



Rehabilitation, Complex and Long-Term Care

RNAO Vision backgrounder

April 2014

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The following document provides a briefing on the background used to develop RNAO's vision related to rehabilitation, complex and long-term (residential) care. The content was identified in consultation with a group of RNAO Board of Directors who possess an expertise in this area and RNAO staff. The information was further validated by reviewing supporting evidence.

Common Context for Action

Patient/client/resident complexity and acuity are rapidly increasing requiring full scope of practice utilization of Registered Nurses (RNs).^{1,2,3,4} However, underfunding creates challenges in meeting the demands of rising acuity and complexity.^{5,6,7} At the same time, rising acuity and complexity requires a highly skilled and knowledgeable workforce, thus demanding more RNs.⁸ However, the RN presence and role is being challenged.^{9,10,11} RN staffing models and staffing levels must be addressed to achieve person-centred care. This can be accomplished by using evidence-based staffing models and adequately funding minimum RN/nurse practitioner (NP)/registered practical nurse (RPN) hours of care delivery to respond to the needs of patients/clients/residents.^{12,13}

There is also great opportunity to increase the utilization of advanced practice nurses in these sectors. For example, clinical nurse specialists are well known for their contributions toward optimal resident outcomes.^{14,15}

Across rehabilitation, complex and long-term (residential) care, there is a need to enhance the image, identity and perception of the RN as an expert health professional at the provider, organization and system level. This will involve a transition from task-focused to person-focused approach to care delivery. For example, RNs can be supported to take a leadership role in advancing quality improvement initiatives through collecting, interpreting and addressing outcomes. In addition, continuing education, through the form of specialty certification can be seen as an enabler. Examples of certification areas include (but not limited to): gerontology, rehabilitation, renal, neurological and palliative.¹⁶ Additionally, there is a need across the health system to recognize, understand and embrace the vital role of these sectors.

Rehabilitation

Defining Rehabilitation Care

The World Health Organization defines rehabilitation care as “... a process aimed at enabling [persons] to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Rehabilitation provides disabled people with the tools they need to attain independence and self-determination.”¹⁷ In Ontario, rehabilitation is provided in a variety of settings spanning a continuum of care from acute care to home care.¹⁸

Health human resources profile of Registered Nurses (RN) and Nurse Practitioners (NP) in the rehabilitation sector

In 2013, the College of Nurses of Ontario (CNO) reports the following number of RN positions in Ontario¹⁹:

- 1,413 (RN) – Rehabilitation Hospital
 - 52.0% full-time, 25.1% part-time and 22.9% casual.
- 16 (NP) – Rehabilitation Hospital
 - 100% full-time

Context for Action

The rehabilitation sector is an important part of the health system that enables the transition from hospital to home. With such an emphasis on hospital discharge, unstable patients may be entering rehab centres too early, challenging the rehabilitation nursing role, while increasing the likelihood for hospital re-admission.²⁰ At the same time, alternative level of care (ALC) patients can be transferred to rehabilitation awaiting long-term care, impacting the ability to discharge from hospital in some instances. There is an opportunity to expand focus and priority of discharge planning from the hospital setting to also include the rehab setting. It is important to note that not all patients necessarily need to receive rehabilitation within a facility. There is opportunity to explore rehab at home and ambulatory rehab programs.^{21,22} Nurses have an opportunity to serve as health coaches, working with patients and families to promote self-management.²³

Complex Continuing Care

Defining Complex Continuing Care

In Ontario, the term “complex continuing care” (CCC) is used interchangeably with “chronic care”. CCC provides continuing, medically complex and specialized services to both young and old, sometimes over extended periods of time. CCC is provided in hospitals for people who have long-term illnesses or disabilities typically requiring skilled, technology-based care not available at home or in long-term care facilities. CCC provides patients with room, board and other necessities in addition to medical care.²⁴

Health human resources profile of Registered Nurses (RN) and Nurse Practitioners (NP) in the complex continuing care Sector:

In 2013, the CNO reports the following number of RN positions in Ontario²⁵:

- 1,837 (RN) – Complex Continuing Care Hospital
 - 55.0% full-time, 28.3% part-time and 16.7% casual.
- 12 (NP) – Complex Continuing Care Hospital
 - 66.7% full-time (remaining data suppressed)

Context for Action

The CCC sector is an important part of the health system that enables the transition from hospital to home. Medically fragile, yet largely independent people, can’t be discharged without adequate community support that has the capacity to meet their care needs (i.e. supportive housing with RNs that provide tracheostomy care).^{26,27} If community supports are unavailable, the patient continues to occupy a CCC bed. There is an opportunity to enhance community supports to facilitate appropriate discharge timing. Additionally, when CCC centres have control over beds, and not Community Care Access Centres, they are able to leverage capacity and accept patients with an increased complexity.

The role of the RN in CCC is critical. Enhancing scope of practice utilization and continuously supporting RNs to serve as team leaders will benefit patients. Both self-assessment and evidence-based practice can be used to help build RNs’ capacity to embrace this leadership role.

Long-Term Care (Residential Care)

Defining Residential Care

Residential care services provide accommodation and support for people who can no longer live at home.²⁸ In Ontario, residential care is offered in long-term care homes, retirement homes and through assisted living programs.

Long-term care (LTC) homes are defined by government as places where [persons] can live and receive support services. They are often the right choice for [those] who need help with the activities of daily living, access to 24-hour nursing care or supervision in a secure setting. In general, LTC homes offer higher levels of personal care and support than those typically offered by either retirement homes or supportive housing.²⁹

Retirement homes are defined in legislation as a residential complex or the part of a residential complex:

- (a) that is occupied primarily by persons who are 65 years of age or older,
- (b) that is occupied or intended to be occupied by at least the prescribed number of persons who are not related to the operator of the home, and
- (c) where the operator of the home makes at least two care services available, directly or indirectly, to the residents.³⁰

Assisted living refers to the provision of housing and services that allow residents to age in place at a retirement home with light to medium supports before having to move to a long term care home. In this way, services bridge the gap and are often the in-between choice of independent supportive living and long term nursing care. Individuals are able to direct their own care, in separate, self contained units. They are cognitively capable and have the ability to make informed decisions regarding their care needs and living arrangements or are living with a spouse / partner that is able to do so. In addition to the basic security and safety, meals, social activities and housekeeping offered in an independent supportive living residence, assisted living services typically include assistance with bathing, dressing, grooming, washing, hygiene, eating, gentle reminders, help with taking medication and assistance for those with mild Alzheimer's disease or dementia. Nursing services are usually provided.³¹

Working Status:

In 2013, the CNO reports the following number of RN positions in Ontario³²:

- 9,135 (RN) – Long-Term Care
 - 48.7% full-time, 29.3% part-time and 22% casual.
- 63 (NP) – Long-Term Care
 - 50.8% full-time, 33.3% part-time and 15.9% casual.
- 635 (RN) – Retirement Homes

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- 46.8% full-time, 33.5% part-time and 19.7% casual.
- NIL (NP) – Retirement Homes

Context for Action

Every LTC home in the province is working diligently to provide the highest level of quality care to their residents. However, the reality is that finite resources, high workloads and complex resident conditions are straining the current system.

Evidence-based legislated minimum standards of care should be adopted in long-term care (LTC) homes³³, including funding for no less than an average of 4.0 hours of nursing care per resident, per day and no less than .59 RN hours per resident, per day; with greater acuity requiring more hours of care. Resident clinical and social outcomes are maximized with a staff mix of: (1) one NP per LTC Home, with no less than one NP per 120 residents, (2) at least 20 per cent RNs, (3) 25 per cent RPNs and (4) 55 per cent personal support workers (PSWs), subject to increases that align with greater acuity. Two RNs working 24/7 per 100 beds are the recommended minimum to allow for surge capacity as it becomes necessary.³⁴

An all too common scenario occurs in LTC homes when a resident develops a relatively common infection (i.e. urinary tract) or requires a certain medication. Physicians typically visit long-term care homes on a week or bi-weekly basis and given the frequency of these issues, are rarely able to respond in a timely manner. Given that RNs and RPNs are in short supply and the current regulatory framework does not enable them to manage these conditions, an ambulance is called and the resident is transferred to an Emergency Department (ED). Toronto's University Health Network estimates that this process costs the health system at minimum, \$589 in transportation and clinical costs for each visit.³⁵ Concurrently, this process is taxing ED/ambulance resources that could be directed towards more urgent matters, increasing ED wait-times, increasing the risk for infectious disease transmission and creates a highly stressful experience for the LTC resident.

The solution is simple, the Ministry of Health and Long-Term Care (MOHLTC) has the opportunity to create NP positions in Ontario's LTC homes (at a rate of one NP for 120 residents, phased in) by making a relatively modest investment when compared to the significant economic savings and quality care impact that this can produce. Increasing the presence of NPs in LTC homes is supported by the Sharkey Report which describes the "demonstrated value" of NPs towards fostering "positive health outcomes for patients/residents".³⁶ While LTC mobile outreach teams, that dispatch RNs and other professionals to LTC homes, have produced impressive short-term gains, they cannot replicate the level of quality resident care and continuity that is offered through a long-term relationship with a dedicated NP. RNAO is encouraged by the MOHLTC's announcement in March 2014 to begin funding NPs in LTC homes.³⁷

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There is a need to increase the subsidy of long-term care and retirement homes.³⁸ While continued efforts are required to enhance the regulation of retirement homes³⁹, there is a parallel need to shift from a culture of compliance to a culture of quality in long-term care.⁴⁰

There is also a need to support RNs to effectively assume leadership roles in long-term care homes.⁴¹ Concurrently, there is tremendous opportunity and capacity to build an evidence-based practice culture in long-term care.^{42,43}

References

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http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf

² RNAO's Primary Solutions for Primary Care Report: www.rnao.ca/primary_care_report

³ The Commission on the Reform of Ontario's Public Services:

<http://www.fin.gov.on.ca/en/reformcommission/chapters/ch5.html>

⁴ Toronto Star Editorial Board:

http://www.thestar.com/opinion/editorials/2013/10/15/let_ontario_nurses_prescribe_basic_drugs_editorial.html

⁵ OANHSS Submission to the Standing Committee on Finance and Economic Affairs:

http://www.oanhss.org/oanhssdocs/MembersOnly/PositionPapers/March_2013_FinanceandEconomicSubmission.pdf

⁶ CUPE – Ontario Must Fund Long-Term Care On Par With Other Provinces:

<http://www.cupe.on.ca/doc.php?did=2486>

⁷ University of Toronto – Improving Seniors Quality of Life:

<http://www.utoronto.ca/seniors/focusGroups/healthCare.htm>

⁸ RNAO Strengthening Client Centred Care in Long-Term Care: <http://rnao.ca/policy/position-statements/position-statement-strengthening-client-centred-care-long-term-care>

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¹⁶ Canadian Nurses Association Certification:

<http://www.nurseone.ca/Default.aspx?portlet=StaticHtmlViewerPortlet&ptdi=153>

¹⁷ World Health Organization: <http://www.who.int/topics/rehabilitation/en/>

¹⁸ CIHI: https://secure.cihi.ca/free_products/OHA_Rehab_07_EN_final_secure.pdf

¹⁹ CNO Data Query Tool

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