Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Nursing Home Basic Care Guarantee

RNAO Submission to the Long-Term Care Staffing Study Advisory Group

June 9, 2020

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Executive Summary

Seventy-nine thousand (79,000) of the province's frailest seniors call Ontario's 626 long-term care (LTC) facilities *home* and trust them to meet their physical, social, spiritual and cognitive needs on a daily basis. The resident population is older, with 93 per cent over 64 years of age, 82 per cent being over 74 and 55 per cent over 84.[1] And while there are definitely challenges in providing holistic care to seniors due to the increasing numbers in the "frail elderly" category and their rising acuity, we know care for older persons in our society can be provided in a manner that is safe, humane and client and family-centred.[2 3 4 5 6]

This submission is in response to the Long-Term Care Staffing Study Advisory Group [7] struck to address Recommendation 85 of the Gillese Inquiry into the criminal acts of a staff member that resulted in the untimely deaths of a number of residents and issued its recommendations on July 31, 2019.[8] Justice Eileen Gillese gave the government a deadline of July 31, 2020 to develop a staffing plan for long-term care, and table it in the legislature.

In this submission, the Registered Nurses' Association of Ontario (RNAO) asks to establish a "Nursing Home Basic Care Guarantee" for residents living in nursing homes. RNAO calls for a new era in LTC by guaranteeing the basic care needed, shoring up staffing levels for regulated and personal support staff, and adjusting the staff mix, so residents in nursing homes can count on consistent, safe and quality care.

A Nursing Home Basic Care Guarantee will give families the peace of mind to sleep at night, and provide staff with resources so they don't struggle to provide the care residents deserve. The Basic Care Guarantee means that no home – whether for profit or not-for-profit – will provide care below the guarantee.

The Basic Care Guarantee is operationalised through a staffing formula that requires minimum staffing hours and the knowledge, competencies and skills demanded by the complexity and acuity of care needs in LTC. The staffing formula to address the crisis of staffing in LTC must include (a) adequate numbers of staff, and (b) the proper skill mix of regulated and unregulated staff – including larger utilization of nurse practitioners (NP), registered nurses (RN), registered practical nurses (RPN).

The guarantee is for a staffing formula that provides no less than 4 hours of direct nursing and personal care per resident per day. The formula also calls to ensure the proper skill mix by allocating a minimum of 0.8 hours (48 minutes) of RN care per resident per day, 1.0 hours (60 minutes) of RPN care per resident per day, and 2.2 hours of PSW care (132 minutes) per resident per day. Such an allocation would provide each resident with safe care and quality of life.

The acuity and vulnerability of LTC residents drives RNAO's staffing formula, and the urgent need for more RN and RPN staff, best equipped with the knowledge and the regulatory mandate to provide safe and quality care. Each home should also have one NP for every 120 residents. The government must also fund each home to hire a nurse (preferably an RN) to focus on infection prevention and control and staff orientation, training and professional development.

RNAO's recommended 4 hours of care, based on past studies of care need, is very conservative given the rising acuity. In 2017, the government committed to providing these 4 hours of direct care. Shockingly, only 2.71 hours of direct care are currently provided to each resident on a daily basis. This means LTC residents in Ontario receive one third less nursing and care hours than the very conservative estimate government committed to, and never implemented, since 2017.

Equally alarming, is that current legislation in Ontario does not specify skill mix ratios for RNs, RPNs and PSWs; it only assigns one RN on-site per shift, which is grossly deficient. We estimate the current skill mix at 0.30 hours of RN care per resident per day, 0.49 hours of RPN care and 1.92 hours of PSW care.

Compared to the Basic Care Guarantee, all three groups are below the recommended levels of nursing and personal care staff hours. For RNs, the shortfall is 63 per cent from the recommended level; for RPNs, there is a shortfall of 51 per cent and for PSWs, the shortfall is 13 per cent. Added to these deficiencies is that only a small number of nursing homes have NPs and most must do without any.

The recommendations in this report, intended as a remedy, detail the required staffing formula:

1. Fund each long-term care home to provide a minimum of 4 worked hours of nursing and personal care to each resident per day, according to the following staff mix formula:
    a. RN staff in all homes at 20 per cent of the total nursing and personal care staff hours
    b. RPN staff in all homes at 25 per cent of the total nursing and personal care staff hours
    c. Personal support worker (PSW) staff in all homes at 55 per cent of the total nursing and personal care staff hours

    This equates to the following number of resident care hours:

    d. a minimum of 0.8 worked hours of RN care per resident per day
    e. a minimum of 1.0 worked hour of RPN care per resident per day
    f. a minimum of 2.2 worked hours of PSW care per resident per day
2. Fund each LTC home for one NP per every 120 residents, in the role of Attending NP or Director of Clinical Care.
3. Fund each LTC Home with one additional nursing full-time equivalent (FTE) staff (preferably an RN) to support the functions of infection prevention and control, quality improvement, staff education, on-boarding and orientation.
4. Fund each LTC home to implement the following mandated standards:

    (a) Disallow LTC staff (RN, RPN, PSW) from working in other LTC homes;

(b) Ensure that nursing and personal care salaries in LTC are commensurate with those paid to the same health workers in other sectors, such as hospitals; and

(c) Ensure that full-time employment with benefits is offered to staff who want full-time work, to enable continuity of care for residents, improve staff retention and remove the need to work in multiple locations.

5. Fund each LTC home to include an appropriate complement of interprofessional staff consisting of: physiotherapy, rehabilitation therapy, speech therapy, social work, dietary, and dental care.

RNAO calls on the Ontario government to establish a Nursing Home Basic Care Guarantee and immediately implement the related staffing recommendations. This is the only way to avoid the ongoing crisis in nursing homes.

These recommendations require increases to staffing levels and changes in skill mix in LTC, with cost implications. Given the current staffing levels and skill mix, Ontario is short 22,898 FTEs in nursing and personal care, including 8,972 RNs, 9,051 RPNs and 4,875 PSWs, when compared with the recommended standard (see table below).

The annual cost in total would be $1.76 billion, which pales in comparison with the many billions Ontario is losing now because it has been forced to partially shut down its economy, to belatedly protect its most vulnerable people. It is also not large relative to the $63.8 billion health budget.[9]

Estimated vs. Recommended Minimum Hours of Nursing and Personal Care Per Resident-Day				
	RNs	**RPNs**	**PSWs**	**Total**
Estimated current skill mix	11%	18%	71%	%100
Recommended skill mix	20%	25%	55%	%100
Estimated worked hours per resident day (2016)	0.30	0.49	1.92	2.71
Recommended minimum worked hours per resident day	0.8	1.0	2.2	4.0
Estimated shortfall of FTEs[10]	8,972	9,051	4,875	22,898
Cost to fill the hours deficit/year	$867,576,366	$610,475,088	$278,623,450	$1,756,674,903

The Canadian Armed Forces report on the homes it was helping recover from COVID-19 showed all of us in simple, stark language how a severe shortage of staffing, equipment and support badly harmed and killed hundreds of the most vulnerable people in Ontario. [11] Cutting corners on LTC funding and on public health has come back to haunt Ontarians and Canadians in a big way. The unemployment rate almost doubled overnight

because we had to shut down much of the economy to compensate for the fact that we weren't able to protect our vulnerable citizens. Billions of dollars have been lost in our haste to cut millions from the budget. We must act now to establish a Nursing Home Basic Care Guarantee because many lives remain at risk. We can avoid even greater costs in the future by investing in LTC staffing today. Such an investment will get us to a staffing level that is safe for residents and provides them with a decent quality of life.

RNAO firmly believes we owe it to the families of those who have lost loved ones to COVID-19 while residing in an LTC home, to enact these recommendations immediately. We owe it to residents who today are in LTC homes, so they and their families know they have a care guarantee that ensures their safety and quality of life. The Basic Care Guarantee must be introduced immediately and its related staffing formula must become a reality in 2020.

The time for deliberation and data collection has clearly expired. In RNAO's view, it is imperative that immediate action be the watchword as we move out of this quagmire of problems to a brighter tomorrow. We are eager and ready to work collaboratively to bring this brighter vision to fruition.

Introduction

This submission is in response to the Long-Term Care Staffing Study Advisory Group [12] struck to address Recommendation 85 of the Gillese Inquiry into the criminal acts of a staff that resulted in the untimely deaths of a number of residents and issued its recommendations on July 31, 2019.[13] Justice Eileen Gillese gave the government a deadline of July 31, 2020 to develop a staffing plan for long-term care, and table it in the legislature.

In this submission, the Registered Nurses' Association of Ontario (RNAO) asks to establish a "Nursing Home Basic Care Guarantee" for seniors living in nursing homes. RNAO calls for a new era in LTC by guaranteeing for the basic care needed, shoring up staffing levels for regulated and personal support staff, and adjusting the staff mix, so residents in nursing homes can count on consistent, safe and quality care. It builds on RNAO's long involvement in LTC policy-making and a number of earlier reports and submissions.[14 15 16 17 18 19 20 21 22 23]

For years, RNAO has been championing the need for attention to safety and quality in LTC, which includes leading edge support and monitoring of the uptake of nursing best practice guidelines (BPGs) through RNAO's LTC program, introduced by the MOHLTC in 2005, in partnership with RNAO in an advisory role, and becoming a program led by RNAO, in 2008.[24 25] RNAO expanded this program in 2014 with the introduction of the Long-term Care Best Practice Spotlight Organization (BPSO) model to ensure sustained organization-wide use of evidence in practice with impressive outcomes for residents, staff and the long-term care homes.[26 27]

In addition, RNAO's voice fueled the government response in 2017 to establish the Long-Term Care Homes Public Inquiry following the deadly outcomes for residents due to the actions of an LTC staff member, that were inadvertently enabled by long standing systemic problems.[28 29 30] For over a decade, RNAO has led the way in speaking out for more regulated staff in LTC, including championing funding for one Attending Nurse Practitioner (NP) for every 120 residents in each of Ontario's 626 LTC homes.[31 32]

Once again in the current COVID -19 crisis, RNAO has been relentless calling attention to pending and then erupting issues in long-term care due to policy neglect. [33 34 35]

On May 12, 2020, with the release of *Enhancing Community Care for Ontarians (ECCO) 3.0*, RNAO has advocated for a robust integrated health system anchored in primary care and ensuring that LTC be an integral part of community care, included in Ontario Health Teams and consistently at the health care decision-making tables. [36 37]

In this report we consolidate RNAO's earlier work by calling for a Nursing Home Basic Care Guarantee with its related staffing formula and other key recommendations for staffing in the sector, to become a reality in 2020.

RNAO calls on the government to adopt, fund and implement a Nursing Home Basic Care Guarantee for residents of nursing homes so they can be assured safe and quality care, their families can sleep at peace, and staff does no longer need to struggle to provide the minimum care needs of their residents. It means that no home – whether for profit or not-for-profit – will provide care below the guarantee.

A Sector in Permanent Crisis

Growing Acuity

The province's 626 long-term care (LTC) facilities are *home* to 79,000 of Ontario's frailest seniors, who along with their families trust them to meet their physical, social, emotional, spiritual and cognitive needs on a daily basis. As the table below shows, the older you are, the more likely you are to be in an LTC home. For example, 0.6 per cent of Ontarians 65 to 74 are in LTC, while 27.3 per cent are over 94. About 44 per cent of all LTC residents are age 85 to 94. Residents are not only older, they also present with severe chronic conditions, which means they need expert evidence-based care from a team of staff who understand how to care for older persons, are compassionate, attentive and can take the time to promote independence and quality of life.

Ontario Estimated Number of LTC Residents by Age Cohort			
Age Cohort	**LTC Residents by Age Cohort[38]**	**Estimated # Residents by Cohort**	**Estimated Share of Cohort Living in LTC[39]**
>94	10.8%	8,496	27.3%
85-94	43.9%	34,533	11.8%
75-84	27.3%	21,475	2.9%
65-74	11.4%	8,968	0.6%
<65	6.6%	5,192	0.04%
Total	100%	78,664	0.05%

Ontario's seniors' population has out-paced the glacial growth in LTC beds for years. Between December 2014 and September 2019, the number of LTC beds grew 0.69 per cent,[40] while the province's population grew 5.6 per cent and the population over 74 grew 17.6 per cent.[41] As a result, Ontario LTC wait lists have risen to almost 35,000 and median wait times are now 152 days.[42] Furthermore, the Ontario's Financial Accountability Office warns that many more LTC beds than planned will be needed just to keep wait lists from growing.[43]

Thus, only the most acute applicants qualify for LTC placement, which means the already-high acuity keeps rising. In turn, LTC homes struggle to address the resulting complex care needs of residents and challenging workloads of staff. Repercussions from this imbalance are felt through the health system. The wait lists contribute to hallway medicine in hospitals, where many of their beds are occupied by alternate levels of care (ALC) patients who no longer require hospital care, yet cannot be discharged because they are not well enough to go home and cannot find an LTC bed.

Pandemic Bares Vulnerabilities

The pandemic has laid bare the extreme vulnerability of the LTC system. Most prominent for the public was the Canadian Armed Forces (CAF) report, which noted the following in the five homes it was requested to assist:[44]

- dangerously inadequate infection control

- dismal quality of care and lack of sanitation
- severe rationing of supplies, which were often expired
- poor communication
- serious understaffing, inadequate support and poor morale
- inappropriate and abusive behaviour

The pandemic exposed all of these issues and more. The problems related to the long-standing shortfalls in staffing and other quality, management, and funding issues that contributed to the devastating outcomes, and which are widely understood and widely reported:

- The resident population is highly susceptible to infectious disease and vulnerable to the most severe consequences.
- Accommodation circumstances make physical isolation very difficult. Many rooms are shared with one or more other unrelated persons. As one nurse said of the crowding, it was only after a number of deaths that the home had the space to be able to implement physical distancing.[45]
- Many staff members hold multiple jobs in order to make ends meet. Outbreaks then travel from home to home, with tragic results. We know this is a big problem for PSWs, but 2,341 RNs in LTC hold two positions and 483 others hold three or more. Thirty-one per cent of RNs in LTC held multiple positions, much more than hospital RNs (19 per cent) and community RNs (24 per cent).[46]
- Many LTC homes initially lacked and many still lack adequate COVID-19 screening procedures and personal protective equipment (PPE) against infection.
- Staffing levels were increasingly inadequate over time to meet the very high needs of residents, and homes quickly became overwhelmed when the virus struck, due to the rising care needs and limited capacity to isolate sick residents. This was further exacerbated by the loss of staff to illness, fear, isolation requirements, and by restrictions on staff working in multiple facilities.

It is not surprising that the pandemic hit the LTC sector to an extraordinary extent. In Ontario, a large majority, 80.1 per cent of COVID-19 related deaths have been in LTC,[47] even though only about 0.5 per cent of Ontarians live in those homes.[48] LTC residents are bearing the brunt of the risk. As of June 8, 2020, at least 298 of 626 Ontario LTC homes had experienced COVID-19 outbreaks, with 1,738 resident deaths and seven staff deaths.[49] The problem is not unique to Ontario, even within Canada. But many jurisdictions have done much better, and Ontario must act quickly to address the urgent issues revealed to improve its performance.

The Imperative for Decisive Action and Investment

It is evident that substantially more resources are needed to meet the needs of Ontario's elderly and to keep them safe in regular times let alone during a pandemic. Just as important as determining what those resources are, and their numbers, is to make sure that the required knowledge and skills are available for their care. This

means establishing the staff skill mix ratios needed not only to keep residents safe, but to keep them healthy, functional and as independent as possible. For all these reasons, RNAO is urging that the government make rapid and decisive changes to staffing to address numbers, ratios, types and roles of staff according to the staffing formula presented herein.

Staffing for Safety and Quality through a Basic Care Guarantee

Establishing a Nursing Home Basic Care Guarantee

The key message of this submission is that RNAO is calling on the government to adopt, fund and implement a Nursing Home Basic Care Guarantee for residents of nursing homes with its related staffing formula. Residents must be assured safe and quality care, and that will be achieved through a basic care guarantee that will apply to homes, whether for profit or not-for-profit.

The Basic Care Guarantee is operationalized through a staffing formula that requires minimum staffing hours and the knowledge, training and skills demanded by the complexity and acuity of care needs in LTC. The staffing formula to address the crisis of staffing in LTC needs to include (a) adequate numbers of staff, and (b) the proper skill mix of regulated and unregulated staff – including larger utilization of nurse practitioners (NP), registered nurses (RN) and registered practical nurses (RPN). We proceed to elaborate on this staffing formula.

Four Hours of Direct Care – A Bare Minimum

In 2017, the government committed to providing four hours of direct care per day per resident.[50] This target mirrors the target in a 2008 report by RN Shirlee Sharkey.[51] It is obvious to anyone who visits an LTC home that most residents need high levels of care and assistance with the activities of daily living, such as dressing, feeding, toileting and bathing. There is no shortcut and four hours of nursing and personal care is a very conservative minimum based on research that is decades old when acuity was lower.[52] Armstrong et al. make this point about the four hour estimate growing more conservative over time as acuity rises.[53]

Based on the best available evidence and given the high and increasing acuity of Ontario's long-term care residents, this regulated and enforced care standard should require a minimum of four worked hours per resident per day of hands-on nursing care and personal support. In short, the guarantee is for a staffing formula that provides no less than 4 hours of direct nursing and personal care per resident per day. In addition, because this is a bare minimum requirement, there should be mechanisms to recognize that at times, such as during a severe outbreak in the home, more staffing will be required on a temporary basis and should be properly funded.

Shockingly, although the recommendation was made in 2008,[54] to this day the four hours of direct nursing and personal care per day per resident has not been implemented leaving residents short of staff to meet their needs. According to the best estimate (discussed later in this report), currently only 2.71 hours of direct care are provided to each resident per day. This means LTC residents in Ontario receive *one third less* of nursing

and care hours than a very conservative estimate suggests for the need. It is not surprising that this is a system in permanent crisis that faced catastrophic consequences with the arrival of the pandemic.

The staffing gap is dangerously large, and a significant staffing increase is required. As RNAO has repeatedly underscored, the warnings have been there for decades. The Casa Verde Inquest,[55] the Sharkey report,[56] and the Gillese report,[57] among many others all identified the need for the province to address inadequate staffing in the LTC sector. On June 5, RNAO released a summary of the recommendations of 35 reports related to staffing and funding models in LTC over the past 20 years,[58] [59] and they consistently flag staffing shortages in LTC.

The Need for a Proper Skill Mix

Equally worrisome is that current legislation in Ontario does not specify skill mix ratios for NPs, RNs, RPNs and PSWs; it only requires one RN on-site per shift,[60] [61] which is gravely inadequate. There are powerful evidence-based reasons a proper skill mix is required for safe and quality care in the LTC sector.

Personal support workers generally study a 28-week program at one of Ontario's Colleges of Applied Arts and Technology.[62] Their curriculum follows the program standard set by the ministry[63] and consists of basic education to provide client-centred and client-directed personal care related to activities of daily living and other needs, when working with dependent and vulnerable older persons and their families. This role is carried out in collaboration with other regulated nursing staff, and the interdisciplinary care team. PSWs play a central role in caring for and engaging residents, and in observing their behaviour and condition.

Once in the role, PSWs are taught what key areas to observe for, through checklists or requests from a supervising RN or RPN, and to report regularly on observations. It is important for them to have ready access to regulated staff so that their observations can be reported and assessed in a timely manner, since it is not reasonable to expect them to know what is urgent or not, given the length and focus of their training.

Considering the PSW staffing shortfall and broad range of personal care, eating, mobility support and toileting activities necessary numerous times a day, as well as the lack of ready available direction and ongoing oversight by RNs and RPNs, the PSW role is at best a challenge, and at worse, impossible. As the CAF report revealed in its reports on struggling LTC facilities, all nursing and personal care staff are simply spread too thin.[64]

In relation to regulated staff, it is important to note that The College of Nurses of Ontario (CNO) determines scope of practice for RNs and RPNs, using a three-factor framework (client, nurse, environment),[65] and as a result, the level of autonomous practice of RNs differs from that of RPNs. The complexity of a client's condition influences the nursing knowledge required to provide the level of care the resident needs. A more complex client situation and less stable environment (lack of time, unclear procedures, and policies) create an increased need for consultation with and/or direct care provision by an RN.[66] Thus in LTC, while RNs and RPNs play full roles in all dimensions of practice, RNs lead and provide care to complex residents and their families.[67]

The current staffing of RNs is dangerously low. As mentioned, current regulation only requires one RN on-site per shift. Once the single RN on the shift completes the LTC home administrative, management and specific required clinical decision-making, there is often little or no time to directly attend to complex patients and follow up with and receive feedback from PSWs and RPNs.

The current staffing of RPNs is also inappropriately low. RPNs play an important role supporting direct care, often in complex situations guided by an RN, and generally take the lead in medication administration up to four times per day to all residents.

In addition, one registered staff (RN or RPN) from this already stretched resource is often placed in the infection control and quality improvement role. Because of competing demands on registered staff – keeping abreast of the myriad of requests from residents, families, other professional team members, and tending to clinical care needs and treatments – infection control and quality improvement roles can fall by the wayside, until there is an outbreak, when it is too late.

Added to these deficiencies is the fact that only a minority of nursing homes (less than 100) have NPs, in spite of the fact that RNAO has been calling since 2012 for one NP per LTC home and no less than one NP per 120 residents.[68]

In short, the current standard fails on two counts: the overall number of hours of care is too low, and there is no consideration of the proper skill mix – a requirement that a certain number of hours of care be provided by NPs, RNs, RPNs and PSWs.

RNAO's Proposed Basic Staffing Formula

In this response, RNAO proposes a simple formula that fulfills the Basic Care Guarantee to address the crisis of staffing in LTC to include:

(a) adequate numbers of staff, in the form of a minimum of 4 (four) worked hours of nursing and care hours per resident per day,

(b) the proper skill mix of regulated and unregulated staff – including larger utilization of nurse practitioners (NP), registered nurses (RN) and registered practical nurses (RPN), equating to the following number of resident care hours:

1. a minimum of 0.8 worked hours of RN care per resident per day
2. a minimum of 1 worked hour of RPN care per resident per day
3. a minimum of 2.2 worked hours of PSW care per resident per day

(c) provide for one NP per every 120 residents, in the role of Attending NP or Director of Clinical Care,

(d) allocation of an infection prevention and control specialized nurse to each LTC home,

(e) mandated human resources standards including - disallow LTC staff (RN, RPN, PSW) from working in other workplaces, ensure that nursing and personal care salaries in LTC are commensurate with those paid to the

same health workers in other sectors, and ensure that full-time employment with benefits is offered to staff who want full-time work, and

(f) a complement of interprofessional staff to augment the nursing and personal support staff.

The proposed staffing ratios have been presented in earlier RNAO submissions with evidenced-based arguments for more RNs and a higher skill mix, to include: RN staff providing 20 per cent of the total nursing and personal care staff hours per resident per day, RPN staff providing 25 per cent of the total, and PSWs providing 55 per cent of that total.[69 70 71 72 7374]

NPs in the Attending role not only assume responsibility for the management and coordination of resident care, but are also critical in health promotion, management of chronic conditions, and the early detection and treatment of medical complications.

The proposed RNAO staffing formula recognizes the specialized nature of LTC and the need to have a nurse (preferably RN) as an additional component of the mandatory staffing, dedicated to lead infection prevention and control as well as on-boarding, orientation, mentoring, and staff development.

The funding will include an appropriate complement of inter-professional staff consisting of: physiotherapy, rehabilitation therapy, speech therapy, social work, dietary, and dental care.

Staffing and Budgetary Shortfalls

The current skill mix in terms of hours of care provided is estimated as 11 per cent RNs, 18 per cent RPN and 71 per cent PSW (see table below).[75 76] The most recent publicly available estimate of the amount of actual nursing and personal care per resident per day in Ontario was 2.71 hours.[77] Using the current skill mix percentages, this equates to 0.30 hours of RN care per resident per day, 0.49 hours of RPN care per resident per day and 1.92 hours of PSW personal support per resident per day.

All three groups are below the recommended levels of nursing and care hours: RN - 0.8 hours (a shortfall of 63 per cent from the recommended level), RPN - 1 hour (a shortfall of 51 per cent) and PSW - 2.2 hours (a shortfall of 13 per cent). Although the three groups have shortfalls, the shortfall of registered staff is the most acute.

The estimated shortfall of nursing and personal care worked FTEs is 22,898, including 8,972 RN FTEs, 9,051 RPN FTEs and 4,875 PSW FTEs. The annual cost to meet this standard for nursing and personal care is under $1.8 billion (see chart below).

The methodology to derive these estimates and estimates of the associated costs appears in Appendix B: *Existing vs. Recommended Staffing in Long-term Care*. The assumptions are conservative, to put upper bounds on the total cost.

Estimated vs. Recommended Minimum Hours of Nursing and Personal Care Per Resident-Day				
	RNs	**RPNs**	**PSWs**	**Total**
Estimated current skill mix	11%	18%	71%	%100
Recommended skill mix	20%	25%	55%	%100
Estimated worked hours per resident day (2016)	0.30	0.49	1.92	2.71
Recommended minimum worked hours per resident day	0.8	1.0	2.2	4.0
Estimated shortfall of FTEs[78]	8,972	9,051	4,875	22,898
Cost to fill the FTE deficit/year	$867,576,366	$610,475,088	$278,623,450	$1,756,674,903

RNAO's Staffing Vision

RNAO's staffing vision for the reinstatement of quality of care and quality of life in caring for our elderly is included in the following description of a new era in long-term care (next page).

Envisioning a new era in LTC: The reward of increased staffing and a mandated skill mix

The person- and family-centred approach is fully adopted in this setting, meaning there is an overall atmosphere of a vibrant community in the home, with family members fully embraced and engaged along with residents in care, activities and socialization, partnering with knowledgeable, available and attentive staff. At a glance it is easy to see that the residents are supported, engaged in communication, and assisted with personal care -- toileting, eating, mobility, and activation -- as needed, and are frequently monitored.

Prominent in this vision is the presence of **Personal Support Workers in numbers sufficient to provide at least 2.2 worked hours of supportive care to each resident on a daily basis.** They provide the majority of direct care to those residents needing support with activities of daily living. In doing so they have regular contact with registered staff that follow up on PSW observations, provide oversight of their personal care, and give direct nursing care as required.

Registered Practical Nurses are evident in this vision in numbers sufficient to provide at least 1 worked hour of care per resident per day, focusing on working closely with PSWs and RNs, and administering treatments, medications and following up on expected outcomes and any related challenges. The RPN cares for and regularly monitors stable residents with physical and mental health needs including those with dementia, those requiring monitoring for cardiac conditions, diabetes, bowel and bladder issues, wound care or hypertension. There is time to conduct regular planned rounds throughout the shift to address issues as they arise, and interact with residents and families.

Registered nurses are available in numbers sufficient to provide at least 0.8 worked hours of care per resident per day, to follow up on observations made by PSW staff, work collaboratively with RPNs, and members of the interprofessional team, and complete full assessments of residents as needed -- to detect infection or any change in overall health status that requires NP follow up. RN staff members are available to monitor or, in specific cases, provide direct care to those residents with more complex clinical, behavioural support and mental health needs, and make decisions related to referrals, follow up and in some cases to transfer to hospital as necessary. The RN staff complement also supports a quality resident admission process including introduction to the facility, a comprehensive assessment and establishment and maintenance of a person-centred care plan, relationship building with the new resident and their family, and full documentation.

Interprofessional team members, including physiotherapy, speech therapy, dietary, dental/oral care providers and others, **are available to meet the numerous specialized needs of residents, on referral from RNs and RPNs.**

The presence of a Nurse Practitioner, for every 120 residents, in an Attending role or as Director of Clinical Care, facilitates a smooth work flow, enabling treatments, referrals, and/or medications to be ordered, changed or discontinued based on resident need. NPs provide expert clinical and gerontology knowledge and skill, enhancing the level of care. For example, palliative needs are well addressed by this coordinated team, and residents who are palliative have pain and other care needs addressed, family members present, and the highest quality of life possible at this stage.

The presence of a full time infection prevention and control nurse, preferably a RN, means protocols for preventing and managing infections are up to date, understood and adhered to by all staff in the home. The role includes conducting regular drills for managing outbreaks, and debriefing and following up as needed. Through this role, staff are on-boarded, fully oriented, and have specific professional development and ongoing opportunities to learn evidence-based interventions tailored to their needs and training/education. Overall, there is a focus on continuous quality improvement, with regular team meetings for review of team functioning, resident care plans, critical incident debriefing and follow up.

This vision of staffing in LTC is based on principles of: adequate numbers, appropriate skill mix, ready availability of advanced clinical knowledge and skill through the NP role as Attending NP or Director of Clinical Care, special attention to staff needs regarding orientation, infection control and quality improvement, as well as access to members of the inter professional team.

However, fixing this system requires more than getting adequate resources -- it means re-thinking the way that we deliver that care, in a more resident- and family-centred way that empowers residents, family and staff to meet each resident's unique needs and to allow them to lead the healthiest and most meaningful lives possible (see for example RNAO's best practice guideline on Person- and Family-Centred Care[79]). In the process, it would move Ontario towards the attributes of RNAO's ECCO 3.0 model including the Quadruple Aim embraced in its health vision: improved patient and caregiver experience; improved population health; greater efficiency; and improved work life of providers.[80]

Recommendations

RNAO calls on the government to immediately adopt, fund and implement a Nursing Home Basic Care Guarantee that fulfills the following recommendations:

Recommendation 1: *Fund each long-term care home and require the provision of a minimum of 4 worked hours of nursing and personal care to each resident per day, according to the following staff mix formula:*

a. RN staff in all homes at 20 per cent of the total nursing and personal care staff hours

b. RPN staff in all homes at 25 per cent of the total nursing and personal care staff hours

c. PSW staff in all homes at 55 per cent of the total nursing and personal care staff hours

This equates to the following number of resident care hours:

d. a minimum of 0.8 worked hours of RN care per resident per day

e. a minimum of 1 worked hour of RPN care per resident per day

f. a minimum of 2.2 worked hours of PSW care per resident per day

This skill mix ratio, and number of nursing and personal care staff, similar to that recommended over the past 20 years, are imperative now given the growing acuity in the LTC sector, which is the key reason a richer skill mix is required.

This is a result of the huge waiting list, so that only the most acute applicants qualify for LTC placement, which means the already-high acuity keeps rising. From 2004 to 2009, Case Mix Measure (CMM) rose by 12.2 per cent, while Case Mix Index (CMI) increased by 7.63 per cent from 2009 to 2016.[81] With gains in Canada's life expectancy, residents in LTC homes are now older, frailer, and experiencing more physical and mental health co-morbidity than ever before.[82 83]

The worsening acuity spans all body systems and hence requires health professionals with very broad understanding of chronic conditions: heart and circulatory diseases, hypertension, bowel and bladder incontinence, gastrointestinal diseases, arthritis, and diabetes.[84] Increases in resident acuity and the prevalence of multiple conditions contribute dramatically to overall care needs.[85] For example, the number of LTC home residents who required extensive support with activities of daily living (ADLs) such as eating and grooming increased by 9,000 between 2013 and 2018, and the rise in residents living with bowel and bladder incontinence meant that more than 9,600 additional residents required assistance with toileting in 2017-2018 compared to 2011-2012.[86]

Similar to increases in the rate of residents living with conditions affecting their physical health, the percentage of LTC home residents living with a mental health condition is high and rising. [87] Nearly 83 per cent of all residents in LTC homes experience some form of cognitive impairment, 44 per cent display some form of aggressive (responsive) behaviour, over 40 per cent live with psychiatric or mood diseases such as depression or schizophrenia, and 63.5 per cent had a diagnosis of dementia in 2018-2019.[88]

Parallel to the rise in physical and mental health acuity in Ontario's long-term care system is an unprecedented increase in violence between residents, from staff to residents, and from residents to staff. Between 2012 and 2016, the Ontario Coroner reported 27 resident-to-resident homicides,[89] and from 2011-2016, staff-to-resident neglect and abuse is reported to have increased by 148 per cent in Ontario.[90]

Further to this, violence in the form of physical assault, verbal, sexual and racial harassment from residents towards personal support workers and nursing staff in LTC homes is described as persistent and widespread.[91] [92] [93] In 2019 nearly 90 per cent of surveyed staff in Ontario long-term care homes reported regularly experiencing violence from residents,[94] and in 2017 the lost time injury (LTI) rate for staff in LTC homes was almost double that of LTI in health care generally.[95] The quick pace required by staff in order to address at least the critical issues, limited time to de-escalate behaviours, lack of ongoing professional development on aggression and responsive behaviors, and poor quality improvement practices related to managing violence in all forms contributes to this seemingly toxic work and care environment.

All members of the LTC health team are essential, but the increasing complexity and growing acuity demand a higher and richer skill mix. In the face of multiple co-morbidities, need for extensive supports, rising mental health conditions and cognitive impairment, increase in all forms of violence, abuse and neglect, lost-time injury, etc., the need for a mix of staff with different levels of training, knowledge and skills is evident. A richer skill mix ratio, similar to those recommended in earlier reports over the past 20 years, is imperative now.

All this means that the shortfall in RN staffing be dealt with as a matter of urgency. There is an abundant, robust body of evidence linking quality outcomes for residents of LTC to care delivered by RNs. Research shows that care provided by an RN reduces the risk of mortality, resident hospitalization and its associated costs, as well as improves outcomes such as those related to pressure injuries, urinary tract infections, catheter use, restraint use and falls.[96] [97] [98] [99] [100] [101] The evidence is clear, greater availability of RNs means greater quality of care in nursing homes.[102]

Health acuity leading to the demand for RN nursing staff is fully outlined in Appendix A: *Resident Acuity and Demographics in Long-Term Care*.

Recommendation 2**:** *Fund each LTC Home for one NP per every 120 residents, in the role of Attending NP or Director of Clinical Care.*

Nurse Practitioners (NPs) in Ontario currently have an untapped potential as Attending NPs in LTC.[103] As RNs with graduate-level training, enhanced scope of practice, and specialty expertise, NPs are ideally suited to serve as the most educated care provider for residents in LTC homes. COVID-19 has showcased the outstanding capacity of NPs in LTC, where NPs already affiliated with LTC homes are practicing effectively in the absence of physicians, successfully managing the full range of resident needs.

NPs in the Attending role not only assume responsibility for the management and coordination of resident care, but are also critical in health promotion, management of chronic conditions, and the early detection and treatment of medical complications.[104] [105] The presence of NPs in LTC homes allows for point of care staff education, resident assessment and rapid clinical decision making averting problems and maximizing care quality. They provide a supportive, mentoring environment for staff which enhances their ability to work at full scope. Overall, homes with NPs have decreased unnecessary transfers to Emergency Departments, implemented best practices and created a holistic, end-of-life care culture.

NPs have proven invaluable to the health care system both before and during the COVID-19 pandemic, where their work, often as the only available medical / clinical director, prevented outbreaks, and or limited their extent and impact. Their full potential must be utilized by ensuring there is one Attending NP for every 120 residents in LTC.

In sum, the increasing acuity of residents in long-term care, presentation of complex problems and need for regular review of interventions, medications and referrals clearly supports the need for a readily available nurse practitioner in the home.

Recommendation 3**:** *Fund each LTC Home with one additional nursing FTE staff (preferably a RN) to support the functions of infection prevention and control, quality improvement, staff education, on-boarding and orientation.*

The current pandemic and regular outbreaks of viral infections in long-term care homes also highlight an urgent need for additional staffing in LTC homes to include a nurse (preferably a registered nurse specialized in infection prevention and control), as that function must be available to ensure the facility is always outbreak-ready and able to manage effectively during outbreaks. Additional components of that role must include on-boarding, mentoring, staff development and quality assurance activities for all staff. Such resources for LTC staff will contribute to a healthier work place that attracts and retains a high calibre of staff in the appropriate numbers to the long-term care sector. (See Appendix C: *Template - Infection Prevention and Control/Professional Practice Nurse Role Description*).

Recommendation 4: *Mandate with attached funding the following standards that address long-standing human resource issues:*

(a) Disallow LTC staff (RN, RPN, PSW) from working in other LTC homes;

(b) Ensure that nursing and personal care salaries in LTC are commensurate with those paid to the same health workers in other sectors, such as hospitals; and

(c) Ensure that full-time employment with benefits is offered to all staff who want it.

COVID-19 has exposed the great danger of workers in an LTC facility keeping employment in other workplaces (this danger was a lesson from the SARS epidemic in 2003).[106] The government rightly banned the practice as an emergency measure during the current pandemic, but they should not go back to business as usual because it is too dangerous and costly. The LTC residents are vulnerable to many infectious diseases, and outbreaks of influenza, for example, are all too often deadly in LTC homes.

The CAF report highlights the severe problem in LTC with inadequate staffing. To repair this, we must not only fund and create the required nursing and personal care positions in LTC, but we must ensure that healthcare workers will accept and keep those positions. If compensation and conditions of work are inferior compared to other sectors, this is less likely to happen. Creating the positions is a huge step forward, as it will allow staffing to thresholds where the hours and support make it more possible to deliver safe and high quality care. That matters a great deal to people who choose to work in LTC. However, at the same time, it is sound human resource policy to ensure they are compensated fairly and have access to full-time employment, if they so choose. Otherwise you risk losing those staff to other sectors.

Finally, it is always better that health providers have the option to work full-time no matter what sector, as that is more consistent with continuity of care for residents or patients, and diminishes the likelihood of providers working in more than one workplace.

RNAO urges the provincial government to mandate the above three human resources standards in long-term care, with the attached funding, for PSWs, RPNs, and RNs. These are necessary standards to assure of safe and quality care, recruitment, retention and quality of work life that must be established if government truly wants to "fix the long-term care sector," as Premier Ford has promised.[107]

Recommendation 5**:** *Fund each LTC Home to include an appropriate complement of inter-professional staff consisting of: physiotherapy, rehabilitation therapy, speech therapy, social work, dietary, and dental care.*

As Appendix A: *Resident Acuity and Demographics in Long-term Care* shows, LTC residents have multiple chronic conditions, requiring the need for specialized services and care on an on-going basis to address quality of life challenges, promote optimal functioning, and enhance independence. RNAOs Best Practice Guidelines (BPGs), evidence-based guides to clinical best practices and decision making,[108] are developed with the input of interprofessional team members and those with lived experience, and demonstrate the need for a strong

interprofessional team in the provision of quality, evidence-based practice. RNAO's BPGs highlight the major role of interprofessional team members in a variety of areas critical to long term care residents.

For example, in falls prevention, occupational therapists select and adapt equipment that aids resident mobility,[109] and physiotherapists help to maintain activity to prevent muscle loss and help restore mobility in the advent of a fall or injury. Oral health is a serious issue in long-term care, that can have consequences related to nutrition and infection necessitating the need for registered dental hygienists and denturists who can contribute to an oral care plan.[110] For those older adults with delirium, dementia, and depression, social workers can facilitate a delirium prevention plan with the resident's family and care partners.[111] In the provision of palliative care, all team members share information, support one another's work, and coordinate interventions maximizing the quality of end of life care for the resident and their family.[112]

For the collaboration to be effective, staffing levels must reach thresholds that allow the time for that collaboration to take place, as the Sharkey report concluded.[113]

Achieving RNAO's Staffing Vision and Formula

Staff recruitment and retention in health care and other settings is influenced by quality of work life. Quality of work life is enhanced by environmental factors such as leadership, teamwork, staffing, professionalism, acceptance of diversity, and workplace health and safety.[114] RNAO has numerous healthy work environment (HWE) best practice guidelines[115] (BPG), which are an important workplace resource, because of their impact on recruitment and retention and on quality evidence-based practice.[116] [117] [118] [119]. Attention to critical workplace factors in long-term care will go a long way in attracting staff to this setting. The opportunity to engage in the LTC specialty practice area, with attention to professional development, implementation of best practice guidelines, and a staff mix that enables quality care, will create a workplace of choice for the many nurses focused on care of older persons and gerontology.

Critical attention must also be paid to health human resources policies for nursing and personal care staff in long-term care. PSWs need the time to work with residents and the training to engage and empower residents. The work provided by all caregiving staff is essential; however, it is undervalued and devalued. Nursing and support staff are too often underpaid and under-supported and many do not enjoy secure, full-time employment. As a consequence, burnout and turnover are problems, and lack of full-time employment drives many to take multiple positions, which is a grave risk especially during pandemics.[120]

Transitioning to the New Model

The staffing formula proposed requires a major increase in registered staff. RNAO estimates 8,972 more RN FTEs are required in order to achieve the goal of 0.8 hours of RN care per resident per day. Examination of availability of RNs to achieve these numbers reveals this target is possible in a reasonably short period of time, pending adequate funding to create positions and concurrent changes in the work environment and quality of work life.

Examination of CNO data indicate there were 8,819 RNs in the general class who in 2019 were registered in Ontario but not working in nursing. They include:

- 2,147 registrants who were nursing outside of Ontario,
- 2,254 who were on leave,
- 688 who were working outside of nursing, and
- 3,730 who were not employed.[121]

We believe that those who were unemployed or working outside of nursing are strong immediate candidates to consider employment as RNs in LTC. Those working in nursing outside of Ontario are candidates to return to nursing in Ontario in the medium run -- particularly those who work across the border. Those who were on leave we expect to return. We should be able to recruit well over 3,000 RNs in the short run from this population alone, and a determined effort on all fronts would get us all the way there in a reasonable time. Just as important as recruitment is a strong retention program to keep RNs in nursing. And finally, to maintain these increases in long-term care, as well as address the province-wide shortfall of RNs, it is crucial to increase the numbers of RNs graduating from Ontario nursing programs by raising the first-year enrolments in nursing by 500 seats, after consulting with the education sector.

There is also a huge deficit in NP positions in LTC. In 2015, the government committed to fund 75 LTC homes to hire one NP in an Attending role.[122] Ontario LTCs are currently at 60 of the promised 75 positions for NPs in this role. RNAO is now calling for 1 NP per 120 residents in all LTC homes, in an Attending NP or Director of Clinical Care role. This target can be achieved through a commitment to fund every year at least 100 additional NPs in these roles over the next six years. This is a reasonable target because NPs are entering the Ontario nursing workforce at a rate of several hundred per year, and all of them should have the opportunity to go to LTC. Given the need for NPs in LTC and elsewhere, it is important for the government to support and fund an expansion of NP education programs.[123]

In those homes without access to an available NP for hire, a registered nurse in a clinical nurse specialist (CNS) role should be hired until such time as an NP can be made available. CNSs hold a graduate degree in nursing and have expertise in a clinical nursing specialty, such as gerontology, chronic disease management or mental health. The role covers five domains: advanced practice, consultation, education, research, and leadership, all of which will enhance the clinical expertise and critical decision making increasingly required in long-term care.[124]

The Consequences of Inaction

The effects of COVID 19, due to the long standing unacceptable practices and distressing situations in LTC were starkly brought to light by the Canadian Armed Forces, to whom we owe a great debt of gratitude. We know from aggregate data that resource and staffing levels across the LTC sector are generally a problem across the province, and that other homes will be similarly pressed to deliver a modicum of care. We know

that LTC homes house the most vulnerable people in the province, and they need much better protection than they have been getting. If the measure of a province is how it treats its most vulnerable, we have failed miserably.

But it is not just a moral imperative. Our failure to invest adequately in public health and in long-term care has contributed to the need to close down our economy. Ontario's unemployment rate jumped from 7.6 per cent in March to 11.3 per cent in April and 13.6 per cent in May.[125] [126] The scale of the drop is unprecedented. This represents unparalleled losses in people's incomes and is causing extraordinary large deficits for all levels of government. In an economy with a GDP approaching $900 billion, billions of dollars in production are being wiped out. This causes a great deal of hardship. In addition to lost tax revenue and huge payments to the unemployed, the government will face the economic and political cost of multi-million dollar lawsuits and inquests. Cutting public health and failing to adequately fund long-term care was extraordinarily short-sighted on the part of many governments, and both government and citizens are paying the price. Now we must do all we can to avoid a recurrence of this situation. There is time to act, but the time is now. Stacked against these astronomical costs and a health sector budget of $63.8 billion, investing $1.76 billion in LTC nursing and personal care is a substantial yet reasonable move. This is truly an investment, not an expenditure, as it will save us from enormous costs in the future.

Conclusion

RNAO's submission describes a long-term care sector in which the number of residents and their acuity has been increasing exponentially over the years, while staff numbers have stagnated. Not only overall staffing is insufficient to provide safe and quality care, but there is a dangerous absence of regulated (higher education, competencies and skills) health providers in the sector.

In this submission, RNAO has proposed to adopt, fund and immediately implement a "Nursing Home Basic Care Guarantee" for residents of nursing homes. The intent is to guarantee the basic care needed, shoring up staffing levels for regulated and personal support staff, and adjusting the staff mix, so residents in nursing homes can count on consistent, safe and quality care.

The Basic Care Guarantee is operationalised through a staffing formula that requires minimum staffing hours and the knowledge, competencies and skills demanded by the complexity and acuity of care needs in LTC. The staffing formula to address the crisis of staffing in LTC needs to include (a) adequate numbers of staff, and (b) the proper skill mix of regulated and unregulated staff – including larger utilization of nurse practitioners (NP), registered nurses (RN) and registered practical nurses (RPN).

We demonstrate why 2.71 hours currently in place of nursing and personal care per resident day delivered largely by PSWs, with the equivalent of 18 minutes (0.3 hours) of RN care and 29 minutes (0.49 hours) of RPN care per day per resident, is dangerous.

RNAO's staffing formula requires a move to a minimum of 4 worked nursing and personal hours of care per resident per day, with a staff mix of at least 0.8 hours of RN care per resident per day, 1 hour of RPN care, and 2.2 hours of PSW personal care. This is urgent and foundational to rebuilding confidence in the LTC sector.

Recruitment and retention for this staff increase will be enabled by mandated and funded human resources standards including: disallowing LTC staff (RN, RPN, PSW) from working in other workplaces; ensuring that nursing and personal care salaries in LTC are commensurate with those paid to the same health workers in other sectors; and ensuring that full-time employment with benefits is offered to staff who want full-time work.

RNAO is also calling for the addition of: (a) one NP per 120 residents to all LTC homes; (b) a full time infection prevention and control/quality improvement nurse (preferably an RN), who can also lead on-boarding, orientation, and professional development; and (c) access to a team of interprofessional staff that will add necessary resources to improve safety, quality of care and quality of life, as well as quality of work life.

This focus on staffing in long-term care is not new as the recent summary of two decades of reports on Ontario's LTC sector shows,[127] nor is RNAO's insistence on a specified skill mix and increased numbers of hours for regulated staff, including NPs. As we look to address the dire situation in long-term care – two decades in the making -- RNAO calls on the Ford government to establish a Nursing Home Basic Care Guarantee and adopt the basic staffing formula presented here. We ask government to release on July 31, 2020 a plan of action for implementation of the Basic Care Guarantee and its related staffing formula to be completed within 6 months – by the start of 2021.

Ontario is not alone in experiencing such challenges in long-term care. With rapid and nimble actions now, we can begin to rescue our long-term care sector from the brink of continuous disaster, and begin to move forward with a long-term care system for residents and families that Ontarians can be proud of.

Acknowledgements and disclaimers

Parts of this material are based on data provided by the College of Nurses of Ontario and by AdvantAge Ontario. However, the analyses and opinions expressed here are those of RNAO, and not necessarily those of the aforementioned organizations.

Appendices

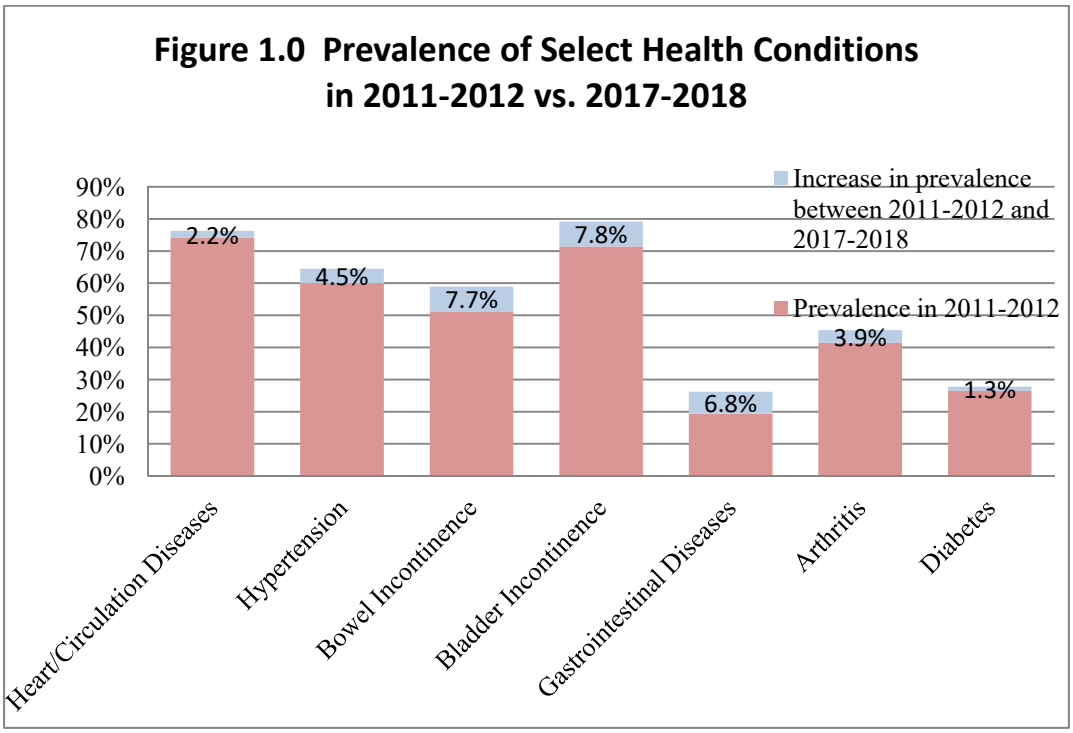
A. Resident Acuity and Demographics in Long-Term Care

Resident acuity, or the clinical complexity and heaviness of care needs, in Ontario's long-term care (LTC) homes is high and has been rising steadily.[128] [129] With gains in Canada's life expectancy, residents in LTC homes are now older, frailer, and experiencing more physical and mental health co-morbidity than ever before.[130] [131] Provincial data demonstrates that in LTC the Case Mix Measure (CMM) and Case Mix Index (CMI), both measures of patient acuity, have increased over recent years. From 2004 to 2009, CMM rose by 12.2%, while CMI increased by 7.63% from 2009 to 2016.[132]

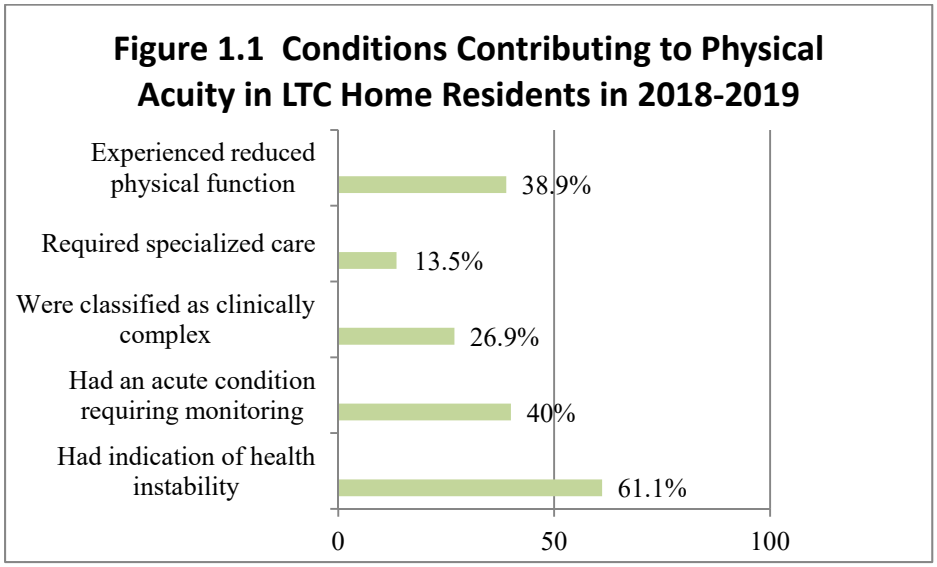
Physical Acuity

As of 2015-2016, 97% of residents in LTC homes had two or more chronic conditions.[133] Data from Ontario's LTC homes reveals that the prevalence of many conditions has increased from 2011-2012 to 2017-2018, as shown below.[134]

Figure 1.0 Prevalence of Select Health Conditions in 2011-2012 vs. 2017-2018



As of 2019 a large share of residents required increasingly complex care including peritoneal dialysis, wound care, post-operative management, suctioning, and pain management, and 84% of new long-term care admissions were categorized into the highest levels of acuity.[135] Figure 1.1 demonstrates the percentage of LTC home residents with special conditions contributing to increased physical acuity as of 2018-2019.[136]

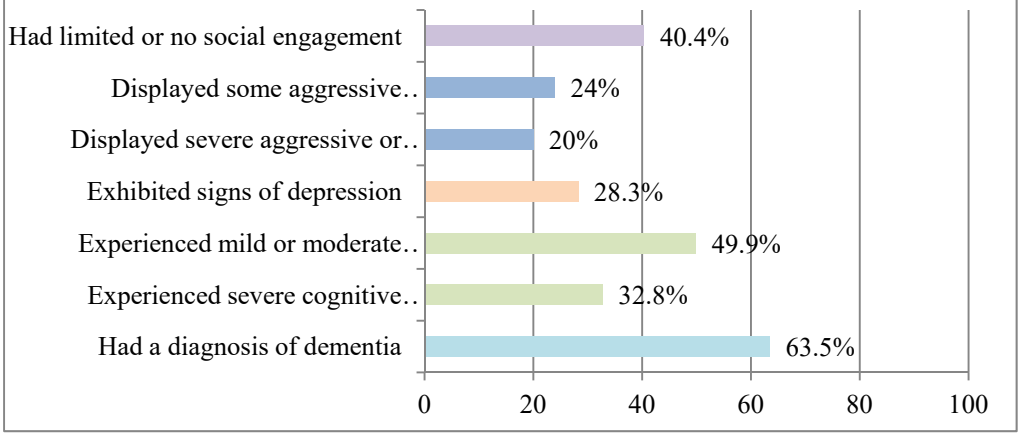


Increases in resident acuity and the prevalence of multiple conditions contribute dramatically to overall care needs.[137] For example, the number of LTC home residents who required extensive support with activities of daily life (ADLs) such as eating and grooming increased by 9,000 between 2013 and 2018, and the rise in residents living with bowel and bladder incontinence meant that more than 9,600 additional residents required assistance with toileting in 2017-2018 compared to 2011-2012.[138]

Mental Health, Cognitive Impairment and Dementia Acuity

Similar to increases in the rate of residents living with conditions affecting their physical health, the percentage of LTC home residents living with a mental health condition is high and rising. [139] Figure 2.0 demonstrates the prevalence of select mental health symptoms and conditions contributing to mental health acuity as of 2018-2019.[140]

Figure 2.0 Prevalence of Dementia and Select Mental Health Symptoms Contributing to Mental Health Acuity in LTC Home Residents in 2018-2019



Of note, nearly 83% of all residents in LTC homes experience some form of cognitive impairment, and 40% of residents have limited or no social engagement.[141] Insufficient social engagement is associated with negative health outcomes, agitation and functional decline,[142] yet the Canadian Armed Forces recent report demonstrates the provision of care that is engaging, unhurried, and allowing for resident independence is rarely achieved.[143] In addition to the above, in 2015-2016 more than 3,600 LTC home residents had a diagnosis of schizophrenia and more than 2,500 residents had a diagnosis of bipolar disorder.[144]

Provincial data indicates the number of LTC home residents with a diagnosis of dementia has been increasing regularly: one percent per year from 2012-2017.[145]As of 2016, there were an estimated 228,000 Ontarians living with dementia.[146] However, this number is expected to double by 2038, when nearly half a million (430,000) Ontarians are predicted to be living with dementia; a leading cause of dependence and disability for seniors.[147] Eighty percent of people living with dementia experience behavioural or psychological symptoms,[148] and nearly half of all LTC home residents experience aggressive or [more recently termed] responsive behaviours as a result of their mental health condition[149] and "changes in the brain affecting memory, judgment, orientation, mood and behaviour." [150]

Though the majority of seniors with dementia in Canada live in the community (61% as of 2015-2016) with support from family members and home and community care services such personal support workers and adult day programs, their dementia is typically less severe than those residing in LTC homes with a diagnosis of dementia.[151] For example, residents with a diagnosis of dementia who are living in LTC homes are more likely to wander (21% vs. 10% in the community), require assistance in ADLs (82% vs. 28%), and experience responsive behaviours (50% vs. 25%).[152] [153]

Experts in patient safety and long-term care have long forecast this rapid rise in LTC home resident acuity.[154] [155] [156] [157] [158] As of 2016-2017, nearly 50% of residents in LTC homes lived with sufficient clinical complexity to classify them in the highest acuity (CMI) grouping,[159] and it is believed the complexity and acuity of LTC home

residents now matches that of patients in complex continuing care beds or alternative level of care beds in acute-care hospitals. [160] Thus, care for residents living in LTC homes is complex, time-intensive, and requires specialized support, knowledge and training.[161] [162] [163] [164] Further, resident acuity in LTC homes will continue to rise as Ontario's population ages, and only the most acute of seniors will qualify for LTCH admission.[165]

Violence

Parallel to the rise in physical and mental health acuity in Ontario's long-term care system is an unprecedented increase in violence between residents, from staff to residents, and from residents to staff. Media reports, [166] [167] [168] [169] [170] Canadian researchers, [171] [172] reports from the Ontario Coroner, and most recently, the Canadian Armed Forces,[173] demonstrate that violence in long-term care is a tragic but pervasive problem. Between 2012 and 2016, the Ontario Coroner reported 27 resident-to-resident homicides; a staggering number that represents the risk associated with increased acuity and decreased availability of staff to provide interventions during a crisis.[174] Staff-to-resident neglect and abuse is reported to have increased by 148% in Ontario from 2011-2016.[175] In 2016, there were 2,198 incidents of staff-to-resident abuse across the province; the equivalent of six LTC home residents experiencing abuse or neglect every day.[176]

Significant harm done to residents currently living in LTC often go unchecked because of conditions like: impossibly high resident -to-staff ratios; frequent staff turnover; dependency on rotating agency staff to fill vacancies; chaotic workloads; and sharply increasing resident acuity.[177] [178]Further to this, violence in the form of physical assault, verbal, sexual and racial harassment from residents towards personal support workers and nursing staff in LTC homes is persistent and widespread.[179] [180] [181] In 2019 nearly 90% of surveyed staff in Ontario long-term care homes reported regularly experiencing violence from residents,[182] and in 2017 the lost time injury (LTI) rate for staff in LTC homes was almost double that of LTI in health care generally.[183] Despite the implementation of Behavioural Supports Ontario (BSO), an initiative to support persons with responsive behaviours in local health integration networks, violence in all forms continues to be an issue that contributes significantly to job dissatisfaction, injury, emotional trauma and burnout.[184]

B. Existing vs. Recommended Staffing in LTC

As mentioned above, RNAO has called for four worked hours of nursing and personal care per resident day in LTC. At 20 percent RN, 25 percent RPN and 55 percent PSW (Row 1 in the table below), and combined with our ask for four hours of nursing and personal care, that translates into 0.8 worked hours of RN care per day, 1.0 worked hours of RPN care and 2.2 worked hours of PSW care (Row 2).

But the actual skill mix is 11% RNs, 18% RPN and 71% PSW (Row 3).[185] The latest publicly available estimate of the worked hours of nursing and personal care per resident-day is 2.71 in 2016.[186] From this, we can estimate actual hours (Row 4) and hour deficits (Row 5) per resident day for RNs, RPNs and PSWs. From the hours deficit/resident/day and the number of residents and a scaling factor[187] to translate worked hours to paid hours (Row 6; 21 percent is allowed for RNs and 20 percent is allowed for RPNs and PSWs), we obtain the FTE deficit (Row 8). There is a total shortfall of 22,898 FTEs, with 8,972 of them being RNs and 9,051 of them being RPNs. There is also a shortfall in FTEs for PSWs as well (4,875), even though they currently have 71% of the hours. From the deficits per resident days, we can get the FTE deficit (Row 7).

To get the total catch-up cost, we make the following assumptions about annual unit employment costs (Row 8). For RNs, we used midrange of the ONA acute care RN contract and scaled it up 24% for employment costs, to get $96,696 per year.[188] For RPNs, we used the midrange of the ONA acute care RPN contract, adding 24% for employment costs ($67,450).[189] For PSWs, we took an average of average PSW wage rates for municipal LTC homes in Ontario 11 municipalities and assumed 24% employment costs for them as well ($57,151).[190]

The total estimated cost for adequate nursing and personal care is estimated at $1.76 billion. The RN component of that cost is estimated at $867 million (Row 9).

Costing to Bring Nursing and Personal Care in LTC up to Recommended Level				
	RN	**RPN**	**PSW**	**Total**
1. Recommended skill mix	20%	25%	55%	100%
2. Recommended worked hrs/res day	0.8	1	2.2	4
3. Actual skill mix	11%	18%	71%	100%
4. Actual hours 2016	0.2981	0.4878	1.9241	2.71
5. Hours deficit/day	0.5019	0.5122	0.2759	1.29
6. Scaling factor worked hours to paid hours	1.21325245	1.199261993	1.199261993	
7. FTE deficit	8,972	9,051	4,875	22,898
8. Annual unit cost/FTE	$96,696	$67,450	$57,151	
9. Cost to fill the FTE deficit/year	$867,576,366	$610,475,088	$278,623,450	$1,756,674,903

C. Template for Position Description for Infection Prevention and Control / Professional Practice Nurse in Long Term Care

Position Description: Nurse Lead Infection Prevention and Control/ Professional Practice

POLICY

The facility shall assign the specific responsibilities of Infection Prevention and Control /Professional Practice on a full time basis to a regulated nursing staff, preferably a Registered Nurse, in the role of Nurse Lead Infection Prevention and Control/ Professional Practice

PURPOSE

- To ensure compliance with governing bodies and legislation such as the:
  - Health Protection and Promotion Act (HPPA)
  - Long Term Care Homes Act
  - Accreditation Canada
  - Occupational Health and Safety Act and Ontario Regulations
  - Personal Health Information Protection Act (PHIPA)
- To liaise between the local Public Health Units, Ministry of Long Term Care (LTC), Ministry of Health and Ministry of Labour
- To promote staff awareness of the Infection Control Program
- To coordinate surveillance programs
- To report to the Infection Control Committee
- To act as a resource, advocate facilitator, coordinator, educator and role model for professional practice
- To provide orientation, mentorship and ongoing professional development
- To apply quality improvement methodology
- To participate in research activities
- To develop an Emergency Preparedness Plan to manage a potential emergency or disaster
  - to reduce risk of transmission
  - to reduce incidence of infection
  - to respond to events as they occur
  - to resolve the consequences when the emergency/disaster ends

RESPONSIBILITIES

This is a nursing leadership and development role focused on the key areas of infection prevention and control, quality improvement, and professional development and orientation. The principle duties and responsibilities of this role focus on: planning, implementation, education, communication, facilitation, collaboration, mentoring, and supervision of infection control and prevention practices to ensure sustainability through QI methodology.

Infection Prevention and Control (IPAC):

- **Implement, and monitor** the Infection Control Program through the application of the principles of infection prevention and control
- **Collaborate** with all Departments and Services to support a comprehensive understanding of IPAC principles.
- **Collect Data** regarding ongoing infection prevention and control strategies including specific **prevention**, **monitoring,** infection rates and outbreaks, mitigation strategies, actions and results and **report** to the Infection Control Committee.
- **Plan** and **deliver** educational programs related to infection prevention and control.
- **Chair** the Infection Control Committee.
- **Audit** all services to ensure infection prevention and control standards are being met.
- **Report** communicable diseases according to guidelines to the appropriate government agencies.
- **Supervise** the establishment and maintenance of appropriate isolation/precautionary techniques, in collaboration with management.
- **Proactively Monitor** for external trends that may indicate a potential outbreak and internal trends with the use of line listing and implement an action plan.
- **Supervises** and implements **Occupational Health and Safety (OHS) program**
- **Supervises** residents' and staff **immunization program**
- **Supervises** and implements **Antibiotic stewardship program** in collaboration with Professional Advisory Committee
- **Implement Public Health Ontario (PHO) "Just Clean Your Hands" Program**
- **Monitor** daily the websites for Public Health and MOH for bulletins or updates on infectious diseases and required actions

Professional Practice:

- **Continuously upgrade** education to maintain current evidence based skills and knowledge
- **Identify trends** related to key practice issues related to care of older persons, activities of daily living, chronic disease management, mental health, regulatory changes, to integrate into educational programming.
- **Promote and implement** evidence-based practice, including RNAO Best Practice Guidelines, and participation of staff in program-based quality and risk management initiatives.
- **Assess** educational needs of staff, implement educational plans (for orientation and continuing professional education), and **evaluate** educational programs.
- **Develop** coaching and mentoring programs in **partnership** with staff, and other stakeholders.
- **Mentor and coach** new staff, **s**taff in new role
- **Provide coaching and or mentoring** to staff related to performance issues
- **Develop** and **implement** a tracking system of continuing education and professional development.

- **Communicate** to all staff opportunities for continuing education
- **Document** and **Report** on continuing education and professional development programming and related results
- **Define** a quality improvement program for the staff, including **goal setting, monitoring and evaluation, documenting** and **reporting**
- **Collaborate** and network with stakeholders
- **Ensure** staff receives annual education as mandated under the Long Term Care Homes Act, 2007

Endnotes

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[3] E.g., the Butterfly Approach is a home-like approach that focuses on connecting with residents as unique individuals in homelike settings. Evidence demonstrates that the approach is associated with: increased staff interactions with residents; improved staff-resident relationships; decreased medication use; fewer exit attempts; a greater sense of freedom, self, inclusion and job satisfaction among staff; a more relaxed environment; and improved sense of teamwork. Armstrong, P., Banerjee, A., Armstrong, H., Braedley, S., Choiniere, J., Lowndes, R. and Struthers, J. (2019). *Models for Long-term Residential Care: A Summary of the Consultants' Report to Long-Term Care Homes and Services, City of Toronto.* April 15. https://www.toronto.ca/legdocs/mmis/2019/ec/bgrd/backgroundfile-130891.pdf. P. 34.

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