. Research evaluating outcomes related to nursing leadership in this health sector is encouraged.

Although the NSWHN data offered a large, national sampling methodology and rigorous data testing, limitations to this secondary analysis do exist. The use of a single-item measure for nurses' job satisfaction, and its required dichotomization, was a study limitation. Although some researchers report correlations between single-item measures and multiple-item scales,²⁹ future research is recommended with a larger sample to further validate the findings of this study. The potential for multicollinearity must be considered as well. Multicollinearity may cause instability of item parameter estimates in multivariate modeling, distorting regression model interpretation.³⁰ Some suggest that centering of explanatory variables diminishes the potential for multicollinearity, however when the number of study cases is small, centering may not be the best approach.³⁰ Finally, the age of the data could be considered a limitation as the last of the interviews in the NSWHN were collected in January 2006. This limitation was partially addressed with the knowledge translation activity, the KT Think-Tank, held May 19, 2010 where it was determined that the study results and issues raised were highly relevant to current practice.

In conclusion, the mounting scrutiny of the Canadian public health system as evidenced by high-profile events in the last few years has increased awareness of the role of public health, yet little is understood about the work environment of nurses in this sector. Although previous research has revealed the negative impact of work overload and the importance of autonomy to PHNs' practice, this is the first study to highlight the significance of the interaction between these two modifiable variables. Development of PHN workload measures, support of nurses in public health leadership roles, multi-generational research, and future opportunities for knowledge-translation activities specific to public health practitioners may facilitate PHNs to work to the full scope of their practice competencies, reduce negative health system outcomes during surge capacity events, and improve PHNs' job satisfaction overall.

REFERENCES

1. The Joint Task Group on Public Health Human Resources, 2005. Building the Public Health Workforce for the 21st Century: A Pan-Canadian Framework for Public Health Human Resource Planning. Ottawa, ON: Public Health Agency of Canada, 2005.
2. Wilson E. The last word: Public health infrastructure needs investment. *Can Nurse* 2007;103(1):44.
3. National Advisory Committee on SARS & Public Health. Learning from SARS – A Renewal of Public Health in Canada, 2003. Ottawa: Health Canada, 2005.
4. Duffield C, Roche M, O'Brien-Pallas L, Catling-Paull C. The implications of staff 'churn' for managers, staff and patients. *Nurs Economics* 2009;27(2):103-12.
5. Tullai-McGuinness S. Home healthcare practice environment: Predictors of RN satisfaction. *Res Nurs Health* 2008;18(4):54-69.
6. Canadian Institute for Health Information. Zoom in on the 2005 National Survey of the Work and Health of Nurses: Satisfaction and Respect on the Job; How Do They Relate to Absenteeism of Nurses? Ottawa: CIHI, 2008. Available at: http://secure.cihi.ca/cihiweb/en/zion_20080229_e.html (Accessed June 10, 2009).

7. Canadian Institute for Health Information. Canada's Health Care Providers. Ottawa: CIHI, 2007. Available at: http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf (Accessed January 13, 2009).
8. Marchildon G. *Health Systems in Transition: Canada*. Toronto, ON: University of Toronto Press Incorporated, 2005.
9. Villeneuve M, MacDonald J. *Toward 2020: Visions for Nursing*. Ottawa: Canadian Nurses Association, 2006.
10. Murphy GT, Birch S, Alder R, MacKenzie A, Lethbridge L, Little L, Cook A. *Tested Solutions for Eliminating Canada's Registered Nurse Shortage: Final Report 2009*. Ottawa: Canadian Nurses Association, 2009. Available at: http://www.cna-aiic.ca/cna/documents/pdf/publications/RN_Highlights_e.pdf (Accessed June 1, 2009).
11. Canadian Institute for Health Information. *Workforce Trends of Regulated Nurses in Canada, 2007: List of Data Tables*. Ottawa, ON: CIHI, 2007. Available at: http://secure.cihi.ca/cihiweb/en/statistics_nursing_2007_e.html (Accessed March 5, 2009).
12. Hogan M. *Public Health Nursing in Canada: A Review of the Literature for the Community Health Nurses' Association of Canada, 2008*. Accessed August 14, 2009 by emailing info@chnac.ca.
13. Cohen BE, Reutter L. Development of the role of public health nurses in addressing child and family poverty: A framework for action. *J Adv Nurs* 2007;60(1):96-107.
14. Meagher-Stewart D, Underwood J, Schoenfeld B, Lavoie-Tremblay M, Blythe J, MacDonald M, et al. *Building Canadian Public Health Nursing Capacity: Implications for Action: Health Human Resource Series Number 15*. London, ON: Nursing Health Service Research Unit, 2009.
15. Best MF, Thurston NE. Canadian public health nurses' job satisfaction. *Public Health Nurs* 2006;23(3):250-55.
16. Campbell SL, Fowles ER, Weber BJ. Organizational structure and job satisfaction in public health nursing. *Public Health Nurs* 2004;21(6):564-71.
17. Ryan RE. *The public health nurse: Looking back and looking forward* [thesis]. Kansas, MO: University of Kansas, 2007.
18. Shields M, Wilkins K. *Findings from the 2005 National Survey of the Work and Health of Nurses*. Ottawa: Statistics Canada, Catalogue no. 83-003-XPE, 2006.
19. *Microdata User Guide: National Survey of the Work and Health of Nurses 2005*. Ottawa: Statistics Canada, 2009.
20. Canadian Institutes of Health Research. *Knowledge to Action: A Knowledge Translation Casebook*. Ottawa: CIHR, 2009. Available at: http://www.cihri-sc.gc.ca/e/documents/kt_casebook_e.pdf (Accessed June 24, 2010).
21. Underwood J, Baumann A, Akhtar-Danesh N, MacDonald-Rencz S, MacDonald M, Matthews S, et al. *National Community Health Nursing Study: Comparison of Enablers and Barriers for Nurses Working in the Community: Health Human Resource Series Number 14*. Hamilton, ON: Nursing Health Service Research Unit, 2009.
22. Hannam S, Yordi B. *Engaging a Multi-Generational Workforce: Practical Advice for Government Managers, 2011*. Available at: <http://www.businessofgovernment.org/sites/default/files/Engaging%20a%20Multi-Generational%20Workforce.pdf> (Accessed March 5, 2011).
23. Cho J, Laschinger HKS, Wong C. Workplace empowerment, work engagement and organizational commitment of new graduate nurses. *Can J Nurs Leadership* 2006;19(3):43-60.
24. Lavoie-Tremblay M, Wright D, Desforbes N, Gelinas C, Marchionni C, Drevniok U. Creating a healthy workplace for new-generation nurses. *J Nurs Scholarship* 2008;40(3):290-97.
25. Storey C, Cheater F, Ford J, Leese B. Retaining older nurses in primary care and the community. *J Adv Nurs* 2009;65(7):1400-11.
26. Underwood JM, Mowat DL, Meagher-Stewart DM, Deber RB, Baumann AO, MacDonald MB, et al. *Building community and public health nursing capacity: A synthesis report of the national community health nursing study*. *Can J Public Health* 2009;100(5):I1-I11.
27. Falk-Rafael A, Fox J, Bewick D. Report of a 1999 survey of public health nurses: Is public health restructuring in Ontario, Canada moving toward primary health care? *Primary Health Care Res Dev* 2005;6:173-83.
28. Underwood J, Baumann A, Ciliska D, Meagher-Stewart D, Deber R, MacDonald M, et al. *Maximizing Community Health Nursing Capacity in Canada: A Research Summary for Decision Makers*. Ottawa: Canadian Health Services Research Foundation, 2010.
29. Nagy M. Using a single-item approach to measure facet job satisfaction. *J Occup Org Psychol* 2002;75(1):77-87.
30. Schroder M, Lander J, Levine-Silverman S. Diagnosing and dealing with multicollinearity. *Western J Nurs Res* 1990;12(2):175-84.

Received: April 7, 2011

Accepted: July 4, 2011

RÉSUMÉ

Objectif : En santé publique comme dans d'autres volets du secteur de la santé au Canada, le recrutement et la fidélisation de la main-d'œuvre présentent des difficultés. Beaucoup d'infirmières et d'infirmiers travaillent en santé publique, mais on a fait peu de recherche sur leur satisfaction professionnelle. Or, la satisfaction professionnelle est liée au recrutement, à la fidélisation et aux résultats positifs pour les clients. Nous avons voulu examiner les liens entre trois facteurs modifiables du milieu de travail (l'autonomie, la maîtrise de la pratique et la charge de travail) et la satisfaction professionnelle des infirmières et infirmiers de santé publique (ISP) au Canada.

Méthode : Nos données proviennent de l'Enquête nationale sur le travail et la santé du personnel infirmier de 2005 (taux de réponse : 79,7 %; 18 676 infirmières et infirmiers). Nous avons employé des analyses de régression logistique à deux ou plusieurs variables pour cette analyse secondaire. Nos constatations ont été discutées avec des ISP en exercice, des responsables des politiques et des chercheurs de tout le Canada lors d'une séance de réflexion sur l'application des connaissances.

Résultats : Sur les 271 ISP, 53,5 % se sont dits « très satisfaits » de leur emploi. L'interaction entre l'autonomie et la charge de travail était un prédicteur significatif de la satisfaction professionnelle ($RC=0,97$, IC de 95 % = 0,96-0,99, $p<0,01$) tout comme l'interaction entre l'âge et la charge de travail ($RC=1,01$, IC de 95 % = 1,00-1,01, $p<0,01$). Les participants à la séance de réflexion ont sélectionné des axes prioritaires pouvant s'appliquer à la pratique, à la gestion et à la recherche en santé publique.

Conclusion : L'autonomie est un important facteur pour la pratique, mais ceci est la première étude à avoir observé l'influence négative de l'autonomie des ISP lorsqu'elle est combinée à une charge de travail excessive. Nos constatations statistiquement significatives concernant la charge de travail et la présence d'écarts intergénérationnels donnent à penser qu'il faudrait élaborer des outils de mesure de la charge de travail et des stratégies de ressources humaines en santé publique adaptés à une main-d'œuvre multigénérationnelle.

Mots clés : infirmières de santé publique; lieu de travail; satisfaction professionnelle; autonomie professionnelle; charge de travail; maîtrise de la pratique; application des connaissances