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

85 years

Speaking out for health. Speaking out for nursing.

Position Statement

Strengthening Client Centred Care in Long Term Care

Adopted by the RNAO Board of Directors on June 25, 2010.

Position

RNAO strongly supports the development of Long Term Care Homes (LTCHs)[1] utilizing a resident/client-centred care model, where Ontarians have access to continuity of care and continuity of caregiver from a primary nurse. RNAO also strongly endorses strengthening inter-professional care so all health disciplines work closely to support high quality care in all health care settings. Regardless if a home is not-for-profit or for-profit, adhering to the appropriate nursing care delivery model and skill-mix, is paramount to optimize resident, staff and organizational outcomes. Excellence in resident/client centred long term care is supported by four pillars:

- Nursing care delivery models that advance continuity of care and continuity of caregiver by assigning each resident one nurse per shift, that nurse being an RN or an RPN working to full scope of practice and accountable for delivering or directing the total nursing care required by that individual resident;
- Assignment of the most appropriate caregiver based on the resident's complexity and care needs and the degree to which the resident's outcomes are predictable, with RNs assigned total nursing care for complex and/or unstable residents with unpredictable outcomes, and RPNs assigned total nursing care for stable residents with predictable outcomes. A resident whose condition is or becomes unclear will be cared for by RNs. This prevents shifting a resident back and forth between RNs and RPNs thereby reducing fragmentation of care and reducing multiple risk factors. When Unregulated Care Providers (UCPs) are utilized, they are assigned to assist RNs or RPNs, where appropriate and under their supervision, with attention given to prevent disrupting the continuity of care provided by the assigned nurse;
- Workforce stability, by achieving 70 per cent full-time employment for all nurses and UCPs, supports continuity of care and continuity of caregiver, improves intra and inter-professional team work, reduces costs and facilitates staff satisfaction and retention;
- Not-for-profit funding, that supports a healthy work environment for all staff, enables a resident to experience a higher quality of care, higher quality of life, reduces risk and prevents unnecessary hospitalizations and other health system costs.

Background

As a society, we have a duty to respond to older persons' needs, promote their health, and care for them when they are ill; this is a sign of a healthy society with a strong social fabric that does not abandon the frail and / or infirm.[2]

Residents in long term care homes (LTCHs) have increasingly complex care needs compared to residents 15 years ago.[3] [4] [5] [6] The average age of residents in LTCHs has climbed from 75 in 1977 to 86 in 2002 as residents seek LTC closer to the end of their lives and "residents with multiple care needs that were previously cared for in chronic care hospitals are now cared for in LTC (long term care) homes."[7] While complexity is increasing, the number of LTC residents is also expected to rise. One estimate projects between 565,000 to 746,000 LTC beds will be needed across Canada by 2031; up from a supply of 194,000 beds in 2002.[8]

A severe shortage of LTC services is impacting the entire health-care system confirming the interconnected role LTCHs have with hospital and community services. Currently, at least 21, 500 Ontario residents are waiting for a LTC bed in homes that are 98% full.[9] [10] In January 2010, 4,977 Ontario hospital patients were designated as Alternative Level of Care (ALC) residents, costing millions of health-care dollars unnecessarily each year.[11] Those waiting for LTCHs account for 60 per cent of all ALC days[12] and their wait times have tripled since the spring of 2005 to an average wait time of 105 days. Significant variance in wait times is observed within the province, (e.g., Eastern Ontario region's waiting list has grown considerably with seniors waiting an average of 237 days; dramatically higher than the 169-day average reported in 2009.)[13]

Retirement homes have been used to relieve hospital ALC pressures but with dire consequences. Inappropriate placement of ALC residents in retirement homes led Ontario's Chief Coroner to recommend retirement homes be required to meet the same standards of care and services as a licensed LTCH if such services are necessary.[14] With the passage of Bill 21, Retirement homes will be regulated to provide similar care and services as a licensed LTCH.[15] This solution introduces a slippery slope towards the privatization of health-care services and requires seniors to pay for their access to health care; a contravention of the *Canada Health Act*.

Although the Ontario government states that it "is committed to providing homes where our seniors can live in dignity with the highest possible quality of care,"[16] funding for LTC services has failed to keep pace with increasing care needs. A strong positive relationship between nurse staffing levels and the quality of care in LTCHs has been consistently established.[17] [18] A 2002 landmark national study in the United States carried out by the Center for Medicaid and Medicare Services (CMS) found that a minimum staffing level of 4.1 "worked hours" of nursing and personal care hours (not "paid hours")[19] is required to avoid jeopardizing the health and safety of LTCH residents.[20] Yet in early 2007, the Ontario government released information that LTCHs in the province only averaged 2.86 worked hours of nursing and personal care per resident day.[21] Furthermore, it has been well documented that Ontario's LTC homes have a resident population with higher care needs than a number of other jurisdictions, while residents have received less nursing, personal care, and rehabilitation therapy than found in the majority of comparator jurisdictions.[22] Additional PSW and RPN funding have since increased hours of care delivery, but the ministry has not produced any guidelines to consider the optimal skill mix required for quality services in LTC.

The Ministry of Health and Long Term Care is currently implementing many LTC quality initiatives to address significant and repeated concerns that Ontario LTCHs inadequately safeguard residents' safety

and dignity. Evidence of poor quality and a media-led public outcry triggered an investigation[23] by the Ontario Ombudsman in 2008. Although many agree quality initiatives are necessary to improve care in LTCHs, many of the quality initiatives have been introduced but have not been funded at the home level and therefore are perceived as an additional burden on already stretched staff.[24]

Access to Registered Nurses

Access to registered nurses (RNs) in all sectors is essential to achieve optimal health outcomes. There is conclusive evidence of a strong linkage between staffing, and particularly RNs, in long term care facilities and resident/client outcomes including: lower death rates, higher rates of discharges to home, improved functional outcomes, fewer pressure ulcers, fewer urinary tract infections, lower urinary catheter use, and less antibiotic use.[25] [26] Increasing access to registered nurses in LTCHs also reduces hospitalizations that incur significant system costs and resident morbidity.[27] [28] Despite the current trend to move complex continuing care beds out of hospitals into LTCHs and the need to reduce hospitalizations from LTC, LTCHs across Ontario chose to reduce rather than increase their inadequate proportion of RNs by 269 FTEs from 2006 to 2007.[29] This reduction has both ethical as well as cost implications. According to one recently published Ontario-based study, up to 55 per cent of potentially avoidable hospitalizations (PAHs) could be reduced by adjusting human resources and physical resources in LTCHs.[30] Nursing care delivery models that undermine the importance of RNs' knowledge and reduce direct care hours provided by RNs result in reduced continuity of care and continuity of caregiver, fragmented care, and higher morbidity and mortality. The evidence is clear that in long term care homes RNs are more effective in improving resident outcomes and reducing cost.[31] [32] [33] [34] [35] [36]

Additional Resources:

RNAO Best Practice Guidelines

RNAO has developed evidence-based Healthy Work Environment Best Practice Guidelines (BPGs) that, when applied, serve to support the excellence in service that LTC nurses are committed to delivering in their day to day practice. Relevant Healthy Work Environment Guidelines include: *Developing and Sustaining Effective Staffing and Workload Practices*[37], and *Collaborative Practice among Nursing Teams*[38] among others[39] [40] [41] [42] These BPGs should be used as markers in all staffing and scheduling practices as well as nursing care delivery models.

RNAO also has numerous Clinical BPGs relevant to the older adult. These include:

- Client Centred Care,[43]
- Prevention of Falls and Fall Injuries in the Older Adult,[44]
- Risk Assessment and Prevention of Pressure Ulcers,[45] and many others.[46] [47] [48] [49] [50] [51] [52] [53] [54] [55] [56] [57] [58] [59] [60] [61] [62] [63] [64]

These evidence based tools support nurses in optimizing the residents' clinical and health outcomes.

Nurse Practitioners and Clinical Nurse Specialists

NPs are able to prevent the emergence of many sub acute events in long term care[65] [66] [67] by providing primary care to residents and leadership to nursing staff. NPs can also contribute to decreasing the need to hospitalize LTC residents by detecting medical complications and providing early treatment. The ratio of NPs to residents in

LTCH should be no less than one NP per facility with no more than 100 residents per NP;[68] Clinical nurse specialists (CNS) have also demonstrated a strong ability to improve residents' outcomes in LTC homes.[69] [70] [71] [72] While not optimally established in the current provision of Ontario's LTC services, studies recommend CNS interventions and research in LTC within the following areas: (a) Advanced Practice Nurse (APN) practice, (b) outcomes related to psychogeriatric and mental health nursing services, and (c) outcomes related to geriatric specialization.[73]

The Elder Health Strategy

Developing an elder health strategy that provides an integrated model of care across sectors and disciplines to address the needs of seniors who require nursing services across the system will not only reduce the burden on seniors and their caregivers, it will also reduce system costs.[74]

Definitions

For the purpose of this *Strengthening Client-Centred Care Position Statement*, the following BPG definitions apply:

Client-centred care: "an approach in which clients are viewed as whole persons. It is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination and participation in decision-making."[75]

Skill mix: "the distribution of nursing personnel per skill category (e.g., RN, RPN, NP) and per skill level."[76]

Four Pillars Strengthening Resident / Client-Centred Care:

Pillar 1: Continuity of Care & Continuity of Caregiver

Continuity of care and continuity of caregiver are fundamental to resident /client centred care.[77] Skill-mix applications done in the absence of a stated commitment to continuity of caregiver compromise both nursing practice and resident safety.

As set out in RNAO's *Client Centred Care* Best Practice Guideline,[78] continuity of caregiver enables nurses to provide holistic resident care, facilitate higher coordination, and create clear accountability. Continuity of caregiver enables all regulated nursing staff, RNs and RPNs, to participate in and be accountable for the entire care process, which is essential for resident safety, quality outcomes and nurse satisfaction.

Currently, RPNs combine medication administration (which they provide for most or all of the residents in the home) with supervision of UCPs, and other interruption prone tasks, thus setting the stage for "structured interruptions"[79] in medication administration to occur regularly throughout their shift. Recent evidence suggests that nurses make procedural failures and clinical errors 75 per cent of the time when interrupted during medication administration.[80] Structured interruptions occur when the care provider's time must be divided among too many tasks, and therefore is susceptible to constant interruptions, creating frustration and stress and often resulting in unfinished tasks or less than optimal care.[81] Recently enacted LTCH regulation 31(2) and (3) now require LTCHs to minimize the number of care providers and to demonstrate this in written and evaluated LTC staffing plans. This legislation underscores the necessity of changing nursing care delivery models in LTCHs.[82] Reducing the skill mix of UCPs in LTC and increasing the proportion of registered staff will result in fewer

interruptions and fewer medication errors, increase accountability and allow RNs and RPNs to provide total resident care in an increasingly acute health care environment.

Pillar 2: Most Appropriate Care Provider

Choosing the most appropriate care provider, based on the resident's complexity and care needs and the degree to which the resident's outcomes are predictable, is central to resident centred care and ensures the following clear accountabilities:

1. Each resident is assigned one nurse or UCP per shift who works to his/her full scope of practice and is responsible and accountable for delivering the total nursing care required by that resident, with UCPs requiring a nurse to provide medication administration;
2. The resident's assignment to an RN, RPN or UCP is based on the level of complexity of the resident's condition, care requirements and predictability of the resident's outcomes, with RNs assigned the total nursing care for complex or unstable residents with unpredictable outcomes, RPNs assigned the total nursing care for stable residents with predictable outcomes, and UCPs assigned to the most stable and predictable residents. Research demonstrates that increasing RN staffing ratios in LTC reduces hospitalizations and associated health system costs, improves client outcomes and reduces mortality;[83 84 85 86 87 88 89 90]
3. Residents whose condition is unclear remain under the care of a RN to prevent shifting residents back and forth between RNs and RPNs; and
4. UCPs assist the RN or RPN as directed and under supervision, without disrupting the continuity of care provided by the assigned nurse.

This "primary nursing" nursing care delivery model contrasts sharply with "functional/ team nursing" in which three different roles – RNs, RPNs and UCPs – provide separate or "fragmented" components of nursing care. Fragmentation of care increases the risk and incidence of medication error, enables assessments to be miscommunicated or overlooked and creates an increased and avoidable risk to the resident's overall safety.[91 92 93]

"Stabilized Primary Nursing" nursing care delivery model is recommended for LTC given the resident's relative length of stay and the increasing acuity and mental health challenges LTC is currently accommodating. Stabilized primary nursing enables the RN to assess, plan and provide care to complex, unstable and unpredictable residents while requiring information-sharing and consultation to occur between the RPN and the UCP when a stable resident changes condition.[94]

Long Term Care environments have been recently compared to intensive care units in terms of the levels of uncertainty and instability.[95] As complex continuing care patients move from hospitals into LTCHs, training and nurse qualifications must change to be consistent with the complex care that is being provided in this environment.

Researchers have confirmed that efficiency-oriented minimum LTC nurse staffing points exist.[96] Recommendations based on a synthesis of the literature[97] include:

- direct care RN staffing levels of .75 hours of care per resident day, not including administrative RNs, which should be subject to change to account for co-morbidity or resident case-mix differences, and
- 24 hour RN staffing.

According to the most recent comprehensive skill mix review conducted in 2001, RN hours in LTC varied significantly across the country with Ontario residents receiving .23 hours per resident per day in Ontario and Saskatchewan residents receiving more than double at .59 hours. At that same time, Mississippi and Maine were providing 1.0 hours per resident per day. [98]

The number of RN FTEs in LTCHs is however declining in Ontario as well as across Canada, despite an increasing need for complex care, monitoring and supervision and improvement in evidence-based outcomes.[99] [100] In 2005, following the Casa Verde nursing home inquest, the Ontario Chief Coroner's recommended that the ministry require no less than .59 RN hours per resident per day,[101] however by 2007, LTCH staffing reports[102] indicated RNs had .304 worked care hours per resident per day; down from .312 in 2004. In that same time period, RPNs increased worked care hours from .329 in 2004 to .370. Similarly, PSWs increased worked care hours from 1.725 to 1.876. The Ontario ministry's "Nurse-Led Outreach Teams" attempt to bolster the low RN / NP skill mix but effectively fragments care further.

As LTCHs are increasingly being asked to care for residents with dementia complicated with behavioural disturbances, health providers are being asked, as recommended in the Chief Coroner's report, to "urgently examine the issue of staff-mix and staff-to-resident ratios for the purpose of ensuring that sufficient, adequate, appropriate, and safe care can be provided to elderly residents in licensed long term care homes."[103]

Recommendations to address skill mix concerns in LTC have now been raised at least twice by the Coroner's office,[104] [105] particularly in regards to the provision of mental health services, yet the reduced hours of RN hours and an increase in PSW worked care hours demonstrate a deskilling of LTC staff mix and a lack of regard for the Coroner's specific recommendations.

Based on the Coroner's recommendations, the evidence provided, and the potential for RNs in LTC to alleviate system pressures on hospitals by providing care for Alternate Level of Care (ALC), mental health and complex continuing care residents in the LTC setting, RNAO recommends that the ministry act on their provincial promise to hire additional nurses by funding and mandating a new minimum of two RNs per 24/7 rather than the currently mandated one RN per 24/7 in LTCHs across Ontario per 100 beds.

Adding one additional RN per 24/7 will aid the recruitment and retention of directors of nursing and personal care, who feel obliged to provide care when staff is unavailable, and will also improve recruitment of new graduate nurses who must be mentored by other nurses to provide excellent health care to complex care seniors.

Pillar 3: Workforce Stability

Continuity of care and continuity of caregiver must be supported by full-time employment practices in all sectors. A level of 70 per cent full-time employment for all nurses is considered the minimal condition for ensuring continuity of care and continuity of caregiver for residents.[106]

RNAO has long advocated for 70 per cent full-time employment[107] for all nurses. Full-time employment in the LTC sector is currently lower than other sectors for RNs and higher than other sectors for RPNs highlighting the need for further analysis. In 2009, RNs (general class) working in LTC had 63.7 per cent FT employment as compared to the 65.4 per cent average across sectors. RPNs working in LTC had

61.7 per cent FT employment as compared to the 58.6 per cent average across sectors.

Staff turnover, now 12 - 14 per cent for full time and 22 per cent for part time RN/RPN LTC staff [108] [109] has a high impact on the quality, continuity and stability of resident care.[110] Costs associated with staff turnover are considerable for any organization but especially for chronically underfunded LTCHs. As demand for LTC increases over the next decade with a concurrent aging workforce (the average age of LTC nurses in Canada is 48.8 compared to 43.4 in hospitals and 46.9 in community health),[111] workplace injuries, burnout, stress leaves and high turnover rates will become major obstacles to workforce stability.[112] High turnover rates in LTC have been linked not only to unhealthy work environments that include poor staff morale and low staffing levels[113] but have also been linked with adverse clinical outcomes including increased rates of infectious disease, acute care hospitalizations,[114] violence and increased mortality.[115]

Increasing fulltime employment is an effective strategy to decrease agency staff utilization. In addition, 70 per cent FT employment has been positively correlated with nurse retention.[116] Wage disparity remains a significant deterrent to recruitment of LTC nurses. Despite an aging workforce, the average wage and salary of FT RNs working in LTC was $70,314; less than hospital nurses would receive after just 6 years of work.[117] [118] [119] Strong supervisory support is a significant factor influencing LTC nurses' decision to stay,[120] and a culture oriented to quality improvement initiatives including the use of best practice guidelines is correlated with lower turnover.[121] RNAO Healthy Work Environment (HWE) best practice guidelines provide key strategies that improve recruitment and retention efforts.[122] [123] [124] [125] [126] [127]

Increasing the number of nursing student placements in LTC and hiring more nursing graduates are excellent strategies to both strengthen workforce stability in LTC and reinforce students' knowledge, skill and attitudes in the care of older adults. New graduates are currently unprepared to care for the elderly.[128] In fact, results of the 2006 Canadian Registered Nurse Examination indicated that fewer than half of answers related to patients over 80 years old were correct.[129] Strong clinical placements require an increased proportion of nurses, particularly RNs with advanced practice degrees, in order to ensure attractive and quality learning experiences. Quality learning experiences in LTC include:

- managing clinical complexities of multiple diagnosis and polypharmacy,
- psychogeriatric assessments and therapeutic interventions,
- palliative care and managing family dynamics during times of grief,
- information management, quality improvement and nursing research using the RAI MDS[130] database, and
- nursing leadership, management and supervision.[131]

Currently LTCHs are not typically well funded for training opportunities which new grads may expect to further their professional development. P.I.E.C.E.S.[132] training or similar mental health training has been recommended by the Chief Coroner as mandatory,[133] yet current funding is insufficient. Financial incentives such as "Grow Your Own RN" fund matching programs, loan repayment programs and bursaries to obtain certification in geriatrics

may boost recruitment while increasing quality of care in LTC.[134]

Pillar 4: Not-for-Profit funding

LTCHs do not bear the costs associated with hospitalization which provides a disincentive to reduce system wide costs. LTCHs in fact experience a perverse incentive in the form of reduced workloads and costs recovered by a vacant bed with each hospital transfer. A recent CIHI report noted as a key finding that ten per cent of acute hospitalizations in Canada were patients transferring from another continuing care setting (e.g., retirement home, LTCH or complex continuing care beds).[135] The cost of such hospitalizations is currently being analyzed by LHINs, however available research indicates that for-profit LTCHs have significantly lower staffing levels, reduced quality of care and higher hospitalization rates than do not-for-profit homes.[136] [137] The current emergency department (ED) and alternative levels of care (ALC) crisis that hospitals are experiencing is in part due to the rising number of for-profit LTC homes.[138] Since 1998 almost two-thirds of all LTC beds in Ontario were given to for-profit homes despite the ministry's legislated commitment to support not-for-profit LTCHs.[139] Medicare principles must be reinforced in the future as additional LTC beds are awarded with priority given to not-for-profit publicly funded health-care organizations.

Conclusion

Evidence is overwhelming that nursing care delivery models that advance continuity of care and continuity of caregiver from the most appropriate nurse ensures safe, high-quality resident centred care. The most appropriate provider: RN, RPN, or UCP is assigned based on the resident's complexity and care needs and the degree to which the resident's outcomes are predictable.

Models of care delivery that are variations on "functional / team nursing" result in fragmented care and are detrimental to residents and to nurses. Incorporating a more applicable "Stabilized Primary Nursing" model enables each player on the health-care team to optimize utilization of skills thereby reducing risk and increasing quality for LTC staff, residents and the healthcare system as a whole.

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