Ontario's Long-Term Care Homes
IPAC Human Resources
Survey Report

Dec. 4, 2020

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Introduction

Infection Prevention and Control (IPAC) is a critical issue at all times across all health-care sectors, and especially in the midst of a pandemic. With the rising death toll in long-term care (LTC) homes, where nursing and other resources are limited, IPAC is even more important. The Registered Nurses' Association of Ontario (RNAO) has consistently advocated for enhanced staffing resources in LTC for close to two decades[1], and the call for additional staffing has escalated since the beginning of the pandemic. RNAO's Nursing Home Basic Care Guarantee[2] (NHBCG) urges a staffing formula that provides no less than four worked hours of direct nursing and personal care per resident, per 24-hours. The formula also calls for a skill mix of 0.8 hours (48 minutes) of RN care, one hour (60 minutes) of RPN care and 2.2 hours (132 minutes) of PSW care per resident, per 24-hours. Such an allocation would provide each resident with safe care and quality of life. The NHBCG recommends implementing full-time employment to enable continuity of care for residents, as well as staff satisfaction and retention. Full time employment would also serve to improve IPAC practices. Lastly, the NHBCG urges government to fund one nurse practitioner (NP) for every 120 residents (or a clinical nurse specialist where an NP is not available), and to fund and direct each home to hire a nurse (preferably an RN) to focus on infection prevention and control and staff orientation, training and professional development. The NHBCG also urges to fund an appropriate complement of interprofessional staff.

In 2017, the Canadian Nurses Association (CNA) recognized IPAC as a nursing specialty practice[3] required to meet criteria that include standards of practice, specialty core competencies, and core knowledge. Numerous formal courses are available through Public Health Ontario (PHO) and the Public Health Agency of Canada (PHAC), as well as colleges and universities.[4] CNA endorses PHAC's IPAC certification process to recognize this specialty practice in nursing, based on requisite knowledge and skills.[5] The IPAC resources across health sectors must be considered a specialty role guided by a clear position description and supported through formal IPAC preparation.

The complexity of a robust IPAC program, especially during a pandemic, is evident in the checklist provided by Public Health Ontario.[6] In all health-care settings, a specialized IPAC lead is necessary for a sound and effective IPAC program, and is particularly important during potential and actual outbreaks. A qualified IPAC lead is a critical resource in establishing successful IPAC processes. However, full and consistent attention to infection prevention and control is only possible with the backing of an adequate and knowledgeable complement of regulated and unregulated staff supported to carry out evidence-based practices and oversight.

Purpose and Distribution of RNAO IPAC Survey

On Wednesday Nov. 25, 2020 at 3:00 p.m., RNAO issued an online survey to directors of care (DOC) and assistant directors of care (ADOC) in all 626 LTC homes in Ontario to obtain information about IPAC to accurately inform the IPAC needs in LTC. The deadline for responding to the survey was set to Monday Nov. 30, 2020 at 12 noon at which time the survey was closed. In conducting this survey, RNAO's goal is twofold: to ensure LTC homes and their staff can deliver the care residents need and deserve during and after this difficult pandemic; and to prevent further devastating outcomes for residents and staff in Ontario's LTC homes. Email reminders were sent on Nov. 26, Nov. 27, and Nov. 30.

LTC Home IPAC Results - High Level Summary

The survey results show concerning information related to: the amount of time and resources devoted to IPAC in LTC homes; role clarity for the IPAC staff; level of preparation of the IPAC staff, including resources within and external to LTC homes; and the lack of standards related to IPAC programs and resources. Overall, IPAC in LTC homes is not given the profile and resources it must have for ensuring safe IPAC practices.

Survey highlights:

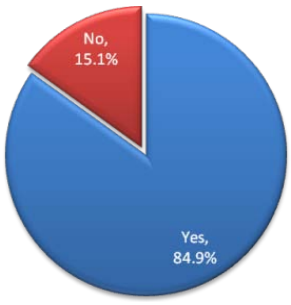
1. A total of 246 of the 626 homes responded to the survey in the five days the survey was open, which included the weekend. This high response rate (39.3 per cent) with short notice is indicative of the interest and/or urgency felt by the homes. The survey was completed largely by the directors of care. Of the 160 homes that responded to the question regarding home ownership status, 48.8 per cent (78 homes) were for-profit homes; 34.4 per cent (55 homes) were not-for-profit homes; 14.4 per cent (23 homes) were municipal homes; and the remaining 2.5 per cent (4 homes) were charitable homes. Responding homes ranged in size from 14 to 456 beds, with 44.7 per cent (110 homes) reporting less than 100 beds, 45.1 per cent (111 homes) reporting from 100-199 beds, and 10.2 per cent (25 homes) reporting 200 beds and more.

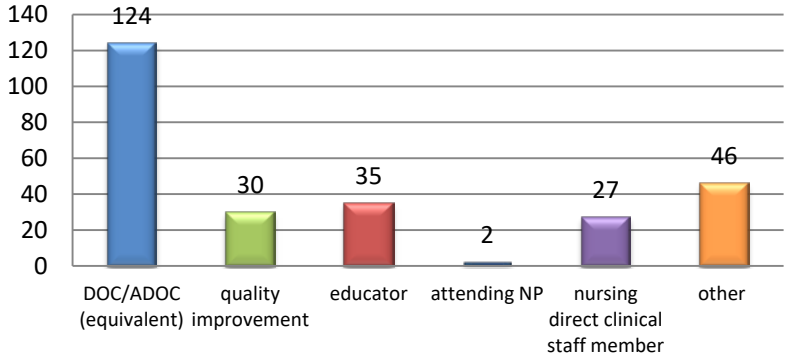
2. Eight and a half per cent (21 homes) of respondents indicated they did not have a staff member responsible for overseeing IPAC, even though it is a requirement under the *Long Term Care Homes Act, 2007* and Ontario Regulation 79/10.[7] Of these 21 homes, 20 homes answered further questions about the oversight of the IPAC program, with 45 per cent (nine homes) reporting the IPAC position was vacant. The length of time the position was vacant ranged from more than five years reported by three homes, and from three months to one year reported by the other five homes. One home did not indicate how

long the position was vacant. The remaining 55 per cent (11 homes) of these 20 homes reporting no staff member in the IPAC role appear to have no IPAC position, as they reported no vacancy.

3. Of the eight and a half per cent (21 homes) without a staff member responsible for IPAC, six homes reported they received services from an external resource, which included a hospital or their corporate or head office. This assistance was reported to be received in person by four LTC homes and online by two LTC homes daily, weekly or as needed or requested. Five of the six homes said the external IPAC services met their needs for assistance. Only one LTC home in this group indicated the external resource was assigned by the government of Ontario. Fourteen of the 21 homes did not receive external IPAC assistance and one home did not respond to the question.

4. Only 15.1 per cent (34 homes) reported having an IPAC staff member fully dedicated to IPAC. The remaining 84.9 per cent of respondents (191 homes) indicated the IPAC staff was engaged in another formal role in their LTC home. Respondents indicated more than one role in many cases. The roles attached to the IPAC responsibility included being the DOC or ADOC (64.9 per cent or 124 homes), quality improvement staff (15.7 per cent or 30 homes), educator (18.3 per cent or 35 homes), attending NP (1.0 per cent or 2 homes) or a direct care nursing staff (14.1 per cent or 27 homes). There was a further 24.1 per cent of homes (46 homes) that indicated the individual responsible for leading the IPAC program was also responsible for a variety of other roles, such as wound care, resource nurse, employee health nurse, foot care nurse, shared resource with another facility, occupational health nurse, Resident Assessment Instrument (RAI) co-ordinator/manager (eleven homes), and staff who oversee housekeeping and laundry services. The majority of LTC homes have not established the IPAC role as a specialized position.





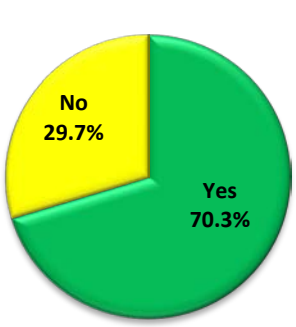
5. In the majority of the homes with a staff member in the IPAC position, 76 per cent (168 homes), indicated that the staff member is an RN, while 15.8 per cent (35 homes)

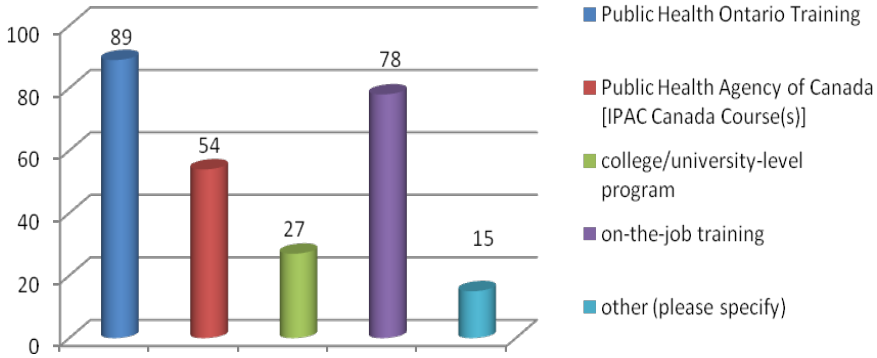
reported it is an RPN. Responses from the other 8.1 percent (18 homes) about who filled the IPAC role included NPs (two homes), the ADOC, IPAC specialists, and members of an IPAC team where the LTC home was part of a hospital. Four LTC homes did not respond to this question.

6. 10.8 per cent (23 homes) indicated the IPAC position in their home has been filled for less than three months. A total of 13.1 per cent (28 homes) indicated the position has been filled from three months to nine months, including 6.6 per cent (14 homes) that had the position filled from three months to six months and 6.6 per cent (14 homes) that had the position filled from over six months to nine months. A further 3.8 per cent (8 homes) indicated it was filled for over 9 months to one year. 12.2 per cent (26 homes) indicated the position has been filled for over one year to three years and 6.6 per cent (14 homes) indicated it had been filled for over three years to five years. 53.5 per cent of homes (114 homes) indicated the IPAC position in their home has been filled for more than five years.

7. Just less than one half (49.1 per cent or 108 homes) indicated they had a formal position description for the IPAC role, while 50.9 per cent of homes (112 homes) reported they did not have such a description.

8. In 70.3 per cent of homes (154 homes), the IPAC staff had formal IPAC training. Respondents selected a variety of options with the majority reporting this training was





acquired through the Public Health Ontario training (57.8 per cent or 89 homes), while 50.6 per cent (78 homes) selected "on-the-job training." Others indicated the training was provided through the Public Health Agency of Canada courses (35.1 per cent or 54 homes), and college and university programs (17.5 per cent or 27 homes). Still others (9.7 per cent or 15 homes) identified a variety of different sources of training, such as corporate head office, from a hospital IPAC team, online courses, and past experience in ICU.

9. In 29.7 per cent of homes (65 homes) respondents indicated they did not have any formal training in IPAC. It is noteworthy, however, that in those homes indicating they had formal training, 50.6 per cent (78 homes) selected "on the job training" and 9.7 per cent (15 homes) other types of informal training such as corporate head office, from a hospital IPAC team, online courses, and past experience in ICU. If this type of training was not combined with a formal IPAC course, many more LTC homes may be relying on informal training to prepare IPAC staff.

10. 79.1 per cent of respondents (174 homes) reported the IPAC program in their home was supported by an external resource, which included a broad variety consisting of public health (74.1 per cent or 129 homes), corporate head office (41.4 per cent or 72 homes), hospital (25.9 per cent or 45 homes), and other sources - consulting services, the LHIN/Ontario Health and other regional resources. In relation to the frequency of support provided, 38.2 per cent of respondents (66 homes) selected "other", and the overwhelming majority indicated receiving this support on an as-needed basis, on request. The other homes received assistance with varying frequency: daily (15.0 per cent or 26 homes), weekly (26.0 per cent or 45 homes), every two weeks (8.7 per cent or 15 homes), and monthly (12.1 per cent or 21 homes).

    Those receiving this support indicated it is provided in a combination of ways, with approximately 75.3 per cent (131 homes) indicating they received online consultation, and 50.6 per cent (88 homes) indicating there were in-person visits to the home. Another 33.3 per cent (58 homes) reported telephone, webinars and weekly networking virtual meetings. 58.0 per cent (101 homes) reported this external service met their needs fully or almost fully; 19.0 per cent (33 homes) indicated the service reasonably met their needs, 14.4 per cent (25 homes) indicated there was uncertainty regarding the service's ability to meet their needs, and the remaining 8.6 per cent (15 homes) reported the service did not at all meet their needs or they were minimally met. 28.1 per cent (48 homes) reported this external IPAC resource was assigned by the government of Ontario.

Quick Facts

1. Eight and a half per cent of homes (21 homes) responding do not have a staff resource currently responsible for overseeing the IPAC program in their home.

2. A further 10.8 per cent (23 homes) reported filling the IPAC position in the last three months.

3. A further 13.1 per cent of homes (28 homes) indicated the IPAC position had been filled from three to nine months ago, coinciding with the current COVID-19 pandemic.

4. 79.1 per cent of homes (174 homes) indicated they are receiving assistance with their IPAC program from a great variety of external resources ranging from public health, to hospital, to corporate or head offices to regional offices and consultants.

5. Only 15.1 per cent (34 homes) of the total of 191 homes with a staff member in the IPAC role indicated this staff member was fully dedicated to IPAC.

6. 84.9 per cent (191 homes) of the 225 homes with a staff member in the IPAC role indicated the IPAC staff member was engaged in another formal role in their LTC home. The "other" roles included DOC or ADOC, quality improvement, educator, attending NP or nursing direct clinical staff. These roles are significant administrative and/or direct clinical care roles. Several other LTC homes identified that the IPAC staff member was also engaged in a variety of other roles ranging from wound care nurse to RAI co-ordinator to occupational health nurse.

7. The majority of respondents - 76 per cent of homes (168 homes) indicated their IPAC staff member was an RN; and 15.8 per cent of homes (35 homes) indicated an RPN occupies the role.

8. Over half (50.9 per cent or 112 homes) indicated they did not have a formal position description for the IPAC lead.

9. Close to 30 per cent of homes (29.7 per cent or 65 homes) indicated their IPAC staff resource did not have formal training in IPAC.

Recommendations

1. IPAC should be enforced as a mandatory role in long-term care, with specific full-time equivalent (FTE) requirements depending on the size of the home. This requirement should start with a base of 0.5 FTE for homes with up to 50 beds. Homes with 51 to 150 beds should be funded and allocate one (1) full-time FTE. Homes with 151 to 200 beds

should be funded and allocate 1.5 FTE. Homes with 201 to 250 beds should be funded and allocate 1.75 FTE; and those with over 251 beds should receive funding for two (2) FTE.

2. All IPAC roles must be supported by a standard position description, which clearly outlines the role, expectations, accountabilities and resources, and reflects recognized IPAC standards.

3. All staff in the IPAC lead role must be provided with time and funding to achieve formal and/or specialty education in IPAC.

4. All LTC homes must be given immediately the funding and directives to fulfill the requirement of a registered nurse (RN) or a registered practical nurse (RPN) in the IPAC role, which meets the above three recommendations.

5. LTC homes must be staffed to the level of RNAO's Nursing Home Basic Care Guarantee in order to provide the necessary staff support for safe care and IPAC compliance.

6. A network of LTC IPAC specialists must be developed and supported by continuous quality improvement and best practices' rapid learning to ensure we build and sustain IPAC capacity within the LTC sector in Ontario.

Conclusion

IPAC, an essential aspect of safe, quality care across all sectors of health care, is especially important in LTC where intense and ongoing attention to IPAC can impact the health and well being of vulnerable residents and staff. IPAC becomes even more critical, as a life saving component of care during outbreaks and in particular during a pandemic. Urgent attention to IPAC needs in LCT care is imperative to stop the surge of COVID-19 now sweeping the sector and claiming resident and staff lives, leaving families and communities in anguish.

References

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