



## ***Staffing and Care Standards for Long-Term Care Homes***

***Submission to the Ministry of Health and Long-Term Care***

**Registered Nurses' Association of Ontario**

**December 2007**

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The Registered Nurses' Association of Ontario (RNAO) is the professional association for registered nurses in Ontario. RNAO members practice in all roles and sectors across the province, including long-term care. Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of Ontarians. We welcome this opportunity to respond to questions posed in the review of staffing and care standards for long-term care homes.

**(a) What are the key factors that affect human resources/staffing requirements and standards related to quality of care and quality of life of residents of LTC homes?**

Ontario's older age groups are growing rapidly. The population of people over 65 years is projected to more than double from the 1.6 million, or 12.9 per cent of the population in 2006 to 3.5 million, or 21.4 per cent of the population, in 2031.<sup>1</sup> Between 2001 and 2006, those aged 80 years and older comprised the fastest-growing segment of all seniors. This cohort of Ontarians accounted for 26.8 per cent of all seniors in 2006, which was an increase from 23.1 per cent in 2001.<sup>2</sup>

Seniors, especially the most elderly, have a disproportionate share of serious and chronic illness.<sup>3</sup> It has been well documented that Ontario's LTC facilities 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.<sup>4</sup> A snapshot of key descriptors from Ministry of Health and Long Term Care (MOHLTC) data reported in 2004 found the average age of admission to LTC to be 82 years; percentage LTC residents assessed at mid to heavy care as 80%; percentage of residents having some degree of incontinence as 86%; percentage having Alzheimer Disease, dementia, or mental disorder as 64%; percentage requiring assistance with transferring as 72%; and percentage requiring constant, complete, or total help with eating as 39%.<sup>5</sup>

As of December 2006, Ontario had 352 LTC homes with 39,862 beds in the for-profit sector out of a total 614 facilities and 75, 128 beds that includes not-for-profit charitable, municipal, and nursing home sectors.<sup>6</sup> This is an important systemic consideration as not-for-profit delivery of long-term care has

been associated with higher staffing levels and improved outcomes for residents.<sup>7</sup> In a study using data from British Columbia, the mean number of hours per resident-day in both direct care provided by RNs, LPNs, and resident care aides, activity aides, and support staff in dietary, housekeeping, and laundry was higher in the not-for-profit facilities than in the for-profit facilities.<sup>8</sup> In Manitoba, for-profit LTC facilities had higher rates of acute care hospital admissions due to quality-of-care related diagnoses than did not-for-profit LTC facilities.<sup>9</sup> The findings of significantly lower quality of care and less nursing care in for-profit nursing homes, particularly investor owned nursing homes, are well documented in the United States<sup>10 11</sup> and in a systemic review of the literature of nursing homes in North America.<sup>12</sup>

In the context of a growing and aging population with frail LTC residents with higher and more complex care needs, RNAO has consistently argued that reform of long-term care must occur within an overall seniors' strategy and an elder health framework focused on aging in place. Thus, long-term care legislation must be part of health care transformation focusing on health promotion and quality of life.<sup>13 14</sup> RNAO endorses the principles of the National Framework on Aging<sup>15</sup> to guide policy development: dignity, independence, participation, fairness and security. The Elder Health Coalition<sup>16</sup> suggests using these principles as the foundation of an Ontario seniors' health framework and recommend that its development be guided by:

- Creating supportive environments, including independent living options, elder-friendly services, and enhancing the accountability of long-term care facilities and services to provide the best care possible.
- Supporting caregivers, including providing better quality, more flexible respite and other supportive services, training, and extending the range of assistance available in the community to help seniors age in place by choice.
- Providing optimal care, including preserving seniors' independence and dignity, emphasizing positive aging and cultural awareness, promoting best practices to preserve privacy, and encourage self reliance, and developing more senior sensitive services.

Policy and service delivery decisions must be guided by the core values of healthy ageing and choice for older persons. In the case of LTC facilities, this implies a philosophy that is resident-centred with high-quality services that are ready to respond to residents' unique situations, conditions, and choices. LTC facilities are residents' homes and each facility has a duty to provide services that ensure dignity, security and comfort. Residents have the right to be properly sheltered, fed, clothed, groomed and cared for.<sup>17</sup> 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.

**(b) What are the implications of these factors on human resources/staffing requirements and standards?**

The government of Ontario "is committed to providing homes where our seniors can live in dignity with the highest possible quality of care."<sup>18</sup> In its influential report on *Crossing the Quality Chasm*, the Institute of Medicine identified the six elements of quality as care that is safe, effective, efficient, timely, person-centered, and equitable.<sup>19</sup> To fulfill this commitment to our frail seniors with increasing and more complex health care needs, LTC facilities must ensure that their facilities have sufficient numbers of appropriately educated, compassionate staff to provide effective, safe and culturally competent care. Critically important to long-term care quality is the individual's quality of life. Providing individuals with more choice and control over the services that they receive in the settings of their choice will enhance quality of life.<sup>20</sup> Staffing models that facilitate high quality, resident-centred care must be multi-disciplinary in order to address the range of physical, psychological, emotional, spiritual, and social domains.

A preferred model of care delivery would include nurse practitioners, registered nurses, and registered practical nurses working to full scope of practice in each facility. This team of regulated professionals will be assisted by personal support workers to provide safe and comprehensive care for residents. Additionally, other disciplines such as physiotherapists, occupational therapists, recreational

therapists, and social workers are essential to deliver programs that will enhance the abilities of LTC residents and increase their social engagement. The importance of activities, activation to residents' wellbeing, and lack of rehabilitation activities in LTC homes has been both documented<sup>21</sup> and acknowledged by government.<sup>22</sup>

Utilizing nurse practitioners to provide primary care to residents and leadership to nursing staff has shown to improve access to care for residents,<sup>23</sup> quality of care for residents<sup>24</sup> and the opportunity to provide a role model for nurses related to assessment skills and problem-solving medical issues.<sup>25</sup> The Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project<sup>26</sup> demonstrated positive outcomes for residents, staff, and the health care system to the extent that Monique Smith recommended additional nurse practitioners in the LTC sector.<sup>27</sup> While it was difficult to extrapolate from the pilot project about a program model due to variances in the needs and priorities of the facilities and geographical distances, key informants suggested the ratio of nurse practitioners to facility should be 1:1, or one nurse practitioner per 200-300 residents.<sup>28</sup> In addition to nurse practitioners, advanced practice nurses engaged as clinical nurse specialists have been shown to improve resident outcomes in nursing homes.<sup>29 30</sup>

A number of studies have shown strong links between staffing (particularly RN) in long term care facilities and patient/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.<sup>31 32</sup> The RN role entails ensuring achievement of standards of care that address all resident needs: physical, psychosocial, and spiritual and includes setting care giving goals, identifying relevant care practices for the residents, mentoring, coordinating services and providing supervision.<sup>33</sup> RPNs have an essential role in providing quality care in LTC. RPNs have the educational preparation, knowledge, and skills required to meet the needs of residents whose care needs are stable and have predictable outcomes.<sup>34</sup> As with advanced practice nurses and RNs, RPNs should be working to their full scope of practice within the multi-disciplinary team.

RNAO is fully supportive of the role of Personal Support Workers (PSWs) and believes that they are integral to a comprehensive spectrum of care for persons living in LTC facilities. Compassionate,

dedicated, and hard-working PSWs provide an essential service to many LTC residents assisting them with routine activities of daily living such as feeding, bathing, dressing, transferring, and continence care. PSWs do not, however, practice from a distinctive, systematic body of knowledge in assessing, treating or serving clients.<sup>35</sup> They do not have the breadth and depth of education, knowledge, and skills necessary to independently assess, treat, or serve clients and their work must be directed by a plan of care developed by a regulated care provider.<sup>36</sup> Thus, PSWs must always work in the context of a well supported team of regulated professional staff.

**(c) What are the components that would go into establishing a staffing standard and what is the evidence to support this?**

Given that the needs of many LTC residents have become more complex, there are two crucial elements to be considered in determining the appropriate level of care: the first is levels of care and the second is the mix of care providers. Early in 2007, the government released information that long term care homes in Ontario were averaging 2.86 hours of nursing and personal care per resident day.<sup>37</sup> This falls short of the no less than .59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal care for the average Ontario case mix measure recommended by the Casa Verde Coroners' inquest,<sup>38</sup> and the 3.5 hours per day that the Ontario Health Coalition,<sup>39</sup> RNAO,<sup>40</sup> and Ontario Nurses Association<sup>41</sup> are calling for that would bring Ontario into line with care standards in other jurisdictions. In addition to the 3.5 minimum hours per resident, per day, for nursing and personal care, RNAO recommends a minimum staffing standard be established for programming and support services. These staffing standards should support adequate services for: rehabilitation, activities and activation, as well as nutrition. A starting point would be .5 hours per resident day of this form of staffing.

The mix of care providers is the second important aspect of nursing and personal care. An Ontario study released in 2001 indicated that health care aides provide 75 per cent of care; RPNs 13 per cent and RNs 11 per cent.<sup>42</sup> With the increased employment of RPNs in the intervening period, the mix between RPNs and HCAs has likely shifted by a few percentage points.

An expert panel convened in the United States made recommendations both about minimum staffing levels and the appropriate mix of nursing staff.<sup>43</sup> The panel called for a full time RN Director of Care in each facility, a full-time RN assistant director of nursing for facilities with 100 beds or more, and a full time director of in-service education for facilities with more than 100 beds. The panel also made recommendations about direct care provision by licensed nursing staff: including conducting assessments, giving treatments and medications, delivering hands-on care and supervising unregulated staff. Consistent with the previous discussion, the expert panel also suggested urging all facilities to have a NP on staff.

Given the available evidence, and the staffing standards in other jurisdictions, pending a more rigorous evidence-based study to determine appropriate staffing levels, a minimum staffing standard of 3.5 hours per day should be established for facilities with an average case mix. Extrapolating from the experiences of other jurisdictions and considering the differences in levels of educational preparations within different contexts,<sup>44</sup> RNAO suggests a staff mix of: 1 nurse practitioner per facility, 20% registered nurse, 25% registered practical nurse, 55% personal support workers/health care aides.

**Current Staffing Mix in Ontario, Expert Panel Recommended Staffing Mix, and RNAO Recommended Staffing Mix (as percentage of total )**

	<b>Ontario Staff Mix</b>	<b>Expert Panel Recommended<sup>c</sup></b>	<b>RNAO Recommended</b>
Nurse Practitioners	20 NPs in selected facilities <sup>a</sup>	1 per facility	1 per facility
Registered Nurses	11 <sup>b</sup>	25	20
Registered Practical Nurses	13 <sup>b</sup>	15	25
Health Care Aides	75 <sup>b</sup>	59	55
	<sup>a</sup> Ont. NP LTC Pilot Project <sup>b</sup> PricewaterhouseCoopers, 68.	<sup>c</sup> Harrington, Kovner, 9.	

This staffing pattern would result in substantive improvements in residents’ clinical and social outcomes (such as reduced rates of pressure ulcers and falls, decreased aggressive behaviours with improved dementia care, increased residents’ and families’ satisfaction) and improved system utilization (such as decreased transfers to emergency departments).

**2. (a) What are the key priority areas that directly impact on resident outcomes related to human resources/staffing requirements and standards?**

Key priority areas that directly impact on resident outcomes related to human resources/staffing requirements and standards include:

- Funding to ensure an adequate number of staff to provide a minimum staffing standard of 3.5 hours per day, with the appropriate competencies (one NP per facility, 20% RN, 25% RPN, and 55% PSW) to perform all the required elements of nursing and personal care;
- Seventy percent full-time employment for nurses and PSWs in all long-term care facilities is an essential standard to ensure continuity of caregiver, prevention and early detection of complications, commitment to resident-centred care, and positive relationships between nurses and residents;<sup>45 46 47 48</sup>
- Implementation of minimum standards for staff orientation;<sup>49</sup>
- Implementation of RNAO's Clinical<sup>50</sup> and Healthy Work Environments<sup>51</sup> Best Practice Guidelines;
- Reasonable work assignments such that all regulated and unregulated staff function within their competencies and individual productivity capacity;
- Appropriate equipment and tools to carry out nursing and other caregiving work;
- Development and education opportunities to maintain and enhance professional competencies;<sup>52</sup>
- Comparable remuneration to that of regulated and unregulated staff working in the acute care sector to ensure successful staff retention and recruitment.

**(b) How should these priorities be determined?**

RNAO urges the government to reform long term care within an overall seniors' strategy and an elder health framework focused on aging in place. To fulfill the promise of "providing homes where our seniors can live in dignity with the highest possible quality of care," it is essential that Ontario act quickly



to implement a minimum staffing standard of 3.5 hours with attendant requirements on the mix of providers. In order to improve the quality of care delivered to LTC residents, the knowledge and skills of regulated and unregulated care providers must be nurtured. We know that full implementation of RNAO's Best Practice Guidelines in all LTC facilities would result in much needed improvements in residents' health and social outcomes. Further data collection and research on optimal staffing to improve health outcomes is vital as well as measures to support healthy work environments that will strengthen recruitment and retention of LTC staff.

### **3. What are innovative approaches, research, performance indicators and best practices that we should consider?**

RNAO's recommendations are consistent with those of the Canadian Healthcare Association, who suggest the following measures to improve quality of care in long-term care facilities:<sup>53</sup>

- Widely implement practices that have been shown to result in high quality care using evidence-based best practice such as those identified in RNAO Clinical Best Practice Guidelines and RNAO Healthy Work Environments Best Practice Guidelines. The Saskatchewan Health Quality Council, for example, implemented RNAO's BPGs on preventing<sup>54</sup> and treating pressure ulcers<sup>55</sup> in seven nursing homes and experienced a 58% decrease in the prevalence of residents with pressure ulcers.<sup>56</sup>
- Implementation of RNAO's Clinical<sup>57</sup> and Healthy Work Environments<sup>58</sup> Best Practice Guidelines. To successfully implement these would require an expansion of the LTC BPG Coordinators to 14 (one per LHIN) and to have them report to RNAO;
- Improve collection of information on staffing ratios, admission waiting lists, discharges, level of care being delivered, health of residents, quality of care, and deaths.
- Collect outcome specific data such as rates of falls, pressure ulcers, medication utilization, etc.
- Conduct research and education within long-term care facilities to evaluate and improve care.

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[http://www.rnao.org/Page.asp?PageID=861&SiteNodeID=270&BL\\_ExpandID=](http://www.rnao.org/Page.asp?PageID=861&SiteNodeID=270&BL_ExpandID=)

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