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

Position Statement

Strengthening Client Centred Care in Home Care

Adopted by the RNAO Board of Directors, Feb 5, 2011

Position

Registered Nurses' Association of Ontario (RNAO) strongly supports the development of home care[1] services utilizing a client centred care model in which Ontarians have access to continuity of care and continuity of caregiver from a primary nurse in the most appropriate setting. RNAO also strongly endorses strengthening inter-professional care so all health disciplines work closely together to support high quality client care, ensuring the right care is provided to the right client in the right place by the right care provider. Whether for-profit or not-for-profit, home care organizations must ensure the appropriate nursing care delivery model, skill-mix, and access to Registered Nurses (RNs). Adherence to the principles and spirit of Medicare are paramount to optimal client, staff, organizational and system outcomes. Excellence in client centred home care is supported by four pillars:

- Nursing care delivery models that advance continuity of care and continuity of caregiver by assigning each client one principal nurse,[2] that nurse being an RN or a Registered Practical Nurse (RPN) working to full scope of practice and accountable for delivering the total nursing care required by the client;
- Assignment of the most appropriate caregiver based on the client's complexity of care needs and the degree to which the client's outcomes are stable and predictable, with RNs assigned total nursing care for complex and/or unstable clients with unpredictable outcomes, and RPNs assigned total nursing care for stable clients with predictable outcomes. Clients whose condition is unclear remain under the care of RNs to prevent shifting a client back and forth between RNs and RPNs. When unregulated staff are utilized, they are assigned to assist RNs or RPNs where appropriate and under their supervision, avoiding disruption of the continuity of care provided by the assigned nurse;
- Workforce stability, by achieving 70 per cent full-time employment for all nurses, supports continuity of care and continuity of caregiver, improves intra and inter-professional team work, reduces costs and facilitates staff satisfaction and retention; and
- Investment in publically funded not-for-profit home care services supports universal access to necessary home care when and where it is needed in the spirit of the *Canada Health Act*.

Background

Vibrant communities depend on everyone having the opportunity to live at home with dignity as independently as possible whatever their background, wherever they live and whenever possible. Home care

agencies support vibrant communities by providing a range of services from post-hospitalization follow-up to homemaking and personal support services. These services enable people with acute and chronic conditions to remain active and strong members of our community.

In 1997 the provincial government of the day instituted managed competition as the sole service delivery model in Ontario's home health care system. In January 2008, Hamilton residents protested the disqualification of two long-standing not-for-profit home care agencies in the bidding process; namely the Victorian Order of Nurses (VON) and St. Joseph's Home Care.[3] [4] [5] A province-wide moratorium was subsequently placed on the competitive bidding of home care contracts. In December 2008, the government chose to resume competitive bidding and quietly lifted the moratorium. Various accountability measures were announced at the time and accreditation is now required for all service contracts.[6] There are, however, no current plans to issue Request for Proposals (RFPs), subject to Ministry of Health and Long-Term Care (MOHLTC) Directives for CCAC Procurement.[7] Instead, contracts are being extended based on compliance with CCAC requirements. An integrated strategy is required to avoid unnecessary system costs. Increasing access to home care and community services, for example, enables patients in alternative level of care (ALC) beds to leave hospital sooner, availing beds to patients in emergency rooms who are waiting to be admitted to hospital."[8] In 2009, 50,000 patients stayed longer than necessary in hospital waiting for discharge care to be arranged. This waste accounted for 16 per cent of all hospital patient days.[9]

Competitive bidding is antithetical to client centred care as it inevitably leads to home care contracts awarded on the basis of price rather than quality. Ontario remains the only province relying exclusively on competitive bidding and home care is the only health sector in Ontario where direct care is contracted out.[10] North American jurisdictions that have implemented competitive bidding conclude this model reduces wage costs but generates higher turnover and reduces continuity of care.[11] [12] Successful models of care delivery across the country should be considered instead, including innovative models such as the publicly administered and cost-effective SIPA (French acronym for Système de services Intégrés pour Personnes Agées en perte d'autonomie) model in Quebec.[13] [14]

Access to Registered Nurses

Access to registered nurses in all sectors is essential to achieve optimal health outcomes. While access to RNs and home care services is increasing in certain LHINs, access is not equal across the province.[15] [16] [17] When health care restructuring occurred in the 1990's unprecedented cuts were made to home care services awarded to various agencies by Ontario's Community Care Access Centres (CCACs). Since that time home care funding has fluctuated with little consistency in service delivery expectations or quality indicators. Currently health care dollars are severely limited leading certain CCACs to restrict funding for much needed nursing and personal care services. This restriction has dramatically increased service wait times and effectively reduced required access to nurses.[18] [19]

Client centred care requires a reconceptualization of the client as one who lives within a family unit. This concept prompts recognition that restricting access to RNs inevitably shifts care responsibilities to family members. Often families do not have sufficient resources to manage the burden of care in addition to their other responsibilities. The additional burden may cause detrimental effects on family well-being as well as increased safety risks and diminished quality of care for clients. Advances in treatments and technology, limited resources, decreased length of hospital stay, increased day surgery treatment and changes in consumer expectation have significantly increased the care requirements of today's community

client.[20] While there is limited evidence[21] [22] [23] [24] that relates care provided by RNs with better health outcomes in home care, convincing evidence from both hospital and LTC sectors demonstrate that increasing the proportion of RNs is effective in improving client outcomes and reducing cost. [25] [26] [27] [28] [29] [30] [31] [32] [33] [34]

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 home care nurses are committed to delivering. Relevant guidelines include: Developing and Sustaining Effective Staffing and Workload Practices,[35] and Collaborative Practice among Nursing Teams.[36] These BPGs should be used as markers in all staffing and scheduling practices and models of nursing care delivery.

RNAO also has numerous clinical BPGs relevant to community health nursing. These include:

- Client Centred Care,[37]
- Decision Support for Adults: Living with Chronic Kidney Disease,[38]
- Reducing Foot Complications for People with Diabetes,[39]
- Supporting and Strengthening Families through Expected and Unexpected Life Events.[40]
- Assessment and Management of Pain,[41]
- And many others[42] [43] [44] [45] [46] [47] [48] [49] [50] [51] [52]

Definitions

For the purpose of the *Strengthening Client Centred Care in Home 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."[53]

Skill mix: "the distribution of nursing personnel per skill category (i.e. RN, RPN) and per skill level."[54]

Four Pillars Strengthening Client Centred Care:

Pillar 1: Continuity of Care & Continuity of Caregiver

Continuity of care and continuity of caregiver are fundamental to client centred care. As set out in RNAO's Client Centred Care Best Practice Guideline,[55] continuity of care and continuity of caregiver enables nurses to provide holistic client care, facilitate coordination of services based on changing client needs, and create clear accountability. Researchers and decision-makers are currently examining continuity of care as a variable in quality care outcomes. In one recent Ontario-wide home care study[56] involving 740 home care clients and 700 nurses, clients received, on average, 67 per cent of their visits from the same nurse. Only 22 per cent of clients had all of their visits by the same nurse and only 34 per cent of the sample had 80 per cent or more of their visits by the same nurse.

Consistency of care provider is challenging in home care since clients may require more than one visit per day, require weekend care, are admitted on a Friday or Saturday, or the level of client predictability, stability or complexity changes resulting in a transfer of care from RN to RPN or vice versa. Continuity of a principal caregiver is important to client care because the nurse must keep track of changes, or a lack thereof, in the client's condition. They must also detect subtle changes in the client's appearance or demeanor that indicate

changing client needs and note accurate observations when communicating with the physician about any deterioration in the client's health.[57]

One consequence of competitive bidding is that many clients risk being shuffled to a different agency to begin a new therapeutic relationship with a new nurse.[58] Rural and elderly populations are especially affected by this loss of continuity as nursing and home visits are an important source of social support and interaction. In these instances, managed competition reduces the client's power by discontinuing therapeutic relationships and diminishing the client's control over their choice of care provider. One recent study found a significant relationship between longer service contracts and greater consistency of principal nurse visits,[59] suggesting that nurse scheduling and assignment may be optimized by fewer contract changes. Currently, "independent CCAC client satisfaction surveys indicate that home care clients are generally satisfied with the services they receive".[60]

While CCACs have set standards for continuity and the acceptable number of caregivers for each client, based on number of visits required per month, home care clients may soon experience care provided by a team of practitioners based on their particular condition(s) / diagnosis rather than a principal care provider such as an RN. The Integrated Client Care Project[61] announced in 2009 as a key component of Minister Caplan's "Strengthening Home Care Services in Ontario", focuses on "specialization, integration and coordination". This new model may improve quality of care for clients while providing nurses with more autonomy in clinical decision-making and time allowances. Throughout the inevitable restructuring it will be important for health care practitioners and service providers to ensure holistic care is provided and continuity of care and continuity of caregiver remain optimized.

Pillar 2: Most Appropriate Care Provider

Choosing the most appropriate care provider based on the complexity of client's care needs and the predictability of the client's outcomes is central to client centred care and ensures clear accountabilities:

1. Each client is assigned one principal nurse[62] (RN or RPN) who works to his/her full scope of practice and is responsible and accountable for delivering the total nursing care required by that client;
2. The client's assignment of an RN or an RPN is based on the level of complexity of the client's condition, care requirements and predictability of the client's outcomes, with RNs assigned the total nursing care for complex or unstable clients with unpredictable outcomes and RPNs assigned the total nursing care for stable clients with predictable outcomes;
3. Clients whose condition is unclear remain under the care of an RN to prevent shifting clients back and forth between RNs and RPNs; and,
4. Unregulated staff assist the RN or RPN as appropriate and under their supervision, without disrupting the continuity of care provided by the assigned nurse.
5. RUG (Resource Utilization Group) scores derived from RAI MDS (Resident Assessment Instrument Minimum Data Set) Community Health Assessments (CHA) indicate the intensity and complexity of care that long-stay clients receive; a useful tool in determining which client should receive care by RN vs RPN or UCP.[63]

Funding policies that have given rise to competitive bidding and privatization of services have caused unwarranted introduction of inappropriate skill mix

applications. RNs must always assess the complexity, stability and predictability of each admission to home care services in order to coordinate safe and high quality care. This is particularly warranted in post-hospitalization and post-surgical admissions. Use of eligibility screening-tools[64] by non-regulated staff to prioritize clients' health care needs and to select service providers is inadequate for a safe and comprehensive assessment. Safe and high quality community nursing assessments require fostering client trust within a therapeutic nurse-client relationship. Once a relationship is established, a tremendous degree of skilled judgement is required to conduct a comprehensive assessment that sufficiently identifies care needs that are not always obvious or stated at intake. RNs who assess and continue caring for clients who are complex, unstable and unpredictable are exemplifying continuity of care and continuity of caregiver. RNs who recognize within their assessment, the need for a timely referral of care to an RPN or UCP are also exemplifying this care. In this manner, continuity of care and continuity of caregiver allows every health care provider to participate in and be accountable for the entire care process; essential for client safety, quality outcomes and staff satisfaction.

The assumption that RN care is financially unsustainable is not supported by the available, albeit, limited evidence.[65] [66] [67] According to one recent University of Toronto report, the percentage of RN visits in home care was positively related to better emotional and social functional outcomes for clients.[68] Home care agencies seeking to improve quality while reducing risk and unnecessary costs associated with staff turnover should be looking at strengthening their full-time RN workforce.

Pillar 3: Workforce Stability

Continuity of care and continuity of caregiver must be supported by full-time employment practices in all sectors.[69] 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 clients.[70] Evidence shows that workforce stability, with higher proportions of full-time RN staff, is significantly associated with continuity of care and continuity of caregiver, and with lower mortality rates and improved client outcomes.[71] Conversely, excessive use of part-time and casual employment for RNs is associated with decreased morale,[72] an unstable workforce where nurses move to other jurisdictions to find full-time work,[73] [74] [75] [76] disengagement among nurses, and lack of continuity of care for clients. [77] [78]

The number of home care visiting nurses in Ontario decreased between 1999 and 2009 from 7546 to 5,007 despite increased population and increased need for community health services. In the same ten year period casual positions decreased from 30.7 per cent to 19.3 per cent and FT positions increased from 36.2 per cent to 48.7 per cent.[79] While encouraging, this percentage of FT RNs is well below the total nursing average of 65.4 per cent FT employment.[80] The proportion of PT visiting nurses has remained steady over the past 10 years at 32 per cent; however 16 per cent of PT community nurses would prefer FT employment.[81] [82] Given this demand, home care FT employment could reach as high as 64.7 per cent. In stark contrast to home visiting nurses, the total number of CCAC nurses / case managers increased from 1668 to 3281 in the past decade moving from 68.6 per cent to 73.6 per cent FT work.[83] Increasing the number of CCAC nurses while decreasing visiting nursing positions may reduce, or at least be perceived as reducing, funds available to ensure accessibility and appropriate workloads of direct care staff.

With the implementation of managed competition and concurrent privatization, cost-cutting measures have resulted in the intensification of work in home health care. This has impacted workforce stability in a

profound way. According to provider organizations, threats to workforce stability include: challenges to meet goals with insufficient funding; high turnover rates (home care had an attrition rate of 15 per cent in 2007);[84] difficulties in recruitment; an aging workforce (average age is 45);[85] lack of regular hours; and, a large disparity in compensation between home care and other health care sectors.[86] [87] Wage disparity led OHHCPA and OCSA to recommend a 50 per cent increase in compensation in 2000.[88] Many providers have suggested there should be an ongoing mechanism to review CCAC / Ministry base funding to avoid cyclical wage disparity between sectors.[89]

While wages remain low, workload has risen sharply. Frontline staff is being asked to provide an increased level of service in a reduced amount of time. Nursing visits from 2008 to 2009 increased by 89,055, while 46 fewer nurses were employed.[90] The marginally increased FT employment during this time could not have addressed the increased number and acuity of home care visits. Intensifying work by coordinating clinics to serve multiple clients at the same time may be justified as long as clinics succeed in meeting clients' individual needs and the nurse-client therapeutic relationship is preserved. Recent research shows that nurses paid on a per-visit basis rather than an hourly basis were less satisfied with their job[91]. Those paid hourly were more satisfied with their time for care suggesting work intensification without reciprocal social and monetary rewards may lead to low staff morale.[92] Researchers have pointed to high levels of stress, burnout, and physical health problems, concluding that restructuring home care services resulted in numerous work environment concerns that may be leading to decreased job satisfaction, increased absenteeism, and increasing fear of job loss along with a stronger propensity to leave.[93]

Certain retention and recruitment efforts in home care have served to weaken client centred care and must be eliminated. Despite RNAO's attempts to eliminate the "elect-to-work" model, and the MOHLTC's recommendation to do the same,[94] this practice continues to date and in 2007 replaced approximately 788 FTE RNs with casual / elect to work staff.[95] Retention and recruitment efforts instead should focus on the reasons nurses choose home care: flexible hours; dissatisfaction with institutional nursing; ability to have 1:1 relationships with clients and not feel rushed; preference for independence in practice; avoid night shifts; enjoy the variety; minimal weekend work; and more time with family.[96]

Pillar 4: Publically Funded and Not-for-profit Home Care Services

The percentage volume of nursing services provided by for-profit provider agencies rose from 18 per cent in 1995 to 46 per cent in 2001. By 1997 for-profit businesses were awarded more than 50 per cent[97] of the Ontario contracts. Since the rise of for-profit agencies managed competition has been diverting funds away from direct care and into costs associated with the competitive bidding process and into the pockets of shareholders. Lower wages and reduced access to adequate supplies are noted more often in for-profit than in not-for-profit Canadian home care agencies.[98]

While for-profit businesses are praised for their incentive to be cost-conscious and innovate, not-for-profit providers compete with a distinct disadvantage. Many not-for-profit providers have a long term employment history and when the employer loses a contract, they are subject to very high severance payouts. For-profit agencies rely more on a casual pool of workers and are not impacted to the same degree financially.[99] According to one study, more nurses from not-for-profit agencies were employed on a full-time basis than for-profit agencies (35 per cent versus 26 per cent).[100]

Additional Organizational Processes

Additional organizational supports that strengthen client centred care in home care and strengthen inter-professional collaboration include: 1) nurse managers with a span of control that supports their engagement with staff;[101] and 2) better utilizing the knowledge and skills of registered nurses in different roles, such as Nurse Practitioners (NPs)[102] and Clinical Nurse Specialists (CNSs).[103] As clients are being discharged from hospital at a more acute stage of recovery, or are waiting for placement into a long term care home, the sustainability of the home care workforce is critical to the sustainability of health care in Ontario and the health of Ontarians.

The anticipated demand for home care services and nurses in home care is expected to increase to 9 per cent of the total nurse demand by 2020.[104] This requires the development of both short and long term strategies to ensure nursing human resources will be able to meet growing client care needs in the community.[105] A comprehensive national home care strategy following the same principles and spirit of the *Canada Health Act* enables people to live with dignity and as independently as possible in their own communities. Current initiatives, such as the Integrated Client Care Project, provide hope for a more effective, integrated, funded and balanced era of home care service delivery in the near future.

Conclusion

Evidence suggests that nursing models of care that advance continuity of care and continuity of caregiver from the most appropriate nurse ensure safe, high-quality client centred care. The most appropriate principal nurse, RN or RPN, is assigned based on the client's complexity and care needs and the degree to which the client's outcomes are predictable. Altering evidence-based skill-mix applications to employ less skilled staff compromises nursing practice and client outcomes. Service providers must stabilize the home care workforce by employing a ministry mandated 70 per cent full time workforce of nursing staff equitably compensated at parity with nurses who provide care in hospital settings. Finally, the government must consider the overwhelming evidence against managed competition and advocate for a comprehensive national home care strategy that supports readily accessible publically funded not-for-profit home care services to enable people to live with dignity and as independently as possible in their communities.

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[2] The principal nurse is an individual nurse who makes the majority of visits over a client's home care stay as defined in Doran, D., Pickard, J., Harris, J., Coyte, P., MacRae, A., Laschinger, H., Darlington, G. & Carryer, J. (2007). The relationship between characteristics of home care nursing service contracts under managed competition and continuity of care and client outcomes: Evidence from Ontario. *Healthcare Policy, 2*(4), 97-113.

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*Parts of this material are based on data and information provided by the College of Nurses of Ontario; however, the analyses, conclusions, opinions and statements expressed herein are those of the author, and are not necessarily those of the College.