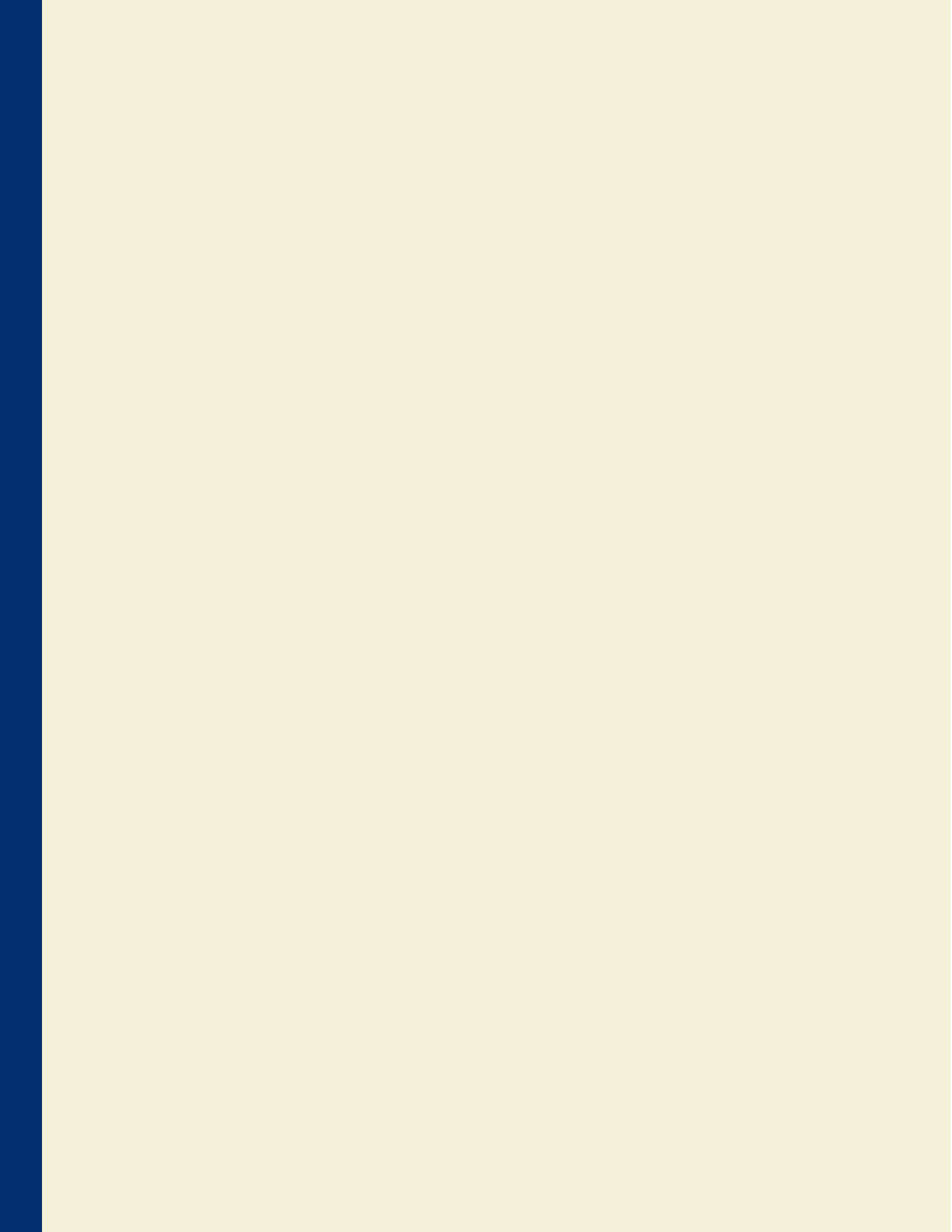
People Caring for People

Impacting the Quality of Life and Care of Residents of Long-Term Care Homes

A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario

May 2008



saint ELIZABETH
HEALTH CARE
CARE TO BE AMAZED

May 14, 2008

Honourable George Smitherman
Minister of Health and Long-Term Care
10th Floor, Hepburn Block, 80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister:

This review is about improving the care of residents of long-term care homes.

This has been a rewarding experience. I saw first hand the high level of commitment of staff, Long-Term Care (LTC) home operators, residents and families to create a better experience for all residents. Also, I had the opportunity to talk to and receive advice from a great number of individuals, many of whom spoke passionately about the need for improvements to the provision of care and to the environment within which the care is provided.

My mandate for this review was to provide advice on a comprehensive framework for determining human resources implications related to quality of care and quality of life of residents of LTC homes.

I took a broad approach at what is meant by resident care and looked at the various factors that impact on the care services and related human resources requirements. I considered all of the talent in LTC homes that touches the lives of residents impacting their quality of care and quality of life including nurses, personal care workers, allied health professionals (e.g., therapists, dieticians/nutritionists, social workers, etc.) physicians, pharmacists and other health service providers.

LTC home residents, their families and all those involved in providing care identified the need for improvements to human resources capacity within LTC homes and other factors that affect the provision of care.

I am convinced based on the research and stakeholder input that to address staffing requirements related to residents' quality of care and quality of life we need to take a broad approach that goes beyond setting staffing targets or a provincial staffing ratio. I am also convinced that any approach must be sensitive to the particular circumstances of each LTC home and the needs of their residents. Consequently, for this reason, I am not recommending that there should be a regulation under *The Long-Term Care Homes Act 2007* that provides a provincial staffing ratio or staffing standard.

My recommendations provide a process and tools to strengthen capacity for better care, and establish a strong foundation for quality care and accountability for resident outcomes. They provide the building blocks for a sustainable strategy for improving the quality of care and quality of life of residents.

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In addition, an environment of change for better care is also created by establishing a strong relationship between resources spent on resident care and the quality and outcomes of care that residents receive.

There are three components to my recommendations:

- Provincial guidelines to support funding increases for resident care over the next four years;
- Local planning to enable each LTC home and their stakeholders to determine how best to provide to residents an increase in nursing, personal care, program and support services, and to provide to staff opportunities for professional development and team collaboration. This will also provide a mechanism and process for stakeholder ownership of how best to allocate staffing resources in their LTC homes;
- Annual evaluations to validate that funding is addressing resident care needs and determine additional enhancements, changes or adjustments that may be required.

The recommendations also address in a significant way the need for a stronger focus on the quality of the care that residents receive, their care outcomes, resident satisfaction and staff satisfaction and engagement, beyond the current reporting system which is predominantly focused on compliance with MOHLTC standards and guidelines.

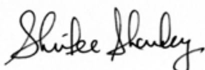
The implementation of the recommendations, particularly the staff enhancements, must be a dynamic, flexible and learning process. In other words, there must be continuous evaluation and validation of their impact on residents and their outcomes and the ability to make changes to staffing targets, improvements or shifts in the way staff resources are utilized to achieve expected outcomes.

I believe that these targeted recommendations can provide significant leverage for the broader provincial aging at home strategy and elder care.

The recommendations provide a great opportunity for improvement by building on the dedication and commitment of staff, LTC home operators, residents and families to the provision of quality care. They set the stage for a change in how LTC homes plan to use their staff resources to meet resident needs. They create a shift towards more collaborative planning and accountability at each LTC home involving residents and their families, as well as staff and other health service providers in determining how available resources are used to meet resident needs and improve outcomes.

Thank you for the opportunity to provide advice that I know will have a positive impact on the quality of care and quality of life of residents of LTC homes.

Sincerely,



Shirlee Sharkey
President & CEO
Saint Elizabeth Health Care

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INTRODUCTION

Purpose of the Long-Term Care Staffing and Care Standards Review

This report presents the findings and recommendations of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario (the Review). The Ministry of Health and Long-Term Care (MOHLTC) established the Review in September 2007 to provide independent advice that would inform the development of regulations under *The Long-Term Care Homes Act 2007*[1]. MOHLTC appointed Shirlee Sharkey[2] as an independent facilitator to lead the Review.

The Review was carried out over a seven month period, from October 2007 to April 2008. During that time, the review team held extensive consultations and conducted an in-depth literature review to inform the decision-making process.

The mandate of the Review was to provide advice on the development of a comprehensive framework for determining human resources implications related to quality of care and to the quality of life experienced by residents living in Long-Term Care (LTC) homes in Ontario. The framework addressed, at a minimum, issues related to the:

- Capacity of human resources at LTC homes;
- Needs-based requirements of residents;
- Quality of the work environment; and
- Quality management within LTC homes.

The Review was carried out with a view to the broad context of long-term care and community care in Ontario. In making its recommendations, the review team considered various issues that directly or indirectly have an impact on health human resources requirements and the provision of quality care to LTC residents.

The review team consulted stakeholders and other experts, including residents and their families, staff and other health care professionals. We also considered available research. Consequently, the Review looked at staff in LTC homes in a broad context including all regulated professionals (e.g. Registered Nurses (RNs), Registered Practical Nurses (RPNs), Nurse Practitioners (NPs), physicians, pharmacists, allied health professionals and unregulated staff (e.g., Personal Support Workers (PSWs), and others).

[1] The *Long-Term Care Homes Act 2007* received royal assent in June 2007 and provides the provincial government with the authority to set care and staffing standards for LTC homes in regulation.

[2] Shirlee Sharkey is the President and CEO of Saint Elizabeth Health Care.

REVIEW HIGHLIGHTS

The Review's recommendations will ensure that two principal goals are achieved:

I. Strengthen staff capacity for better care, and

II. Establish a strong foundation for quality care and accountability for resident outcomes.

These goals, which are shared by stakeholders, provide the building blocks for a sustainable strategy for better care. Together they act as a lever for creating an environment of change for better care by establishing a strong relationship between resources available to LTC homes for the provision of resident care and the quality and outcomes of care provided to residents. A key objective of the Review was to develop a sustainable strategy that continually promotes quality of care and quality of life for residents.

I. Strengthen Staff Capacity for Better Care to LTC Residents

LTC homes employ approximately 45,000 FTE[3] staff that provide nursing personal care, and program and support services to residents, including approximately 28,900 PSWs, 10,650 licensed nurses and 3,600 allied health professionals.

[3] FTE refers to full time equivalent.

We took a comprehensive approach to defining resident care in LTC homes. When we examined staffing in LTC homes, we included anyone who touches the lives of residents affecting their quality of care and quality of life including nurses, personal support workers, allied health professionals (e.g., therapists, dieticians/nutritionists, social workers, etc.) physicians and pharmacists.

LTC home residents, their families and all those involved in providing care identified the need for improvements to human resources capacity within LTC homes as well as improvements to the environment within which care is provided.

Residents and their families identified the need for greater capacity to address residents' care needs. Specifically, they noted that there should be an enhanced focus on individual care needs, more flexibility in the way care is delivered, and mechanisms to enable them to be active participants in care decisions.

Staff and other care providers requested increased staff capacity and the flexibility to provide care in accordance with the needs of residents. They spoke about improvements to the work environment that promote a team approach

to care, and opportunities for skill improvement and innovation.

LTC home operators and LTC home associations identified the need for more resources to improve staff capacity and to create environments that give the flexibility required to address the needs of their residents.

While all stakeholders agreed that additional staff capacity is needed, their views on how to achieve these improvements vary. Some call for a standard that sets minimum hours of direct nursing and personal care available to residents. Others suggest a broader approach that encompasses not only staffing increases but also additional resources for improving the work environment.

We are not persuaded that simply establishing a minimum staffing standard will fully address quality of care of residents. Studies by experts provide only limited evidence on staffing standards and the link to quality of care. Although some research found that a staff skill mix with higher proportions of RNs is associated with better quality of care, there is no consensus among experts on a minimum staffing standard.

Recent studies argue that staffing in LTC homes is a complex activity that requires consideration of a range of issues related not only to sufficient staffing capacity, but also to such factors as the mix of residents and their care needs, a home's philosophy of care, the service delivery model, the use of team approaches to care, and staff skill mix and experience. These studies strongly caution that simply establishing a staffing standard does not by itself address quality of life and care issues of LTC residents, and may in fact impede the consideration of other factors.

If all available resources are used exclusively to increase staffing numbers, then the other areas related to improving the quality of the workplace, such as staff education and development, leadership development, team building, and other areas would be affected. Regardless of this debate, there must be confidence in LTC homes that there will be consistent and predictable funding to sustain workforce stability.

We are convinced that the complexity of determining staffing requirements related to residents' quality of care and quality of life requires a comprehensive approach beyond setting staffing ratios and staffing standards. Consequently, for this reason, we are not recommending that there should be a regulation under The Long-Term Care Homes Act 2007 that provides a provincial staffing ratio or staffing standard.

Our recommendations call for:

- ***Provincial guidelines to support funding increases for resident care over the next four years;***
- ***The development of annual staffing plans at each LTC home, which take into consideration a range of issues (such as those discussed above) and which involve staff, residents, families and community partners (including Local Health Integration Networks (LHINs)), in planning how resources should be better aligned to meet resident care needs and improve care outcomes; and***
- ***Annual evaluations to validate that funding is addressing resident care needs and to inform decisions about staff enhancements.***

Our recommendations are based on the best available evidence. In setting parameters for enhanced capacity, we were challenged by the lack of a robust methodology that could be easily applied to Ontario's LTC homes.

Therefore, we considered in a comprehensive way the vast amount of information and input from various sources including:

- Input from stakeholders as to what factors need to be considered, including levels and mix of staffing and programs that are required when looking at staff capacity;
- Discussions with LTC home operators, staff and other health service providers about staffing patterns today, enhancements, and information about best practices and innovative approaches that have worked;
- Discussion in the literature as to what could be considered appropriate levels, including minimum and optimal staffing levels;
- The practices in other provinces, and recent provincial studies on staffing standards and approaches being considered by those provinces; and
- Program enhancements that have been announced by the provincial government.

Based on our assessment of this evidence, we are recommending that provincial guidelines be established to support decisions on funding enhancements to provide to residents a comprehensive range of nursing, personal care, programs and support services; and to provide to staff opportunities for professional development and team collaboration. The provincial guidelines are designed to achieve up to four hours of care per resident per day over the next four years. However, this may be modified based on the results of the annual evaluations and learnings.

Consequently, the implementation of these recommendations to enhance capacity must be a dynamic, flexible and learning process that can be adjusted based on resident needs and available human resources. There must be regular evaluations and validation of the impact of staff increases on resident outcomes and quality of care and life, and the ability to make improvements or modifications to staff resources and the mix of staff resources that are required for better care. Accordingly, we have built into our recommendations the requirement for annual evaluations based on resident outcomes.

The staff increases that the provincial government announced in the 2008/09 budget and increases announced prior to that continue to provide a solid foundation for implementing these recommendations as it concerns the provision of nursing and personal care. The addition of 3,200 nurses (including 1,200 RPNs announced in the 2007/08 provincial budget) and 2,500 PSWs will increase the average hours of care provided by nursing, personal care and allied health professionals to approximately 3.5 hours.

However, there will be a need for additional investments over the next four years, particularly in the areas of personal support services (e.g., activities of daily living, meal time assistance, comfort care, etc.) and program and support services (e.g., therapy, social work and dietary/ nutrition programs). These enhancements can significantly improve residents' quality of life by providing additional capacity to meet the holistic needs of residents including those related to a changing cultural environment, empowerment, harmony and satisfaction.

II. Strengthen Accountability for Quality Resident Outcomes

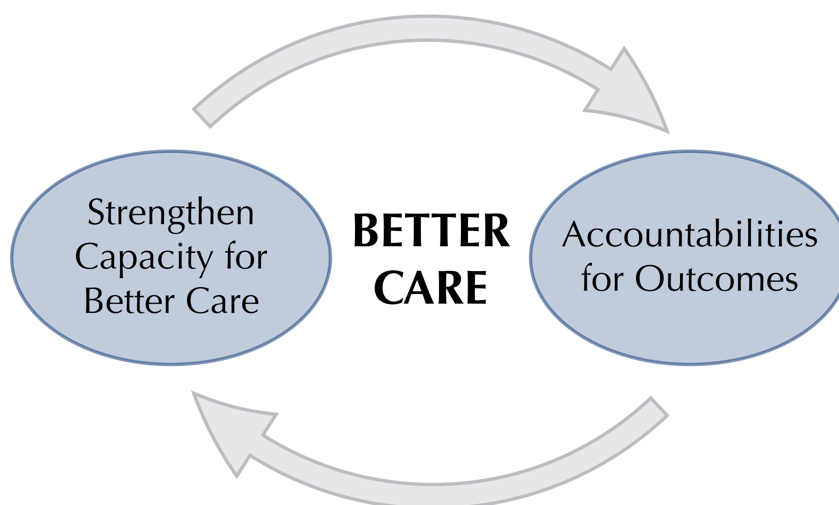
We found that, currently, there appears to be a weak focus on accountability for care outcomes. In addition, the level of accountability that LTC homes have for the quality of resident outcomes is inadequate.

The current reporting mechanism appears to focus predominantly on compliance with MOHLTC standards and financial accountability. Stakeholders told us that LTC homes' efforts to be in compliance with MOHLTC requirements drive to a significant extent organizational priorities and decisions that affect staff capacity. Many stakeholders told us that often this results in situations where staff focus on compliance-related administrative and process activities instead of on providing care. In addition, they indicated that time dedicated to resident care is diverted to compliance related functions, many of which are related to documentation and other paper work.

As a result we recommend strengthening accountability in LTC homes by linking resources to resident outcomes. We also recommend implementing measures to enable public reporting and to develop quality measurement tools and satisfaction surveys.

These recommendations concurrently *establish a strong foundation for quality care and accountability for resident outcomes and strengthen staff capacity for better care*. They address the key issues that have an impact on human resources and staffing requirements for the provision of quality care to LTC residents. They align investments in resources with improvements in the provision of care and resident outcomes.

Our recommendations are inter-linked and inter-dependent. Taken in tandem, they work to achieve better care for residents. Since each recommendation supports and creates synergies with the others, the recommendations should be addressed in a comprehensive manner.



CONTEXT

Overview of Ontario's LTC Homes

Based on individual needs, Ontario's LTC homes provide health care services and accommodation to residents that are not able to live independently and require the availability of 24-hour nursing care and supervision within a secure setting.

There are approximately 600 LTC homes in Ontario that provide care to more than 75,000 residents. There are three types of LTC home ownership: private corporations (57% of LTC homes or 53% of LTC beds), non-profit corporations such as, faith, community, ethnic or cultural groups (25% of LTC homes or 25% of LTC beds); and municipally-run facilities (18% of LTC homes or 22% of LTC beds). They employ approximately 45,000 FTEs that provide a range of personal care, nursing, program and support services and other services to residents.

LTC homes are governed by provincial legislation[5]. The MOHLTC sets provincial standards and policies regarding the provision of services to residents as well as the operation and management of LTC homes. These standards guide annual agreements between LTC homes and LHINs[6]. Approximately 75% of LTC homes are accredited by the Canadian Council on Health Services Accreditation (CCHSA).

The average age of LTC residents is 83 years. Those under the age of 65 years account for less than 6% of total residents. More than 85% of residents are classified as requiring high levels of care including constant supervision and assistance in performing one or more activities of daily living (ADL) including dressing, eating or toileting. Approximately 73% of residents have some form of cognitive impairment, including Alzheimer's disease and related dementias. Stakeholders told us that residents of LTC homes in Ontario require more care and more specialized services than in the past. This trend is attributable to several factors including longer life expectancies and advances in medical treatments. Changes in the hospital sector mean

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[4] The number of FTEs does not include other staff of LTC homes such as administrative staff; laundry, housekeeping and maintenance staff; etc.

[5] Pending the proclamation of the new *Long-Term Care Homes Act 2007*, three act govern LTC homes: *Nursing Homes Act, Homes for the Aged* and *Rest Homes Act, and Charitable Institutions Act*

[6] LTC home Service Agreements were assigned to LHINs on April 1, 2007. LHINs will begin negotiating new agreements in 2009 with LTC home operators that will have an effective date of April 1, 2010.

that residents with multiple care needs that were previously cared for in chronic care hospitals are now cared for in LTC homes.

The MOHLTC funds LTC homes on a per diem basis through four distinct funding envelopes: nursing and personal care; programming and support services; food; and other accommodations. It also provides supplemental funding for municipal taxes, pay equity and structural compliance. LTC homes also receive revenue through resident co-payments.

Funding Envelope	What is funded?
1. Nursing and Personal Care	Nursing and PSW staff salaries and wages, education, nursing supplies and equipment
2. Program and Support Services	Salaries and benefits for program staff, therapists, recreational activities, and other programs designed to assist residents to maintain their optimal level of functioning
3. Food	Raw food and approved nutritional supplements
4. Other	Dietary, laundry, housekeeping, building maintenance and costs, indoor and outdoor furnishings

Currently there is no provincial staffing standard for LTC homes. Nor is there a requirement related to fixed hours of care per resident per day or staffing levels[7]. There are requirements in regulation relating to specific staff including the presence of a registered nurse on a 24 hour basis seven days a week and that each home have a Director of Nursing and Personal Care. There is no indication of sector-wide health human resources planning.

Each home determines the level and type of staffing that it provides to its residents based on the assessed needs of each resident and available resources. The accompanying table provides a summary of the average paid hours of care per resident per day based on data reported to the MOHLTC by 84% of LTC homes. Moreover, an analysis of staffing data[8] shows that there is significant variability in the level and type of staffing at each home. The average number of paid hours of nursing and personal care per resident per day ranges from1.9 hours to 5.1 hours.

Staff	% of FTEs	Average Paid Hours Per Resident Per Day
PSWs	67.0%	2.089
Licensed Staff (1)	24.5%	0.762
Program Staff (2)	8.5%	0.264
Total (3)	**100.0%**	**3.115**

(1) Includes RPNs, RNs, NPs, clinical nurse specialists, nurse clinicians and infection control practitioners
(2) Includes therapists, dieticians/nutritionists and social workers
(3) For the period of January to June 2007

In the 2008 provincial budget, the government announced a commitment to the addition of 2,000 nurses within 4 years and 2,500 PSWs within three years. This is in addition to the previous commitment to add 1,200 RPNs announced in 2007.

The following table demonstrates the impact that the additional staff will have on the average paid hours per resident per day once fully in place.

[7] The previous standard of 2.25 hours of personal and nursing care per resident per day was repealed in 1996.
[8] According to the MOHLTC, about 84% of all homes submitted staffing data.

Impact Of Planned Staff Increases – Average Paid Hours Per Resident Per Day	
1,200 RPNs	0.085
2,500 PSWs	0.178
2,000 Nurses	0.142
TOTAL	**0.405**

LTC homes use a variety of approaches to schedule staff to provide services to their residents. Among others, these include regular shifts, split shifts, resident to PSW ratios and licensed nurses to PSW ratios. Some staff and health service providers, such as allied health professionals and physicians, provide services to more than one LTC home and schedule their services/availability in accordance with the arrangements they have made with each LTC home. Similarly, pharmacists enter into agreements with LTC homes for the provision of pharmacy services to residents. Staff scheduling in LTC homes can be a complex process given the dynamic environment in which it takes place (e.g., diverse resident needs, changing resident profiles, and available skills and expertise).

Annually, the MOHLTC reviews each LTC home for compliance with its standards and regulatory requirements. The MOHLTC posts on its website compliance information on LTC homes.

The MOHLTC annually assess residents' care needs using a provincial Levels of Care Classification Tool. LTC homes use this information to determine residents' level of care[9], while the MOHLTC uses the same information to determine the distribution of available nursing and personal care funding. Approximately 35% (or 217) of LTC homes are at various stages of voluntarily implementing a new and more comprehensive resident assessment and care planning system – Resident Assessment Instrument Minimum Data Set 2.0 (RAI-MDS 2.0). (See *Findings and Recommendations* for more information).

REVIEW PROCESS – Connecting With Stakeholders

During the Review, we asked stakeholders to provide input based on the following five questions:

1. 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?
2. What are the implications of these factors on human resources/staffing requirements and standards?
3. What are the components that would go into establishing a staffing standard and what is the evidence to support this?
4. What are the key priority areas that directly impact on resident outcomes related to human resources/staffing requirements and standards?
5. What are innovative approaches, research, performance indicators and best practices that we should consider?

In response, we received over 100 briefs and letters from stakeholder organizations and individuals. We held meetings with more than 30 stakeholder groups, including residents and their families, health service providers (personal support workers, nurses, therapists, social workers, dieticians/nutritionists, physicians and pharmacists), union representatives, LTC homes, provider associations, researchers, Community Care Access Centres, advocacy groups and other experts[10]. In addition, 27 representatives of Family Councils from across the province provided their input by way of a conference call meeting with the review team.

In order to get a first-hand perspective on the operation of LTC homes and issues related to staffing and resident care, we visited a small sample of LTC homes across the province. Where possible, during these visits we met with representatives of the LTC homes' residents and staff. As well, we held round table meetings with management representatives from a sample of LTC homes across the province.

Stakeholder input was supplemented by an extensive literature review of relevant research in Canada and elsewhere. To enhance the Review, we consulted with various experts from across the country that have completed, or are doing, research related to LTC homes and staffing.

We met also with a number of officials in the MOHLTC to understand current policies and initiatives that may have an impact on the scope of the Review.

[10] Appendix 4 provides a list of stakeholders that provided input to the review.

KEY FINDINGS AND RECOMMENDATIONS

I. STRENGTHEN STAFF CAPACITY FOR BETTER CARE

RECOMMENDATIONS

A. Enhance Staff Capacity:

1. Enhance staff capacity to provide to residents a broad range of nursing, personal care, programs and support services, and to provide to staff opportunities for professional development and team collaboration.
2. Establish provincial guidelines to support annual funding for enhanced capacity for resident care to achieve (at this time, pending the results from the annual evaluations and learnings) a provincial average of up to 4 hours of care per resident per day over the next four years, including:
   a. Up to 2.5 hours to be provided by PSWs;
   b. Up to 1 hour to be provided by licensed nurses (RNs and RPNs);
   c. Up to 0.5 hours to be provided by therapists, dieticians/nutritionists, social workers and other allied health professionals.
3. Based on local staffing plans (see *Recommendation 5*) each LTC home should have the flexibility to determine how best to align staff resources and determine staff mix to meet the particular needs of their residents and their local circumstances. Additionally, the learnings that will result from the annual evaluations will inform the accuracy of the previous provincial estimates.

4 Develop strategies to increase recruitment and retention of health providers, including physicians, nurse practitioners, nurses, PSWs and allied health professionals to the Long-Term Care homes sector.

Residents, their families and other stakeholders spoke passionately about residents' needs in LTC homes. They identified various issues related to staff capacity to provide high quality care, particularly 'hands on' and personalized care.

The review team found that lack of appropriate numbers of staff [1,2,3,4,5,6,7,8,9] but also type or mix of staff [10,11,12,13] supports such as equipment [14,15,16] supervision/mentoring[17,18] as well as overall leadership[19,20,21,22] and creativity are affecting the provision of care.

A. Increase Staff Capacity

All stakeholders overwhelmingly supported the need for increased staffing ratios in LTC homes. This includes additional capacity in all categories of staff -- those providing direct care such as PSWs and nurses and those who provide and support the provision of special programs such as therapists, nutritionists and social workers.

Residents, their families, staff and LTC home operators all suggested that the staff-to-resident ratio is too low. Staff (particularly PSWs) are generally very busy and are not always able to address residents' needs in a timely fashion or able to respond to their calls for assistance.

To enhance the quality of care residents receive, we heard that there is a need for more individualized or customized 'hands on' care, particularly with activities of daily living such as dressing, feeding, toileting and other areas of personal care.

To enhance quality of life, we heard there is a need for: more recreational activities (designed for fun and stimulation); the coordination of activities designed for specific cohort groups

Stakeholders told us additional staff capacity is needed in LTC facilities to address gaps in the delivery of care, including:

- Insufficient staff capacity to provide personal attention to sit, talk and provide comfort measures to the residents.
- Inadequate resources to provide restorative, social work and dietary and nutrition programs to residents.
- Insufficient activities and programs to provide fun and stimulation to the residents.
- Lack of attention to provide cues, redirection and orientation to those who are cognitively impaired resulting in residents who often get agitated, confused and aggressive.
- Inadequate expertise and programmatic activity in the LTC homes to address the needs of the younger (under 65 years) residents with multiple sclerosis, acquired brain injury, etc. This cohort remains in LTC homes for many years with inadequate attention to their care needs and quality of life including the ability to interact with others in similar age groups.
- Inadequate resources/expertise to prepare and support families during the transition of the resident from home to residential care. Families spoke of their fears, guilt and anxiety and did not find much support from busy staff.
- Lack of communication between staff resulting in family members spending great amounts of time and effort keeping staff abreast of the resident's condition and care requirements.

(such as younger residents); transitional support for new residents and their families; and comfort measures (such as personal attention and companionship).

Stakeholders' views vary on how to achieve the staffing increases. Some call for a standard that sets minimum hours of direct nursing and personal care available to residents[23,24]. Others suggest a broader approach that encompasses not only resources for staffing increases but also resources that will have a positive impact on the care environment[25,26,27].

Based on expert studies, the review team is not persuaded that simply establishing a minimum staffing standard will fully address residents' quality of care issues.

- While some research found that staff skill mix with higher proportions of RNs is associated with better quality of care[28], there is no consensus among experts on a minimum staffing standard[29] and the link to quality of care[30].
- More recent studies point to the complex nature of staffing in LTC homes[31]. They urge consideration of a range of issues related not only to sufficient staffing capacity, but also to such factors as: the mix of residents and their care needs; a home's philosophy of care; the service delivery model; the use of team approaches to care; and staff skill mix and experience[32,33,34].

The review team accepts the counsel of these studies which strongly caution that simply establishing a staffing standard will not fully address quality of life and care issues of LTC residents. Establishing a standard alone may in fact be a barrier to meeting staff requirements in other areas such as continuing education of staff, improvements to work processes and team collaboration—all of which enable staff to provide better care for residents.

Staff Could be Better Deployed

We heard that improvements are needed in the way staff is deployed particularly during periods of peak activity. These include mornings, at meal times, after meals and at night time. Care provided during these periods is typically rushed in order to adhere to standardized care routines developed by LTC homes to maximize the use of available resources. The result is care that is often focused on organizational needs rather than on residents' needs.

At the same time we found that LTC homes face numerous challenges in ensuring adequate coverage of care 24 hours a day, seven days a week. LTC homes are particularly challenged in covering evenings and weekends as well as during periods of peak activity such as meal times. Scheduling entails organizing 'split shifts', bringing staff for very specific tasks (such as feeding residents); conducting admission assessments; and assisting residents to attend celebratory programs. Flexibility to allow for creative scheduling is often affected by labour contracts, staff availability, and available funding.

Skill-Sets Should be Matched to Residents' Needs

Increasing residents' acuity and care complexity requires staff expertise that often is not available[35,36,37,38,39]. Inadequate staff capacity compounds the problem of alignment of staff expertise and skills to the individual needs of

residents. Since there is limited or no capacity to backfill when staff are away[40], this also has an impact on staff's ability to regularly participate in education/upgrading programs, either on site or off-site. Findings also point to the lack of alignment between residents' care needs and available staff skills and expertise.

Stakeholders highlighted the need for better data and information to understand and plan for the diverse needs of residents. The current Levels of Care Classification Tool (based on the Alberta Resident Classification System) is primarily used by the MOHLTC to determine the distribution of available nursing and personal care funding to each LTC home based on an annual assessment of residents. A new resident assessment system—Resident Assessment Instrument Minimum Data Sets (RAI-MDS) is being implemented at about 217 LTC homes. While we did not assess the various tools that are available, we are convinced that a more comprehensive resident assessment system is needed that can provide a more evidence-based decision-making environment for addressing resident needs and changes in their health condition, as well as care planning and quality management.

Need for More Effective Team-based Care

The ability of care teams to deliver quality outcomes is affected by:

- the type or mix of staff[41,42,43,44]
- effective supervision/mentoring[45,46].

Stakeholders noted there are limited opportunities for staff to work as a team when developing care plans and providing care to individual residents. Many stakeholders indicated that the "busy" and "rush" environment does not promote collaborative approaches among caregivers.

There are indications based on the input from stakeholders that nursing assessment and intervention time is limited by RNs/RPNs, and there is little or no time for team conferences to discuss care issues or to provide adequate supervision and mentoring. Workload is too high for RPNs who administer medications for up to 40-60 residents. Involvement of PSWs in care planning discussions and care conferences is also limited[47,48,49]. The value attached to the input of PSWs in care plan decisions seems to vary across LTC homes.

Physician workload was also consistently mentioned as a barrier to adequate inter-professional collaboration. Stakeholders noted that the number of physicians available to oversee the medical care of residents is inadequate as a result of retirements and inability to replenish by younger or other physicians.

Use of other providers in the skill mix, such as Nurse Practitioners, was highly recommended by stakeholders. Research studies have demonstrated the value that Nurse Practitioners bring to inter-professional collaboration and positive health outcomes for patients/residents[50,51,52]. Furthermore, use of Nurse Practitioners as a complementary health care team member has been shown to have positive impact on the workload of physicians[53].

Support Continuity of Care

The health human resources shortage and perceptions of work demands are factors identified by LTC home providers that affect

their ability to recruit and retain qualified staff and to ensure caregiver continuity for residents. Residents indicated that fragmented staff complements due to shortage and absenteeism affect the quality of care that they receive. They indicated that replacement staff members are not familiar with their individual needs and routines. Work place quality has been identified repeatedly as a key concern in having a healthy, engaged and satisfied workforce in long-term care[54].

Stronger Leadership Needed

Leadership[55,56,57,58] and creativity, demonstrated by management and senior professionals, may also contribute to capacity-building. Numerous stakeholders, including residents, their families, advocates and staff, noted that organizational leadership at LTC homes may not be effectively grounded in a culture of care, specifically a commitment to the provision of care based on individual resident needs. There is concern that organizational requirements such as compliance with MOHLTC standards are given more emphasis than the provision of individualized care to residents. Moreover, many residents and their families also expressed concerns that they were not regularly involved in care decisions and that services were not customized to meet individual resident needs.

Recommendations

Based on these findings, we are recommending enhancements in the areas of nursing, personal care, program and support services staff to ensure there are adequate resources for planning and providing individualized resident care. We expect this to lead to increased capacity for hands-on care which will enhance quality of care for residents and provide more emotional support, comfort measures and programs to enhance their quality of life. We expect that more resources will also be freed up to provide adequate supervision and mentorship of health care team members.

Our recommendations on enhanced capacity are based on the best available evidence. In setting parameters for the increase in staff capacity, we were challenged by the lack of a robust methodology that could be easily applied to Ontario's LTC homes. Therefore, we considered, in a comprehensive way, the vast amount of information and input from various sources including:

- Input from stakeholders as to what factors need to be considered, including levels and type of staffing and programs that are required when looking at staff capacity;
- Discussions with LTC home operators, staff and other health service providers about staffing patterns today, enhancements, and information about best practices and innovative approaches that have worked;
- Discussion in the literature as to what could be considered appropriate levels, including minimum and optimal staffing levels;
- The practices in other provinces, and recent provincial studies on staffing standards and approaches being considered by those provinces; and
- Program enhancements that have been announced by the provincial government.

Based on our assessment of this evidence, we are recommending that provincial guidelines be established to support decisions on funding enhancements to provide to residents a

comprehensive range of nursing, personal care, programs and support services, and to provide to staff opportunities for professional development and team collaboration. The provincial guidelines should lead to the achievement of up to 4 hours of care per resident per day over the next four years, pending adjustments and learning that will occur during the annual evaluations over the four-year period.

Consequently, the implementation of these recommendations to enhance capacity must be a dynamic, flexible and learning process that can be adjusted based on resident needs and available human resources. There must be regular evaluations and validation of the feasibility and the impact of staff increases on resident outcomes and quality of care and life. Also, there must be the ability to make improvements or modifications to staff resources and the mix of staff resources that are required for better care. Accordingly, we have built into our recommendations the requirement for annual evaluations based on resident outcomes.

The staff increases that the provincial government announced in the 2008/09 budget and increases announced prior to that continue to provide a solid foundation for implementing these recommendations as it concerns the provision of nursing and personal care. The addition of 3,200 nurses (RNs and RPNs) and 2,500 PSWs will increase the average hours of care provided by nursing, personal care and allied health professionals to approximately 3.5 hours.

However, there is a need for enhancements over the next four years, particularly in personal care, (e.g., for the provision of activities of daily living, meal time assistance, comfort care, etc.) program and support services (e.g., for the provision of therapy services, social work and dietary/ nutrition programs, etc.). This will provide additional capacity to meet the holistic needs of residents. It will also foster a culture of inter-professional collaborative care, empower local planning teams and create greater harmony and satisfaction amongst residents, families, staff and other stakeholders.

B. Develop Local Staffing Plans and Evaluation Process

RECOMMENDATIONS

B. Develop Local Staffing Plans and Evaluation Process:

5. In order to ensure that staffing resources are appropriately aligned with resident needs, each Long-Term Care home should be required to develop regular/annual staffing plans using a comprehensive approach that involves resident and family council representatives, staff representatives including their unions where applicable, other health care providers, and consultation with their LHINs.
6. The following principles should guide the development of local staffing plans:
   a. The allocation of staff resources gives priority to more "hands on" resident care and individualized care based on resident needs.
   b. The assessment and provision of individualized care needs are based on a team approach that involves the various health and support professionals that provide care and facilitate programs.
   c. Strategies are developed to consistently provide staff learning and development opportunities, including on the job mentorship and coaching time.
   d. Strategies are developed to enhance leadership capacity at all levels.
7. In the interest of implementing a consistent provincial staffing planning process as soon as possible to provide advice on staffing requirements to meet resident needs, the Registered Nurses' Association of Ontario framework should be considered for implementation with a view to further refinements based on an evaluation of how well it is working.
8. Develop a process for evaluating and validating the impact of staffing increases on resident outcomes, quality of care and quality of life.

Residents, their families and staff representatives frequently expressed a desire to be involved in decisions regarding the allocation of staff resources to address resident needs. They indicated that they are able to bring a more informed perspective on staffing requirements linked to resident needs and staff requirements (such as professional development and a team approach to care).

We are convinced that there is a need for a structured process for regularly developing local staffing plans using a collaborative process that involves stakeholders. This creates an opportunity for stakeholders to be involved not only in developing plans, but also in their monitoring and evaluation. Local stakeholder ownership of how best to allocate staffing resources in their LTC home is critical. This will allow the development of short-term and long-term strategies, including recruitment and retention strategies in the local communities, to address potential human resources gaps and shortages.

Annual Planning is Required

We found that an annual review of the staffing plans helps to ensure that the changing needs of residents and the broader environment are taken into consideration each year. We also found that involvement of diverse stakeholders is critical to bringing different perspectives and ideas to the 'planning table'. A partnership approach to addressing the complex needs of the elderly in a broader elder care framework requires stakeholders to have frequent dialogue, mutual trust and respect as well as a common vision, purpose and definitions.

We are convinced of the merit of requiring LTC home operators to annually review and revise local staffing plans. The LTC home should involve the following groups in the preparation of these plans:

- resident and family council representatives;
- staff representatives;
- union representatives (as applicable); and
- community partners including the Local Health Integration Networks (LHINs).

The process outlined will provide a formal mechanism for discussion with representatives of residents, their families and staff on how best to plan for, deploy and engage staff and other health professionals to ensure that residents' needs are met. The process will also identify strategies to support the quality of the workplace such as staff learning and development opportunities and leadership development. Moreover, attention will be paid to the local recruitment challenges of health care providers including physicians, Nurse Practitioners, and other specialized human resources. This approach will ensure that the complexity of resident care needs at present, the changing needs of residents in the future and the complex set of care variables that impact on staffing and care standards are taken into account[59,60].

Planning Framework – RNAO Model

There are a number of examples[61,62,63,64,65] of staffing planning and guiding principles that provide a framework that can be applied to Ontario's LTC homes sector. Based on our assessment, a recent review of the literature and an expert panel convened by the

Registered Nurses' Association of Ontario (RNAO)[66], the RNAO model provides a good framework that can be adapted to LTC homes. In the interest of moving forward, the RNAO framework should be considered for implementation with a view to further refinements based on an evaluation of how well it is working.

Our recommendations to increase staff capacity are strongly tied with the recommendation to develop local staffing plans. The latter acts as an "enabler" to ensure that the process of determining staffing resources involves the key stakeholders in a dynamic process based on residents' changing needs.

These recommendations also support a strengthened accountability framework (discussed in the next set of recommendations) that addresses care standards and compliance, and impacts on resident/family satisfaction, quality of care and staff satisfaction. Together the two groups of recommendations establish a clear link between staff resource allocation and resulting resident outcomes.

The RNAO healthy work environment best practice guideline, Developing and Sustaining Effective Staffing and Workload Practices, provides a comprehensive guide and includes the following key components:

a) A framework of complex set of variables of any resident care delivery model that impact on staffing decisions (inputs, throughputs and outputs);

b) Levels of decision making (strategic, logistical and tactical as well as addressing skill mix, status mix and contingency staffing); and

c) Collaborative process for planning.

Although the RNAO guideline has a strong nursing focus, the framework can be used for developing a broader inter-professional staffing plan.

II. STRENGTHEN ACCOUNTABILITY FOR OUTCOMES

RECOMMENDATIONS

Strengthen Accountability for Outcomes:

9. The Ministry of Health and Long-Term Care should strengthen the accountability of Long-Term Care homes for the provision of quality care by linking resources to resident outcomes through the measurement of quality of care and resident and staff satisfaction.

10. The Ministry of Health and Long-Term Care should establish as soon as possible standardized province-wide tools and processes that regularly measure and enable public reporting on the following areas:

    a. Resident quality of care outcomes based on quality indicators (such as, functional status, continence, falls, wounds, pain, nausea, dyspnea)

    b. Resident and family satisfaction

    c. Staff satisfaction and engagement

11. The Ministry of Health and Long-Term Care should identify an impartial group to expedite the development of quality measurement tools and satisfaction surveys and oversee their implementation across Long-Term Care homes in the province.

Need to Link Accountability to the Quality of Resident Outcomes

The focus of the current reporting framework appears to be mostly on compliance and financial accountability. Also, current reporting systems do not appear to have a specific focus on quality of care and outcomes, nor do they have the ability to provide a sector-wide perspective on the provision of resident care, residents' satisfaction and staff satisfaction.

We found that there is a weak link between the provision of resident services and resident care outcomes. In addition, the level of accountability that LTC homes have for the quality of resident outcomes is inadequate. There is a need for a link between staffing investments and quality of care. Our recommendations support this need to link resources to resident outcomes through the measurement of quality of care and resident and staff satisfaction surveys.

Need for Quality Measurement

There is an urgent need to ensure that resident care outcomes are measured in a quick and efficient manner. There have been numerous studies in the LTC sector to identify measures that are sensitive to the availability and capacity of nursing and direct care provision to residents; albeit, mostly in the US[70]. In Canada, the Health Outcomes for Better Information and Care (HOBIC) have short listed a number of indicators for measurement of quality of care of residents in LTC homes (falls, pressure ulcers, functional status including continence, pain, nausea and dyspnea)[71] and are currently testing these in a sample of homes in Ontario.

These are potential resident quality of care outcomes that can provide useful information to monitor and adjust staffing levels, skill mix, and service delivery approaches.

Consultations with experts and researchers have indicated that access to currently existing databases is limited and problematic. This will need to be addressed in order to provide a meaningful analysis of resident quality care across the LTC sector.

Need for Comparable Information Across the Sector

We found that LTC home operators use home-specific resident/family satisfaction surveys to gauge patient satisfaction. These surveys are not comparable across homes. An extensive literature review[72] outlined a number of recommendations that we support.

These include:

a) Carefully select a satisfaction survey for residents and a separate one for families. A short list of potential surveys with good psychometric properties that could be examined includes the NRC + Picker, Rutgers and Vital Research tools.

b) Use consistent surveys across LTC homes with the ability of homes to add a few home specific questions.

c) Engage a third party source to administer the surveys, analyze and report the findings to ensure consistency and confidentiality.

Similarly, stakeholders indicated that surveys of staff satisfaction or engagement, where used by LTC homes, were not comparable across LTC homes. Studies have found that staff satisfaction and engagement is a key area of focus to achieve quality care for residents[73]. Staff levels of engagement have been associated with their levels of retention[74], burnout [75] and contribution towards quality improvement activities in the home[76].

An extensive meta analysis of research conducted by the Conference Board for Canada identified eight drivers of staff engagement [77]:

- trust and integrity;
- nature of the job;
- ability to link individual performance to organization performance;
- career growth opportunities;
- pride about the organization;
- team members/co-workers ;
- employee development; and
- personal relationship with manager.

In these instances, use of existing common staff satisfaction and engagement tools that can be used across the sector would allow for better comparison of these important measures.

One of the most common issues raised by both residents, their families, staff and providers is the considerable preoccupation of LTC homes with ensuring compliance with MOHLTC standards and guidelines. We heard from most stakeholders that LTC homes' efforts to be in compliance with MOHLTC requirements drive to a significant extent organizational priorities and decisions that affect staff capacity. This results in situations where staff end up focusing on compliance related administrative and process activities instead of providing care. Time dedicated to resident care is diverted to compliance related functions, many of which are related to documentation and other paper work. There needs to be a better balance between compliance and monitoring care outcomes and resident/family/staff satisfaction.

Stakeholders identified a number of principles that could help shift the accountability and regulatory framework. These principles are consistent with those reported in the literature[67,68,69]. They are:

a) Resident centered, holistic care with a focus on providing continuity of care, safety, and connection to the broader community (prevent isolation);

b) Use established care standards as guidance and not rigid rules;

c) Enable flexibility in care and service with a goal of providing individualized care;

d) Maximize inter-professional collaboration as a key resource;

e) Strengthen performance excellence and outcomes; and

f) Enable sector leadership to lead the way to innovation and excellence.

CONCLUSION

We believe our recommendations will help develop a sustainable and dynamic strategy that promotes quality of care and quality of life for residents of LTC homes now and in the future.

The provincial guidelines and the recommended approach to increase funding to enhance capacity for resident care should be implemented over the next four years. Local planning involving local stakeholders is a key enabler of this recommendation as it ensures that staffing decisions are based on local circumstances and particular needs of residents.

Quality measures should routinely be applied to assess the impact that staffing increases are having on resident care. Local staffing plans are critical to the success in the implementation of these recommendations. We have suggested that in the interest of moving forward quickly, consideration should be given to planning frameworks already in place. We have looked at one recently developed by the RNAO and in our view it provides a clear starting point for a standard provincial process.

Standardized, province-wide tools should be established by the MOHLTC as soon as possible. Initially a simple list of quality indicators could be used to begin to measure resident care outcomes, resident satisfaction and staff satisfaction. This information is critical to assessing the impact of staffing enhancements and the need for changes in how they are being implemented. Again, we have provided advice and examples to expedite the implementation of these recommendations.

The implementation of this Review's recommendations should be done in a coordinated manner in order to ensure that there is continual feedback on how enhanced staffing capacity impacts on resident care.

The recommendations arising from the Review will ensure that two principal goals are achieved:

I. Strengthen staff capacity for better care, and

II. Establish a strong foundation for quality care and accountability for resident outcomes.

Furthering these goals will provide the building blocks for a sustainable strategy for better quality of care and quality of life for residents of LTC homes. Implementing the recommendations in this report creates an environment of change for better care by establishing a strong relationship

between resources available to LTC homes for the provision of resident care and the quality and outcomes of care residents receive.

The Review's recommendations provide a wonderful opportunity for improvement in the LTC sector by building on the knowledge, passion and commitment of staff, LTC home operators, residents and families to the provision of quality care. They set the stage for a change in how LTC homes plan to use their staff resources to meet resident needs. They create a shift towards more collaborative planning and accountability at each LTC home involving residents and their families, as well as staff and other health service providers in determining how available resources are used to meet resident needs and improve outcomes.

Implementing these recommendations will have broader implications for the health care system. Stronger and more robust LTC homes can provide needed leverage for the aging at home strategy and broader provincial elder care vision. A robust and sustainable LTC sector is a key element of a strong provincial health care system.

Nurturing the talent within LTC facilities, enabling better allocation of staff and staffing planning, will alleviate some of the pressures staff face. It will put in place the supports staff need to provide the quality of care and quality of life enablers LTC residents require – positively impacting the lives of LTC residents.

Enabling people to better care for people in LTC homes will have a ripple effect, providing people with better options to care for people in the healthcare system as a whole.

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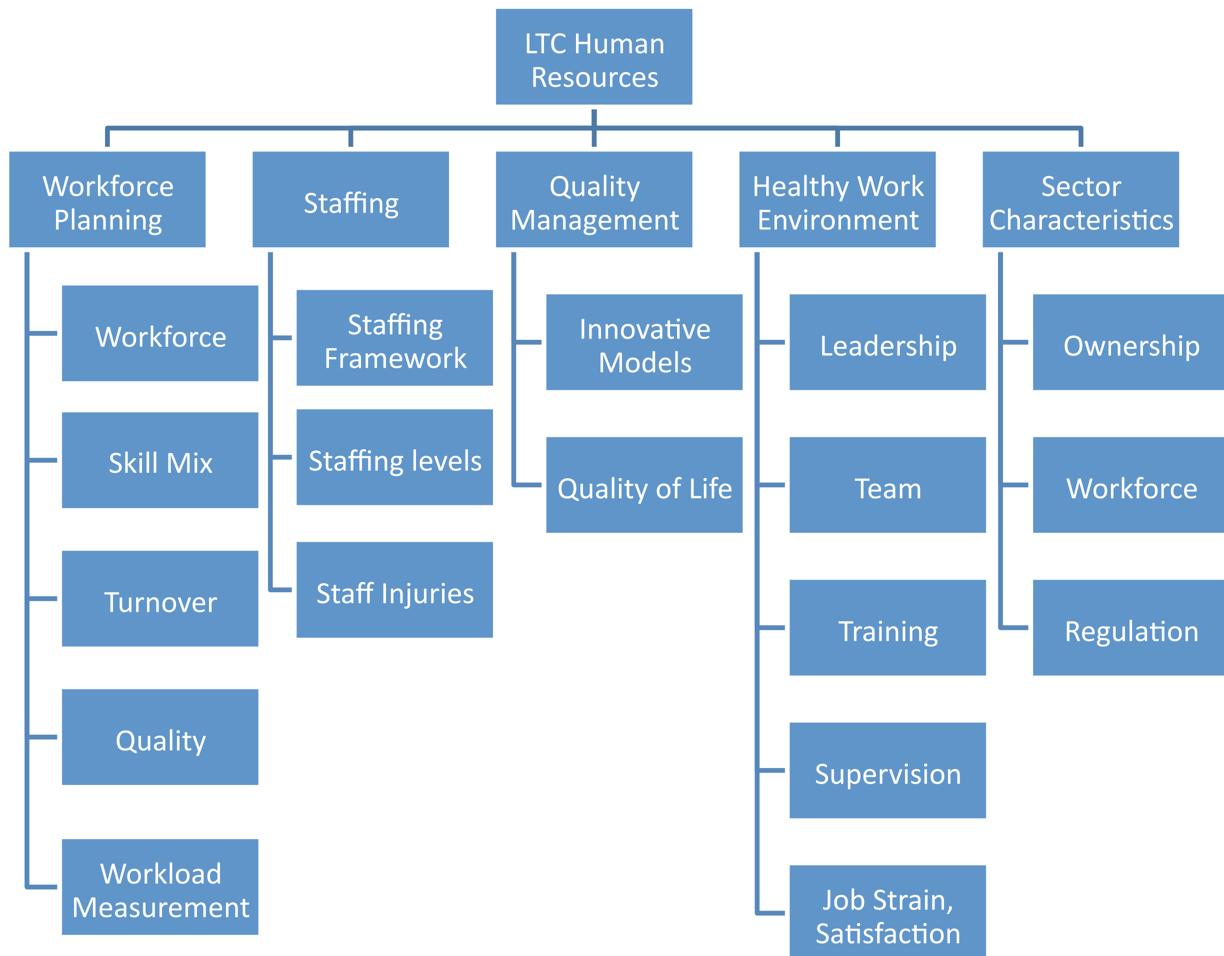
APPENDICES

APPENDIX 1
Review of Select Literature

April, 2008

Literature Review Outline



Workforce Planning

➤Workforce
Skill Mix
Turnover
Quality
Workload
Measurement

Workforce planning is important – need to address care needs, provider demographics, context, models (business versus care as different), educational needs and accountability issues.

Armstrong & Armstrong (2007)*

- Nature of care needs – aging population, people with severe disabilities living longer, chronic illnesses; immigrant and aboriginal population, less children to support parents, less spouses due to divorces, more women in the work place, fewer social services by government, mental health issues in elderly, public demanding more control, demands also created by advertisements of drugs and treatments, Internet;
- Demographics – aging, gendered (80% women), doctors/nurses make up less than third, 30 different regulated professionals, high injury/absenteeism, the further care goes from hospitals, the less regulated the professionals
- Changes in context – early 90's – downsizing, amalgamations, increase in acuity in hospitals, LTC, home; care shifting to unpaid labour; layoffs (85% of Cdn hospitals reduced workforce by 10% between 1994 and 1996) – largest among managerial staff; transformations generally led to dissatisfied and burnout staff; lack of empowerment; 62% belong to a union; changes or reforms not based on evidence but hopes for efficiency and cost savings; new technologies – day surgery, complex home care, TQM, tele-health, managers in health care not required to have health care education (business model)
- Model used for workforce planning
  - Care as different – stresses skill acquisition, continuous learning, clinical autonomy, evidence based accountability, peer review, team collaboration; importance and dependence of interpersonal relationships
  - Care as business – division of labour based on quickly learned tasks, accountability based on evidence, managerial control, substitution by lower skilled for higher skilled providers, flexibility in assigning staff to tasks; encourages for profit
  - Overlap between models e.g. Nurse Practitioners, care pathways
- Reserves of potential staff – those who have left the profession; those working part time/casual; foreign trained professionals who are not working in profession
- Education
  - Need for all workforce to have some training in health care including those providing hotel functions, management as well as unpaid labour – family, friends, volunteers (lack of consistency in unregulated and in unpaid labour education)
  - Need for training in teamwork, inter-professional collaboration, humanities – communication, structure of health care, determinants of health, elder care, care at home, health promotion, evidence based practice, training in rural areas (location), tacit learning opportunities are key (working with experience individuals, teams, mentoring, etc); issues of learning for those who work in isolation –e.g. Home care, LTC care where few professional staff,
  - Need for attention to prior learning assessments, bridge programs
- Accountability
  - Tension between managerial control and professional autonomy where peer review is more valued
  - Many unanswered questions – to who, for what, by whom, flexibility vs. Standardized;

Workforce Planning

Workforce
➢ Skill Mix
Turnover
Quality
Workload
Measurement

Need full time RNs who are trained to manage, supervise and delegate to other team members.

Also need unregulated workers who are appropriately trained and supported.

Skill mix changes require rigorous review of roles and responsibilities

Indicators most sensitive to changes in RN skill mix include pressure ulcers, use of restraints (Weech-Maldonado et al, 2004; Hutt et al., 2000); functional status (Horn et al, 2005); and, hospitalization for sepsis and urinary track infection (Kramer et al, 2000).

Buchan et al (2002): cheaper skill mix can cost more in long run due to poor quality of care

- Determinants of skill mix: Shortage of staff (labour market), cost containment, new types of workers , hospital bed utilization, regulatory environment, custom, organizational culture
- Use of Clinical Nurse Specialists, Nurse Practitioners, can improve care outcomes while maintaining or reducing costs

Bostick (2004)

- Significant association between RN hours and prevalence of pressure ulcers – 6 minute increase in RN time associated with 3% reduction in chance of one resident developing pressure ulcer
- Higher LPN staffing hours – 6 minute increase in LPN time associated with 3% increase in chance of one resident developing pressure ulcer and 1% increase in resident developing incontinence
- Need RN hours to increase with portion of hours spent in direct care instead of admin duties – LPN substitution for RNs not recommended

Crossan et al (2005) – Review –factors affecting skill mix

- Need for training of health care aids; training RNs for supervision, management, delegation; addressing nursing and non-nursing responsibilities; reducing contact with residents will lead to decrease in holistic care

***Hall et al (2004)** – not specific to LTC

- Primary nursing model found to be a better patient care model than total patient care
- RN/unregulated skill mix better than RN/RPN/unregulated – later requires greater communication; also speculate that the implementation of unregulated workers allowed better job analysis, implementation of roles/responsibilities
- All RN – better quality of care

Weech-Maldonado et al (2004) – five US states – large study

- Higher RN staffing – better quality outcomes (pressure ulcers, lower use of restraints,) – but not with lower cognitive decline, mood decline or inappropriate use of antipsychotic drugs
- Part time/contract RNs (agency) less able to influence quality outcomes – speculate that it is related to lack of tacit knowledge

Workforce Planning

Workforce
➤Skill Mix
Turnover
Quality
Workload
Measurement

Without guidance on skill mix determination, there may be a tendency to use cheaper labour.

Unit based staffing decision allows for close matching of resident needs with appropriate skill mix.

Evaluation of any skill mix should ultimately be reflected on how it impacts on residents quality of care and quality of life.

Harrington (2005)

- RN time decreased from 0.8 to 0.6 hprd between 1999 and 2003 – attributed to Medicare prospective payment system
- This is contrary to what researchers and other advocates have been calling for – the need for more licensed nurses.

Canadian Nurses Association (2004) – skill mix lit review

- Lack of decision making models for skill mix determination
- Staffing decisions linked to a number of outcomes: reduce patients' lengths of stay; reduce the occurrence of adverse events; increase patient safety; increase patient and nurse satisfaction; improve overall patient outcomes; avoid costly errors; decrease staff turnover rates; and capitalize on experience and education of staff.
- Staffing decisions should be unit based and patient outcomes used for evaluation.

Workforce Planning

Workforce
Skill Mix
➢Turnover
Quality
Workload
Measurement

Need to value PSWs to retain them.

Address RN burnout and skills - important for quality.

Need to address turnover, staffing levels, worker stability and agency use when addressing quality of care.

Banaszak-Holl et al (1996)

- Involvement of health care aides in care planning had lower turnover – one third lower when aides advice and suggestions were accepted; 50% lower when aides were involved at care planning meetings
- Turnover unaffected by increased training, involvement in resident assessment, workload factors such as primary resident assignments, bed to aide ratio or aide to nurse ratio
    - 52% of staff received less than 30 hours of orientation time; 33% received between 30 and 50 hours and 15% with more than 50 hours
- Turnover 1.7 times greater in for profit homes; where employment opportunities were higher
- Local economic conditions and decision making process involvement had strongest effect on job turnover rates

Brannon et al (2002) – nursing assistants turnover

- Predictors of low turnover rate – no supervisors in management; lower RN turnover, flatter management structure and union contract (10X lower turnover)
- Predictors of high turnover rate – high RN turnover, being a clinical training site(3X higher turnover), for profit ownership
- RN turnover – positive linear association with NA turnover

Castle et al (2005) - 354 homes

- Studied low (0 to 20), medium (21 to 50) and high turnover (> 50) association with 6 quality indicators
    - RNs – turnover negatively associated with quality but different quality indicators at different turnover levels
    - NA and LPN turnover also negatively associated with quality but only at high turnover levels

Castle et al (2007) – addresses turnover, worker stability, agency use

- High RN levels associated with higher quality care;
- High RN turnover associated with higher quality – think this has to do with bringing RNs who are better skilled and less burn out
- High RN stability associated with lower quality – same reason as above
- High NA stability associated with higher quality
- High RN and NA agency use associated with lower quality but high LPN agency use associated with higher quality
- Decrease NA agency use – decrease restraint use and more mobility

Castle (2006)

- Measurement of turnover – wide variation when simply asking homes; high degree of measurement error; need to specify type of turnover, type of staff, differentiate status of staff, etc

Workforce Planning

Workforce
Skill Mix
Turnover
➤Quality
Workload
Measurement

High RN skill mix, leadership stability, appropriate staffing levels and emphasis on basic care are important to quality of care outcomes.

Various quality indicators used in various studies – need to address indicators sensitive to nursing practice; question casual link between staffing levels and quality of care

Rantz et al (2004) – compared factors that were different between different quality homes – quality based on clinical indicators – limited to one state

- Two factors emerged as key – leadership (director of care greater than 5 years was found in better quality homes) – homes were different in costs but staff mix and staffing levels were the same.
- Basic care differences – good quality homes – staff observed doing key care delivery processes such as ambulation, nutrition, hydration, toileting, bowel regularity, prevention of skin breakdown and managing pain – they could discuss the plan of care and also observed to be delivering the care; facilities with poor outcomes could tell but were not found to do
- Good homes also had one staff to two residents for feeding while poor homes had 5 to 6 residents at a time; fewer tube feedings with emphasis on hydration

Friedman (1998)* - compared LTC care in hospital and care in LTC homes

- 20% more hours of care in acute care; acute care – 43% of care by professional nurses, 22% in homes
- Overall quality of care not different; acute care – more tests, meds and specialists consultations – therefore more expensive

Morin (2005)* – stimulated study to see nurses choice of where cut backs are made to meet the budget

- Nurses made greater than 305 cutbacks to 3 out of 7 dimensions of care: personal care, communication and mobility. Areas not impacted as much were feeding, elimination, treatments and diagnostics – the later two areas was less than 4% - medical decisions and not within nursing control.

Arling (2007) – large study – 4 states – using actual resident time – 1st study

- Staff time, per say, not influencing care process or quality of care. The total staffing on a unit and the amount of time devoted to direct resident care can be a function of resident acuity, management practices, skill mix, and technology – raised other questions re skills, experience, dedication of staff; allocation of staff for direct care, etc. Questions the casual link between staffing and quality of care

McClure & Hinshaw (2002) – magnet hospitals – 8 essential factors to attract and retain nurses

- Working with other nurses who are clinically competent.
- Good nurse–physician relationships and communication.
- Nurse autonomy and accountability.
- Supportive nurse manager or supervisor.
- Control over nursing practice and practice environment.
- Support for education.
- Adequate nurse staffing.
- Concern for the patient is paramount

Murphy (2005)

- Studied perceptions of quality from staff
- 3 areas of need: a lack of time and choice for residents; focus on physical care; lack of involvement of residents in decision making
- Lack of staff and predominance focus on routines were identified as contributing factors to issues above.

Workforce Planning

Workforce
Skill Mix
Turnover
Quality
➤Workload Measurement

MDS/RAI commonly used workload measurement tool and linked to funding – but has varying explanatory power (10-50%) for resource utilization – need to address other factors

Experiential attitudes - takes a lot of effort – particularly documentation; there are limitations with certain resident needs.

Work load measurement tools do not address many factors that impact on staffing e.g. Skill base, staff capacity (age, injuries)

Carpenter (2002)

- the RUGIII case mix system showed more care provided to residents with complex medical and nursing conditions than to those with less complex conditions
- a consistent pattern was found, more senior nurses spent greater portion of their time providing indirect care or carrying out unit related activities than direct care and nursing assistants who spent greater portion of their time on direct care
- the findings suggests RUGIII case mix system effectively differentiated between nursing home residents who are receiving low standard and enhanced care time
- system does not state how much RN care time a resident should receive

Dellefield (2006)

- RUGIII explained 10 to 50% of variation in resource utilization. Other factors that impacted on staff variability – competence, experience and education of nurses; workplace characteristics.

Leach (2006)* - pt classification in rural settings in Ont and Manitoba

- Does not address changes in individual resident care when funding comes once a year after the assessment period; technology challenges
- Enormous resource goes into feeding in information- need documentation: does not address human relationship, empathy, affection, etc.
- Staff capacity beyond their skills is not addressed by classification systems such as aging staff and level of injury:
    - The top five accidents listed by nursing home workers in Ontario were musculoskeletal
    - injuries, falls, exposure to dangerous substances, being struck by or against equipment and client-inflicted violence (HCHSAO 2003).
    - In both Manitoba and Ontario over 40 percent of RNs in long-term care were over 50 in 2001.

Mueller (2000) – limitations of workload measurement systems

- do not address the contextual (availability of human resources in the community, regulations, union/labour requirements) and human resources (training, skill mix including availability of non-direct staff, staff absenteeism, turnover) constraints that a home may be facing.
- Additionally, the home's design and layout, philosophy of resident care, service delivery models (e.g. primary nursing, functional model), and availability of supports (leader support, educational offerings, clerical, transportation) will impact on the residents' requirements for direct staffing time and skill mix.

Staffing

➤Staffing Framework
Minimum Staffing Hours
Staff Injuries

Various associations and experts have recommended comprehensive staffing frameworks that go well beyond the number of staff or hours per resident per day

American Nurses Association (2008) – 9 principles for staffing
- Questions the use of hppd – recommends retiring its use as staffing requires a comprehensive approach
- Need to consider individual patient and aggregate needs; unit requirements; clinical competences; involvement of RNs at decision making tables; experienced staff to support less proficient staff; policies; timeliness to fill requirements

International Nurses Congress (2006)
- Provides different resources and tools for addressing safe staffing including pros and cons on minimum staffing levels
- Nurse: patient ratios set a safety net for patients and nurses. The pros include:
  – Safer environments for patients
  – Incentives for nurses to return to the bedside-work of their profession
  – Furthering the collection of nursing relevant data in the healthcare system
  – By fostering the discussion on the subject, showing the complexity of the issue of safe and adequate staffing levels
- Cons include:
  – Tendency to become the norm for nurse: patient ratios
  – Ratios don't reflect the level of expertise an experienced nurse has obtained
  – Data collection and comprehensive workload measurement tools are not available or not applied in many cases

Mueller (2000) – staffing framework involves address the following:
- Standards of care/philosophy of care that guide the delivery of resident care e.g. holistic approach to care, person/family centered care, continuity of care, rehabilitation and restoration, dying with dignity and peace, etc.
- Identification of resident needs is affected by the type of information that is sought, how it is quantified and how the philosophy of care is integrated with the information system.
- Determining required staffing resources to meet residents' needs that involve systematic means for associating the needs with the number and type of health care provider including their education, experience and taking into consideration the standards of care, values and beliefs.
- Allocating health care personnel includes ensuring the right types of personnel are recruited and their continuous development is supported. Appropriate scheduling of staff based on residents' care requirements and outcomes to be achieved within the established philosophy.
- Delivery of resident care system that fits with the values, believes and standards for the home.
- Contextual factors include design and size of home (including space that fits with the type of activities that fit the philosophy of care); availability of personnel for direct care, support (at meal times, paperwork, administrative) and programs that are in line with the philosophy of care and standards; personnel job descriptions, credentials, training and certification; staff absenteeism and turnover; broader community availability for specific skill sets; information systems; provincial regulations; facility routines, policies and research based protocols.

O'Brien-Pallas (1997, 2001)*
- Acute care focused but can be applied to other settings
- Inputs (patient/provider/system characteristics system behaviours), throughputs (nursing care processes, environmental complexity factors , outputs (patient/provider/system outcomes)

Registered Nurses' Association of Ontario (2007)* – best practice guideline – staffing and workload practices
- Strategy, logistical and tactical decision making for nurse staffing decisions
- Principles for staffing
- Collaboration between nursing administration and human resource depts for workforce planning as well as engagement of staff nurses in the decision process
- Need for dedicated resources (infrastructure, human resources) for electronic systems to support workload and staffing practices
- Need for evaluation, accreditation and research to build evidence to support appropriate care delivery models, workload measurement practices and staffing systems.

Staffing

- ➤Staffing Framework
- Minimum Staffing Hours
- Staff Injuries

Ensure staffing plans takes into account productivity time.

Formal staffing plans need the availability of good data and staff involvement in decision making.

O'Brien Pallas et al (2004)* – CHSRF – recommendations to decision makers – hospital focused - can apply to LTC

- Nursing unit productivity/utilization levels should target 85 percent, plus or minus five percent. Levels higher than this lead to higher costs, poorer patient care, and poorer nurse outcomes.
- Maximum productivity/utilization is 93 percent (because seven percent of the shift is made up of paid, mandatory breaks). Units where nurses frequently work at or beyond maximum productivity/utilization must urgently reduce productivity/utilization and implement acceptable standards.
- Productivity/Utilization targets can be met by enhancing nurse autonomy, reducing emotional exhaustion, and having enough staff to cope with rapidly changing patient conditions.
- Overall costs are reduced when experienced nurses are retained. Retention is more likely when there is job security, when nurses can work to their full scope of practice, and when productivity/utilization levels are below 83 percent.
- Retention strategies must address the physical and mental health of nurses, balancing the efforts and rewards associated with work, nurse autonomy, full scope of practice, managerial relationships, innovative work schedules, hiring more nurses into full-time permanent positions, and reasonable nurse-to-patient ratios based on targeted productivity/ utilization standards. These will minimize the effect of persistently high job demands and reduce absenteeism and the use of overtime.
- Investment is needed for infrastructure to collect data that will monitor and improve care delivery processes and measurement of performance outcomes. Data that should be routinely captured, but are not yet, include valid workload measurement; environmental complexity; patient nursing diagnoses and OMAHA ratings of knowledge, behaviour, and status; nurse and patient SF-12 health status; nurse to patient ratios; and productivity/utilization.

Ellis et al (2006)

- Nurse staffing is a complex process - staffing plan involves requires an understanding of the complexity involved in patient care and in matching human resources (skills, number of staff, education, and experience) to patient needs. Only those qualified to do this task should create these plans.
- 5 recommendations:
    - – 1. Effective, formal staffing plans should be implemented in all organizations employing nurses.
    - – 2. Patients should be cared for by highly educated regulated nurses.
    - – 3. Patients should be cared for by experienced nurses.
    - – 4. Workplaces should encourage and sustain improved patient, nurse, and system outcomes.
    - – 5. Standard nurse staffing definitions need to be created and used to ease comparison of research findings and to build stronger evidence for policy and practice.
- These five recommendations can be incorporated into formal staffing plans. Such plans should be specific to the unit, ward, or program; address staffing needs required for quality healthcare delivery; and be formed in consultation with staff nurses, using a shared governance model. The plans should spell out options, repercussions, and alternatives when staffing goals are not met.

Staffing

Staffing Framework
➤ Minimum Staffing Hours
Staff Injuries

Increased staffing levels associated with at least one quality variable; but there are differences in skill mix association with quality variables.

Wide range in staffing levels amongst homes – lack of consensus on what is appropriate minimum levels.

Most (90%) homes are below a US expert group recommendation of 4.1 hours of care per resident per day

Hendrix & Foreman (2001) –addresses efficient optimum

- Determined optimum nurse staffing that minimizes cost of decubitis ulcers in homes – 1 RN for every 11.63 residents; 1 NA for every 7.71 residents; need to decrease use of LPNs; cost of treatment is excessive and hence it is better to staff optimally

Zhang (2006) – efficiency based minimum staffing

- Studied minimum staffing levels at 50%, 70% and 90% quality – quality index included three nursing sensitive indicators: bladder status, skin integrity and mobility.
- For RNs, found non-linear relationship – at 50%, 0.31hrs; at 75%, 1.83hrs; at 90%, 3.3 hrs
- 75% quality ranking requires much more nurse staffing for all categories of staff than the 50%. However, going from 75% to 90% does not involve as great an increase.
- For LPNs, negative relationship between staffing and quality

Dyck (2004)

- Residents receiving 3 or more hprd of nurse aid had 17% less risk of weight loss compared to those who received less than 3 hprd

Horn et al (2005)

- 30-40 mins of RN time associated with fewer UTIs, catheterizations, less deterioration in the ability to perform ADL, and more use of nutritional supplements
- CMS study in 2001, reported long stay nursing home residents, total licensed nurse staffing time should be 1.3 hours, RNs and LPNs combined; 0.57 hours RNs, and at least 2.8 hours for CNAs
- Found better outcomes associated with RN time of 30-40 mins, LPN time greater than 45 mins, and CNA time of 2.25 hours or more associated with lower incidence of pressure ulcers
- 2004 IOM report recommended RN time to increase to 45 mins per resident per day, consistent with threshold for better outcomes in this study

Schnelle (2006)

- Staff in the highest staffed homes (n56), according to state cost reports, reported significantly lower resident care loads during onsite interviews across day and evening shifts (7.6 residents per nurse aide [NA]) compared to the remaining homes that reported between 9 to 10 residents per NA (n515). The highest-staffed homes performed significantly better on 13 of 16 care processes implemented by NAs compared to lower-staffed homes.

Harrington (2006) - California

- State minimum = 3.2+ hours; recommended = 4.1+
- NFP = 81% met min standard in 2000; 93% met in 2003; FP 36% met stn in 2000; 73% met in 2003
- Homes that met the rec standard had one third less deficiencies in quality of care; less complaints
- Between 2000 and 2003, turnover of nursing staff went from 80% to 65% in free standing homes; those meeting the recommended staffing stn had less turnover (55%); high turnover associated with higher # of deficiencies; NFP had lower turnover than FP; wages were significantly lower in high turnover homes

Staffing

Staffing Framework
➤Minimum Staffing Hours
Staff Injuries

Factors other than strict amount of staff time are connected to staffing e.g. Experience of staff, skill mix, staff stability, use of agency staff, etc.

Minimum staffing levels may be a necessary but not sufficient condition for quality of care.

Recent studies question causal link between staffing levels and quality of care and thereby questions the use of hours per resident per day on its own as an indicator of quality.

Harrington (2000)

- Trend towards individual states establishing own minimum staffing standard
- Strong advocacy from citizen group and expert panel (4.1 hprd)
- Florida has the highest (3.9 hprd) with mandated ratios for NAs – 5/ resident (days), 6/resident (evenings), 8/resident (nights)

Bowers et al (2000) – qualitative study with Nurse Aides

- Lower staffing levels results in decrease in continuity of care, looking for shortcuts or cutting corners in care, decreases familiarity with residents and increases turnover
- Relationships with residents were central to quality of care and quality of life – able to treat residents like family, individualized care, help to maintain resident competence and dignity
- Lack of staffing – decrease choices for residents, toileting first to be affected – less visible areas were cut first;
- Working with full staffing but inexperienced staff was worse than working short staffed
- Feelings of guilt when taking breaks, increased stress and frustration.

Arling (2007) – large study – 4 states – using actual resident time

- 1st study using multi-level modeling (unit level and at resident level) – other studies facility level data
- Unit staffing is a contextual variable that influences the amount of care resident receives but does not predetermine it .
- Staff time, per say, does not influence care process or quality of care. The total staffing on a unit and the amount of time devoted to direct resident care can be a function of resident acuity, management practices, skill mix, and technology – raised other questions re skills, experience, dedication of staff; allocation of staff for direct care, etc. Questions the casual link between staffing and quality of care.
- What is important is not how much staff but how staff are used on a unit.

Castle et al (2007) – addresses turnover, worker stability, agency use

- High RN levels associated with higher quality care;
- High RN turnover associated with higher quality – think this has to do with bringing RNs who are better skilled and less burn out
- High RN stability associated with lower quality – same reason as above
- High NA stability associated with higher quality
- High RN and NA agency use associated with lower quality but high LPN agency use associated with higher quality
- Decrease NA agency use – decrease restraint use and more mobility

Staffing

Staffing Frameworks
➤Minimum Staffing Hours
Staff Injuries

Quality care was found to be different amongst homes using the same level of resources – leadership and basic care processes were two themes of interest in differentiating the homes and not the level of staffing.

Staffing policies based on ratios, patient classification, pay for performance or mixed – each has pros, cons.

Murphy (2006) concludes from an exhaustive literature review that research on the impact of staffing on quality in long term care homes can be categorized as follows:

- Minimum levels of nursing and care aides is required to prevent the occurrence of adverse outcomes e.g. pressure ulcers, functional decline (Dyck, 2004; Horn et al, 2005; Hutt et al, 2000; Kramer et al, 2000; Zhang et al, 2006).
- Similarly, nursing and personal care staff levels are associated with improvement in quality of care outcomes such as improvements in activities of daily living, food and fluid intake (Bates-Jensen et al, 2004; Dorr et al., 2005; Harrington et al, 2000; Kramer & Fish, 2001).
- Specific team member contribution to the quality of care processes e.g. assistance with meals, social engagement, exercise (Bowers et al, 2001; Kayser-Jones & Schell, 1997; Rantz & Zwygart-Stauffacher, 2004; Schnelle & Simmons, 2001; Simmons et al, 2001).

Rantz et al (2004) – quality, cost, staffing and skill mix

- Described care processes that are different among poor, average and exemplar nursing homes – used MDS QI indicators to establish the 3 groups of homes.
- No statistical difference in cost, staffing hours per resident or hourly wages across the 3 groups or skill mix – but there was a $13.58 difference between the good and poor groups.
- Care processes were found to be different between the homes with good outcomes vs poor outcomes. These include: director of nursing greater number of years in good outcomes homes; use of group or committee processes; good home staff could tell what should be done and were found to actually do the care processes while the staff in poor homes could tell what should be done but were not following through. There were disconnects across layers of staff in poor homes regarding their care practices. Good homes had 1:2 residents for meal time feeding while in poor care homes, it could be as high as 1:5 or 6 residents. It appeared that there were differences in how staff were organized to be available for meal times. Other differences included # of residents with tube feeding, access to fluids, hydration, advance directives, frequency of toileting, # of pressure ulcers.
- Some care processes were the same re dining, dietician, restraints, staffing complaints, staff retention/turnover
- Developed theoretical model – nursing leadership and basic care processes (ambulation, toileting, regular bowel, pain, skin integrity, hydration etc) – key drivers; also team/group, active QI program
- Providing good quality care may not mean higher costs but could mean lower or at least controlled costs

Robert Woods Foundation (2007)

- 3 staffing policies – ratios, patient classification, Pay for performance
- Ratios – little research to determine optimal ratios (cost/benefit)
- Patient classification – no universal system, acuity based, nurses don't always trust system, gaming, sometimes minimum better than what classification determines
- Pay for performance – more money if meeting or exceeding standards/ outcomes – lots of question re what outcomes to measure
- Recommendations: ratios are not a panacea; use standardized and independently validated pt classification: use diverse opinions in setting policy; assess link between staffing and quality; consider capacity; stronger enforcement policy

Staffing Levels

* Canadian Study

Study	RN	LPN/RPN	NA/PSW	Total
Bates-Jensen et al. (2004)			3.4 +/- 0.7	4.8 +/- 1.1
Dorr et al (2005)	0.5 to 0.67			
Dyck (2004)			>3.0	
Harrington et al. (2000)	1.15	0.70	2.7	4.55
Horn et al. (2005)	0.5 to 0.67	0.75	>2.25	3.67
Horn (2005)	0.30-0.40	0.45	2.25	3.1
Hutt et al. (2000)	>0.25	>0.77		
Kramer and Fish (2001)	0.75	0.55	2.8	4.1
McGregor (2005)*				IC – 2.46 IC&EC – 3.06 Multilevel – 3.18
Schnelle & Simmons (2004)				4.5 to 4.8
Schnelle (2001)			2.8 to 3.2	
CMS Study (2001)	0.57	0.73	2.8	4.1
Zhang (2006) at average, 50, 75, and 90% quality	0.31 0.31 1.83 3.30	0.66	2.06	3.03
Casa Verdes report*	0.58			3.06

Staffing

Staffing Framework

Minimum Staffing Hours

➤Staff Injury

Environmental factors, management supports, availability of equipment and staffing levels – all involved in the experience of staff assaults, injuries and extent of reporting of these.

Morgan (2007)* – org context that puts nurse aides risk for assault and reporting

- Frustration for being blamed for causing aggression, lack of acknowledgment and action to deal with problem, desire for respect, involvement in decision making (resident or facility); sense of abandonment; even family members of residents do not believe that resident can be aggressive
- Felt that others feel aggression is part of their job; give up reporting; feel they are at the bottom of the organizational hierarchy – don't feel part of the team
- Rushing care due to lack of time, rigid institutional routines - could not adhere to principles of dementia care; also lack of specialists, limited training, medication issues, poor physical environment,
- Aides felt they could not change resident behaviours – control was beyond them – e.g. Medication changes, staffing, work policies, environment,
- Home searches for causes however stop at the individual level and do not address other more systemic causes
- Need leadership skills among all levels of management and supervision – need to empower nurse aides: need communication skills and mechanisms
- Training needs to be accompanied by organizational supports for behavior change

Yassi (2004)* - intermediate care facilities in BC

- Safer work environments (lower staff injury rates) are promoted by favourable staffing levels, convenient access to mechanical lifts, workers' perceptions of employer fairness, and management practices that support the caregiving role.
- Link between org effectiveness, injury rate, and quality of life
- care aide involvement in care planning and implementation
- ongoing opportunities for input from care staff being provided and taken seriously by the management
- more favourable staffing levels, expressed as lower resident-to-worker ratios
- "no-lifting" policies communicated well and positively reinforced
- mechanical lifts that are available and accessible
- visible follow-up action for serious incidents of aggression
- no favouritism toward residents or blaming of staff
- positive staff view regarding the facility's philosophy and quality of care.
- Development of conceptual model of healthy work environment **

CIHI (2007)* – Canadian HHR

- Nurses in LTC report poorer health (8.9%) than their counterparts in all other sectors (6.3%).
- Overall, LPNs report poorer health than RNs across all sectors
- Nurses (all categories) in LTC less satisfied with their current job than hospitals or community care sectors – no difference between LPNs and RNs
- Ontario better than other provinces re absenteeism, time-loss injury claims,

Staffing

Staffing Framework
Minimum Staffing Hours
➤Staff Injury

High level of violence experienced by personal support workers in Canadian LTC homes.

Staffing, training, flexibility, communication and other supports are required.

Overall culture, philosophy and organizational effectiveness are important in prevention of staff injuries.

MacDonald & Harder, (2004)

- Older staff tend to have lower rates of work related injury than younger, inexperienced staff, older workers require longer periods of time off work when they do have injury for recovery and rehabilitation. This is reflected in the high sick time and absenteeism rates in the sector.

Banerjee et al (2008)* – York University

- PSW experience violence (physical, emotional, sexual, racism) regularly in Canadian facilities – 50% experience it daily; close to all have experienced violence
- Most incidents go unreported as there is no time for paperwork and feel they will be blamed – making the issue invisible; also there is an expectation that they need to tolerate the abuses.
- Canadian facilities are 7X more likely than other international comparators (Nordic countries) to experience violence, 2X as likely to be exhausted at the end of the day, 3X as likely to have back pain, 4X as likely to be mentally exhausted
- Staff state working short staffed or not having adequate time and support contributes to the problem. Also, lack of training has been cited as a factor with lack of supports to attend training sessions. Nordic countries are better staffed, have flexibility and better communication.

Cohen et al (2003)* - reducing injuries in intermediate facilities in BC

- Significant relationship between high workload, staff injury and worker's report of well being
- Strong relationship between overall worker environment and worker injury rates and well being
    - – Organizational culture (supportive and trusting relationships between staff and managers; high manager expectations of staff backed up with tangible supports, open communication and respect.
    - – Safety environment (policies and procedures; accessible mechanical lifts; low injury facility staff less worried about getting injured)
    - – Organizational effectiveness (able to deliver on promises; staff more involved in care planning and reported positive views of philosophy of care, overall quality and fairness of service to residents, and their own effectiveness/flexibility)
- Enabling conditions: team work, worker participation and genuine communication

Healthy Work Environment

➤Leadership
Team
Training
Job Strain
Job Satisfaction

Critical role of leadership – communication; expectations re quality; mentoring/role model.

Structured participatory & leadership intervention can produce positive staff results in short periods of time.

Leadership and team formation go hand in hand.

Nursing leadership stability is important.

Hall (2005)*

- Staff Perceptions of Supportive behaviour
  - managerial communication behaviours - considerate listening (most prevalent – personal caring and professional valuing behaviour), praise recognition and positive reinforcement, respect and trust
  - role modeling practical behaviours - helping, teaching, advocating
- Staff Perceptions of Factors Contributing to Supportive Supervisory Behaviours - Communication and feedback, lack of info or communication put staff at a disadvantage and made it difficult to perform; Knowledge, greater knowledge by supervisors; RNs made them more able to support staff; Control (When staff feel they have some control over decisions, this made them feel supported)

Scott-Cawiezell (2005)

- Colorado study of nursing home working conditions and organizational performance
- High and Low scoring (in org. performance) homes differed in 4 main areas: 1) emphasis on staff; 2) quality of communication; 3) Team work; and, 4) standards and expectations.
- All findings point to the critical role of leadership, particularly nursing leadership in homes
- Wellspring model built on belief that few staff work in homes for the pay – develop opportunities for staff to contribute to high quality care to residents

Deutschman (2005) – observational study of 3 homes

- Four areas for improvement can be readily identified in these cultures
- 1) Practitioners trying to understand needs of individual elders through a process dominated by other agendas; 2) care giving systems evolved over time; 3) need for leadership as a role model/mentor - conflict with an outmoded hierarchical structure; training/mentoring must focus on developing teams that function as role models for reinforcement of values; job satisfaction is key to retaining both senior and junior staff; 4) need for attention to internal and external relationships with relevant publics

Brabant 2007* - see summary under job strain

Thorne (2005) – oral health – contextual concerns in homes with and without on site dental care services

- Qualitative study – identified success in oral health care program dependent on organizational culture and explicit program strategy – these in turn are impacted by leadership, shared ownership, availability of champion

Rantz et al (2004)

- found that five years of tenure of Director of Nursing was important for quality of care

Anderson et al (2004) study of 164 homes

- found outcomes associated with leaders with more experience and good communication skills included lower use of restraints, lower prevalence of fractures, complications of immobility and resident behaviour.

Healthy Work Environment

➢Leadership
Team
Training
Job Strain
Job Satisfaction

Staff engagement important link to level of burnout. Leader behaviours to empower staff important; but leaders also require support so they have the capacity to provide empowering opportunities.

Participatory interventions with staff can have positive impact on residents' behaviours.

Greco (2006)* - random sample of 322 staff nurses getting their perspective on leader behaviours and their own level of engagement/burnout.

- Organizational structures in workplace are essential in shaping and enhancing work experiences and work life of employees
- Leadership affected nurses engagement/burnout through its effect on empowerment and person – job fit
- When leaders develop organizational structures that empower nurses, they promote a greater sense of fit between nurses expectations of work life quality and organizational goals and processes, creating greater work engagement and lower burnout
- More inclusive, participative style, can have a positive effect
- Staff nurses felt more empowered when leaders behaviours promoted autonomy, encouraged participative decision making and displayed confidence in employees
- Important to acknowledge nurse managers role, significant challenges created to the managers ability to engage in empowering leadership behaviour
  - few management positions, nurse managers increased responsibility, and large spans of control, thus not as visible and available to nursing staff
- High level of severe burnout (53% of sample) can be linked to serious health conditions such as depression, clinical disease

Bourbonnais (2004)* - 14 LTC and 2 hospitals in Quebec

- Participatory intervention - Several characteristics of way work is organized can help reduce work constraints and improve caregivers' quality of life:
  - stable work teams characterized by respect, mutual assistance, fairness, and empowerment of all staff;
  - regular team meetings;
  - good communication (circulation of information vertically, from management to staff, and horizontally, between work teams or shifts);
  - sound leadership by management staff;
  - training to manage verbal and physical aggression of clients and families (in long-term care); and
  - elimination of disruptive behaviour by problem employees toward their colleagues.
- The success of a participatory intervention initiative depends on several factors,
  - commitment, involvement, and support by senior management;
  - the intervention initiative reflecting a priority of the institution's management and board of directors;
  - the importance of management assigning responsibility for smooth progress of the intervention initiative to a person recognized as a leader in the institution; and
  - leadership, credibility, and communication and listening skills of members of intervention groups who are agents for change
- Impact of intervention measured 12 months later with positive results
  - "In the long-term care facilities ...the results at 12 months indicate a significant decline in five targeted psychosocial constraints and one health problem: a decline in the prevalence of limited decision making latitude, the combination of high demand and limited latitude, intimidation at work, aggressive behaviour by residents, emotional demands, and sleep problems. A single significant change was observed in the control group: a decline in aggressive behaviour by residents."

Healthy Work Environment

➤Leadership
Team
Training
Job Strain
Job Satisfaction

Leadership associated with various positive staff/HR indicators.

Various research based models for leadership competencies are available.

McGilton et al (2007)* – addressed job satisfaction of RN & RPN supervisors

- Job satisfaction impacted by their own supervisory support, stress and job category (RN or RPN)
- Supervisory abilities included empathy (meeting staff's needs, understanding their point of view, helping to address resident issues), dependability (presence or availability, keeping staff informed of changes in the environment, balance between staff and resident/family needs) and ability to connect with staff (encouraging, expressing appreciation, showing respect, recognizing strengths and areas of improvement).
- RN supervisor job satisfaction was significantly higher than RPN supervisor
- Relationship oriented leadership styles are important in this sector.

George et al (2002) -shared leadership model

- The model included leadership competencies including ability to negotiate a win-win situation through team learning, ability to facilitate change and influence others, problem solving using a systems framework, shared visioning and encouraging empowerment of others as well as shared decision making.

The Registered Nurses' Association of Ontario (RNAO) (2006) - extensive literature review

- concluded that there are five transformational leadership practices that result in healthy outcomes for nurses, patients/clients, organizations and systems:
  - Building relationships and trust;
  - Creating an empowering work environment;
  - Creating an environment that supports knowledge development and integration;
  - Leading and sustaining change; and
  - Balancing competing values and priorities and demands.
- The research reviewed demonstrated the association between the above transformational leadership and a range of indicators including staff burnout, staff job satisfaction, absenteeism, staff retention, staff commitment, patient satisfaction, patient quality of life as well as patient outcomes such as fractures, use of restraints and level of complications.

Pan Canadian Leadership Capability Framework Project – CHSRF

- Framework comprises of the following C's: Champion caring, Cultivate self and others, Connect with others, Create results, Change systems

Healthy Work Environment

Leadership

➤Team

Training

Job Strain

Job Satisfaction

Teams to be effective, require systematic and thoughtful supports; hence, leadership to initiate and sustain those supports are important.

Teams can have ultimate impact on resident quality of care and quality of life.

Staff engagement, a key to team performance , can be facilitated through key drivers.

Oandansan et al (2006) – key messages from an extensive literature review for CHSRF

- A healthcare system that supports effective teamwork can improve the quality of patient (resident) care, enhance patient (resident) safety, and reduce workload issues that cause burnout among healthcare professionals.
- Teams work most effectively when they have a clear purpose; good communication; co-ordination; protocols and procedures; and effective mechanisms to resolve conflict when it arises. The active participation of all members is another key feature. Successful teams recognize the professional and personal contributions of all members; promote individual development and team interdependence; recognize the benefits of working together; and see accountability as a collective responsibility.
- The make-up and functioning of teams varies depending on the needs of the patient (resident). The complexity of the health issue defines the task. The more interdependency needed to serve the patient (resident), the greater the need for collaboration among team members.
- Patients (residents) and their families are important team members with an important role in decision-making. To enable patients (residents) to participate effectively, they need to learn about how to participate in the team; how to obtain information about their condition; and how each healthcare professional will contribute to their care.
- Teams function differently depending on where they operate. Teams in hospitals have clearly defined protocols and procedures, professional hierarchies, and shared institutional goals, while teams in community-based primary care practices face challenges related to the role-blurring in community settings. This wide variety of settings and tasks means that transferability of processes is not always straightforward. It also highlights the need for a common definition of "team."
- Teamwork is influenced by organizational culture. A clear organizational philosophy on the importance of teamwork can promote collaboration by encouraging new ways of working together; the development of common goals; and mechanisms to overcome resistance to change and turf wars about scopes of practice. Teams need training to learn how to work together and understand the professional role/ responsibility of each member. They also require an effective administrative structure and leadership.
- The larger policy context can promote teamwork by providing consistent government policies and approaches; health human resource planning; legislative frameworks to break down silos; and models of funding/ remuneration that encourage collaboration. Successful team interventions are often embedded in initiatives working to improve quality of care through better co-ordination of healthcare services and the effective utilization of health resources with a focus on the determinants of health.

Gibbons (2006) – literature review on staff engagement

- 8 key drivers identified: trust & integrity; nature of the job; line of sight between individual performance and company performance; career growth opportunities; pride about the company; coworkers & team members; employee development; personal relationship with one's manager

Healthy Work Environment

Leadership
Team
➢Training
Job Strain
Job Satisfaction

Training requirements pervade all aspects of LTC practices and requirements from basic preparation, on-going skill enhancement to how staff work together.

Lack of specific training has been cited as a barrier in many studies and has contributed to negative outcomes for residents, staff and system.

Williams (2005)

- Florida State developed competency based curriculum for dementia care in nursing homes

Boustani (2005)

- The prevalence of BSRD was associated with staff training and resident cognition, mood, mobility, and psychotropic use. Attention to staff training and depression management might improve BSRD.

Brazil (2006)*

- 275 medical directors (61%) representing 302 LTC facilities (57%) responded to the survey. Potential barriers to providing palliative care were clustered into 3 groups: facility staff's capacity to provide palliative care, education and support, and the need for external resources. Two thirds of respondents (67.1%) reported that inadequate staffing in their facilities was an important barrier to providing palliative care. Other barriers - inadequate financial reimbursement from the Ontario Health Insurance Program (58.5%), the heavy time commitment required (47.3%), and the lack of equipment in facilities (42.5%). No statistically significant relationship was found between geographic location or profit status of facilities and barriers to providing palliative care. Strategies respondents would use to improve provision of palliative care included continuing medical education (80.0%), protocols for assessing and monitoring pain (77.7%), finding ways to increase financial reimbursement for managing palliative care residents (72.1%), providing educational material for facility staff (70.7%), and providing practice guidelines related to assessing and managing palliative care patients (67.8%).

- Training and education preparation to work in LTC homes has been cited as a key factor related to staffing, skill mix, team work, supervision and addressing key challenges in LTC such as prevention, dementia, aggressive behaviours, and quality of life.
  - **Bourbonnais (2004)*, Morgan (2005) -** Training needed for management of verbal and physical aggression
  - **O'Brien-Pallas et al (2007)** – Training needed to promote uptake of best practice guidelines
  - **Crossan et al (2005)** – Need for training of health care aids; training RNs for supervision, management, delegation;
  - **Stolee et al (2006) –** Training important in the implementation of service delivery changes e.g. Nurse Practitioners
  - **Banaszak-Holl et al (1996) -** Turnover unaffected by increased training
  - **Morgan (2007)* & Banerjee et al (2008)*** - staff injury associated with limited training
  - **Deutschman (2005) , Oandansan et al (2006), Armstrong & Armstrong (2007) –** Training needed for team work
  - **Kennedy (2006)** – Training associated with staff job satisfaction
  - **Lenhott (2005) –** Regulations have mandated different levels of training for different category of workers

Healthy Work Environment

Leadership
Team
Training
Job Strain
Job Satisfaction

Various factors impact on job strain: type of shifts, preparedness, presence of SCU – environmental support, staffing levels, leadership, staff empowerment, etc.

Different categories of staff experience different levels of job strain.

Bowers (2001)

- Staff coped with staff shortages by minimizing time spent on tasks, creating routines, familiarity with residents (decreased time on assessment), organizing by task (several trips to resident at different times) or by resident (lengthier time with resident but less frequency – chance of interruption high (overall attempt to be more efficient
- Interruptions destroyed routines and made process inefficient
- Other strategies – prioritizing, working faster, combining tasks, changing sequence of tasks, communicating inaccessibility, negotiating time, changing work responsibilities, converting wasted time

Morgan (2002)*

- Nurse Aides (NA) reported higher psychological job demands than RNs and significantly less decision authority than RNs and activity worker (AW); AW reported greater decision latitude than NA
- AWs least likely to have time to get work done than RNs and NA
- Nurses and AWs more likely than NAs to think their job gave them decision making ability
- AWs were more likely than both RNs and NAs to think they were able to be creative with their job
- NAs reported higher psychological job demands than RNs
- Lack of skills in addressing dementia was a major strain for staff; rural staff felt more strain in not having the ability to keep up with their skill level

Morgan (2005)* – study of risk of assault and job strain in SCU and non-SCU facilities

- Staff in facilities with SCU reported less risk for assault, greater preparedness and greater support although staff in SCU did experience greater physical assault
- Those working in SCU felt they had a choice of working there versus those caring for dementia residents in non-SCU facilities.
- Staff in facilities with SCUs, greater proportion of time worked on SCU was associated with greater skill discretion, lower job demands and job strain
- SCU may provide more opportunities for learning, creativity, variety of work and developing special abilities
- Feeling adequately prepared was negatively correlated with job strain, suggesting providing more training may help increase confidence and reduce staff job strain
- Need for a strategy to reduce job strain by lowering job demands and increasing autonomy
  - Most direct strategy is to increase staffing levels
  - Recommended level is 1 NA to 5 residents on day shift (Harrington, 2000)
  - Staff empowerment was one of four leadership activities essential in creating and sustaining SCUs

Healthy Work Environment

Leadership
Team
Training
➤Job Strain
Job Satisfaction

Job strain caused by work environment factors and can be amended by manipulation of these factors: role boundaries, relationships, engagement of staff, career supports, reduction of physical & environmental hassles including addressing excessive paper work and non-nursing duties.

Burgio (2004)

- Use of permanent versus rotational assignments
- No impact on resident outcomes. Permanent assignment – greater satisfaction but no impact on attendance; day shift – greater burnout and absenteeism but evening shift had greater turnover

Kennedy (2006)

- Overall, RNs had more stress and burnout than did other nursing personnel. Most important, RNs had a negative correlation between burnout and personal accomplishment*, indicating that as their lack of personal* accomplishment increased their burnout decreased.
- Strategies to improve job satisfaction and sense of personal accomplishment might include career development and training, employee empowerment, and creating a positive, supportive work environment
- Strategies to enhance the quality of work life of nursing staff include providing support, team work, evaluating job duties and workload, assessing staffing needs, educating staff, and stress-reduction activities. Special emphasis in educating staff should include dealing with emotional needs of an aging population, such as strategies to help clients deal with grief and behavioral intervention techniques for cognitively impaired clients.

Beaudoin, 2003* - Montreal teaching hospitals

- Study on hassles (state of confusion, turmoil , annoyance, troublesome concern) – usually not addressed by workload measurement tools but impact on strain, satisfaction and workload
- 4 most frequently reported hassles – interdepartmental relations, working conditions, physical and environmental hassles
- Need role boundaries and clarity so nurses not expected to take on other people's functions – i.e. Address non-nursing responsibilities
- Training required on social communications

Cherry et al (2007) – re regulatory environment

- Perceptions and satisfaction of nurse aides and licensed nursing assistant
- Regulations pervade their daily work – however these are accepted as a necessary oversight for good care.
- Concern that surveyors created a tense and adversarial atmosphere
- Job dissatisfaction included excessive paperwork, ineffective communication, frequent deaths, combative and uncooperative residents, and inadequate staffing.
- Need strategies to improve the survey process, address care related stressors, promote positive communication techniques, reduce paperwork inefficiencies, and reduce staff shortages.

Healthy Work Environment

Leadership
Team
Training
➤Job Strain
Job Satisfaction

Participatory intervention is key to reducing job strain and promoting job satisfaction.

Nurses have been found to have ++ paid or unpaid overtime work.

50% of LTC staff experienced physical assault by residents

Brabant , 2007* - use of participatory engagement process to improve work environment

- Optimal psychosocial environment enables health care workers to have a workload adapted to capacity, decisional latitude, support from colleagues and superiors, reward, predictability, meaning of work and interaction with patients and finally a satisfactory physical environment.
- Intervention is aimed to reduce or eliminate work constraints, and was implemented by both employees and managers
- 164 constraints identified, most problematic dimension related to workload
  - 35% of constraints received were of workload
  - 17% were predictability, modes of communication
  - 16% was lack of equipment
  - 12% was reward, 11%autonomy, 5% social support, 4% patient relations
- Findings: Health care workers perceptions -Four main perspectives emerged from analysis
  - legitimacy of change
  - commitment, indifference and resistance, range of emotions during times of change
  - day to day concrete changes seen as improvements; have decisional latitude and sense of teamwork
  - elements of success of participatory approach – support from management; use of participatory approach
- Senior management has fundamental role to play in identifying priorities and orienting reorganization
- Organization must be in support and encourage change
- Team to have a good leader, visionary, is important
  - Leader helps employees realized importance of team work and goals able to accomplish
  - Leader, manager, promotes and supports a context in which professional autonomy, decisional latitude, reward, stimulation of ideas and search for solutions to known problems - are all valued
- Social support from superior under this approach played a key role in fostering optimal psychosocial work environment
- Participatory approach greatly aids developing a sense of belonging and seems to have multiplied the interactions among employees

Statistics Canada (2005) National Survey of Work and Health of Nurses

- Average age = 44.3. Average time in nursing = 18.3. Females 3.4 years older than overall employed women and males were 1 year older than overall employed men.
- 9 in 10 had jobs that involved direct patient care; 6 in 10 worked in hospitals with rest in LTC, community, other settings
- 50% worked in unpaid overtime (4 hours per week); 3 in 10 worked over time for pay (5.4 hours per week)
- 52% felt there were enough staff to get work done; 48% felt there were enough staff for quality care
- Half of nurses in LTC reported having experienced physical assault by resident; 44-50% reported having conflict with co-workers; 9/10ths reported positive working relationships with physicians; 88% were satisfied with their jobs (lower than general population which is 92%)

Healthy Work Environment

Leadership
Team
Training
Job Strain
➤Job Satisfaction

Many of the factors associated with satisfaction are related to work environment factors and supports

Research based interventions are available to reduce job strain and increase job satisfaction.

Leurer (2007)* Qualitative research of long tenure nurses found 7 themes
- Nurses want consultation and communication
- Recognition
- Adequate staffing
- Supportive management
- Flexible work schedules
- Support for new nurses – mentoring was only consistent strategy being implemented, not others
- Professional development

Pillemer (1997) –best practices in recruitment and retention
- Career ladder – nurse aides stay at nurse aide level but with each rung, have additional responsibilities, training, recognition in title
- Peer support – permanent assignments develop closer relationships; buddy system; support groups with outside facilitator
- Job redesign – different supervision models; involvement and valuing of nurse aides, source of resident information; information meetings to discuss industry level changes, org specific direction; make meetings fun by including announcements, events, recognitions; get opinions; establish problem solving committees; organizing staff in teams – teams were assigned group of residents for long term and empowered to make decisions re care, supplies, care schedules.

Sung (2005) – Taiwan – nurse aides
- Factors for staying in position (in order of high to low) – monetary needs, relationships with residents, working environment, training opportunities, gratification

Hegeman (2007) – peer mentoring
- Growing strong roots – experienced nurse aides mentor novice ones – change culture from “eating their young” to a supportive one – incentives built in for mentors; 3 week structured program – two separate studies showed positive retention at 3 months post intervention
- Peer mentoring for LTC Charge Nurses – expert – novice as well as true peers; focus on dementia content; communication, leadership, management – positive retention results
- Grant funds were used for training program for mentors – can be a limitation for replication

Quality Management

➤ Innovative Models Quality of Life

A variety of approaches that focus on how resident care is structured and design of staffing policies to meet resident needs.

Flexibility with residents and staffing is a repeating factor.

Lessons from Magnet Hospitals can assist LTC homes.

Advocacy and public transparency through report cards are two models for ensuring accountability.

Angelleli (2006)

- Small, home-like home; built in flexibility; multidisciplines in blended roles; staff work part time with flexibility but earn full time pay – reduction in middle managers allows for the $

Chaplin (2005)

- Aging in place model – assisted living facilities - Kansas – admission policies to these facilities more stringent – only allowed those who were less risk of elopement, ambulatory or wheel chair, bladder incontinent, catheter, etc. Those who were severe cognitively impaired, needed two person transfer, bowel incontinent – not admitted
- Findings from those who did not age in place – found that resident care needs changed significantly and needed nursing facility or acute facility and behaviour problems increased
- Some assisted living facilities ended up changing their criteria in order to allow residents to age in place – also increased staffing

Cohen (2006) – Australia

- Dementia home – 36 beds – 4 units – 9 beds each – day time, operate separately and open up as one unit for night.
- Flexibility a key concept for resident care and staff needs – resident care delivered based on resident needs – eat different times, activities, etc.
- Staff schedules flexible, 3 days work and 3 days off, eat with residents, less than full time schedule but weekend and holiday pay differential provides full time pay
- Low turnover (less than 10%), sick time, greater staff satisfaction

Winslow (2002)

- Magnet hospitals – higher nurse- pt ratios, greater control over practice, participation in policy decisions, continuing professional development – closer surveillance of patients, early identification of problems, effective rescue responses, better outcomes
- Development of quality practice guidelines using literature and 14 focus groups: 1) workload management; s) nursing leadership; 3) control over practice; 4) professional development 5) organizational support

Persson (2004)

- US has mandatory volunteer/paid ombudsman within nursing homes. They play three roles: friendly visitor, mediator or advocate. Most satisfying is the friendly visitor role. Challenges relate to resistance from staff, lack of support, training, etc.

Harrington et al (2003) – designing a report card

- Conceptual framework includes facility and ownership characteristics, resident characteristics, staffing indicators, clinical quality indicators, deficiencies/complaints/enforcements, and financial indicators.

Mukamel et al (2003) – report card

- Although report card in the LTC sector can be valuable, there are a number of key considerations: accuracy, validity, reliability and un-biasness of the quality measures that are used and the format and accessibility of the report for consumers to read and understand the reports. Lessons should be taken from the experience of report cards in the acute care sector.

Quality Management

➤Innovative Models
Quality of Life

Ontario grown model – unique and not attempted else where – holds promise from both infusing best practices as well as supporting specialized supports to staff.

O'Brien-Pallas et al (2007)* – promoting uptake of BPGs in LTC

- Facilitators: Leadership commitment and support, previous knowledge of BPGs, what is mandated gets done, larger corporations (have resources such as educators, consultants, etc), staff buy-in/ participation, education that is customized to level of staff (need role relevance), issues related to quality of resident care had higher value again, related to what was is seen as relevant by staff), greater awareness of BPGs in sector, networking with other homes, communities of practice, credible individuals ore resources (compliance advisor, BPG Blogger)
- Barriers: workload and competing priorities, paperwork/documentation, constant interruptions, new initiatives without new resources, short staffed (unable to get replacements), proportion of regulated versus unregulated staff (higher regulated staff means able to implement more), level at which BPG content is written, language (mostly in English), lack of appropriate # of BPG Coordinators, inability to implement multiple new initiatives simultaneously, LTC funding model (documentation for classification takes priority)
- What has worked:
  - Strategic plan and vision by leadership
  - Presence of support staff (educators, BPG champions)
  - Staff training and education (ability to send staff to workshops, BPG institute)
  - DOC as champion
  - Facilities for education (e.g. Dedicated education room)
  - Dedicated staff for specific projects (gives some RNs leadership opportunity, innovation)
  - Support systems – internal committees, multi-disciplinary involvement
  - External profiling
- Impact of BPG implementation: staff feel empowered – can have rational for care, better communication with families and other staff, able to recommend changes – e.g. Need for equipment, training; able to have more consistency in care planning quality indicators, standardize policies and procedures; resident/family reported minimal changes in practices, were not familiar with the term best practice guidelines and felt that staff were over-stressed. They also added that their care needs were not always
- Recommendations for the MOHLTC
  - Consider increasing the number of BPG Coordinators per region OR consider funding an on-site BPG Coordinator role in each home.
  - Continue to support (fund) the BPG Coordinators and LTC staff members to attend BPG-specific education and development programs such as the RNAO annual Summer BPG Institute and BPG Champion Workshops within the regions.
  - Provide sustainable funding for the BPG Coordinator in Long-Term Care initiative and continue to evaluate the impact of the implementation of BPGs in long-term care on patient, system, and health provider outcomes.
  - Consider providing funds directly to LTC homes to support additional best practices activities such as continued staff in-services, and supplemental staffing needs.
  - Encourage homes to share information about BPG implementation with resident/family councils on a regular basis.

Quality Management

➢Innovative Models Quality of Life

Nurse Practitioner model of care can be effective if implemented with appropriate supports including physician buy-in, collaborative care, administrative support, time to interact with staff and manageable NP to resident ratio.

New innovation or initiatives should address uptake in a systematic manner taking into consideration research based factors associated with innovation, individual, organization and environmental factors.

Stolee et al (2006)* – Pilot of NPs in small city in Ontario

– US has had NP integrated for longer time. Only recently in Ontario – currently only 17 NPs as part of initial pilot, now permanent

– Study comprised of 3 NPs – working 40 hrs – 70% clinical and 30% education, leadership functions

– Positive results in 2 homes and less so in 3rd home.

– Success factors: rounds with physician and staff, collaborative environment, size of home, attitude, experience level of staff – more experienced staff in 3rd home that did not see value for NP; interaction level increased satisfaction with NP; training and support; administrative support as well as turnover of administrator/DOC

– Some role expectations did not become reality – preadmission assessment and medication review at admission – this was related to quick admissions, lack of time, lack of awareness of system of medications

Bryant-Lukosius et al (2004)*, Prescott (1993); Shamian & Chalmers (1996)

- Innovative models using Nurse Practitioners, Clinical Nurse Specialists or other mobile specialist resources have been found to decrease outcomes such as rehospitalisation as well as improve the care of the residents.

Morgan et al (2005)*

- Although the demographic profile of long term care residents now require that all staff need to have knowledge, skills and attitudes that are compatible with addressing the needs of residents with various types of dementias, there is a need for special care units with even more specialized dementia care. These units can address the needs of those residents who are at risk of wondering, who are at early stages of dementia and can be prompted and redirected to participate in daily living activities, those who require specially designed programs and for those who need better management of aggressive tendencies as a result of their dementia.

Berta et al (2005)*

- Point to four sets of factors that influence the uptake or transfer of innovation in long term care homes.
- These are factors associated with the *innovation itself* (complexity), *individual factors* (clinical leadership), *organizational factors* (ability of organization to dedicate resources to a number of activities such as scanning the environment for innovations to support in knowledge transfer activities) and *environmental factors* (legislation, actions of industrial leaders).
- Homes that pay attention to these four sets of factors are better able to create a learning environment and transfer innovation to their operations.

Quality Management

➤Innovative Models
Quality of Life

Multitude of one off initiatives. The initiatives are not always appropriately evaluated or linked to provide synergistic impact.

Focus on management of residents with aggressive behaviours – need for a comprehensive set of supports that work together in a seamless manner – currently appears to be fragmented.

Seniors Health Research Transfer Network*

- Ontario's Seniors Health Research Transfer Network (SHRTN) is a province-wide knowledge exchange network of people involved in seniors' health care. SHRTN brings together researchers, policymakers and caregivers to share tacit and explicit knowledge. This exchange is enabled and facilitated by educators, librarians, members of the SHRTN Communities of Practice and the SHRTN champions.
- The network has an information search service, various knowledge databases, facilitated topic specific communities of practice(e.g. Continence, end of life care), website, etc.

Alzheimer's Knowledge Exchange*

- Similar to SHRTEN, but focus on dementia

Alliance for Quality Improvement in Long Term Care (AQUILT) – CIHR*

- 1) Psychotropic medications/restraints & reducing restraints/chemical restraints - 5 homes/organizations
- 2) Skin health - 4 homes/organizations
- 3) Falls management/prevention – 3 homes/organizations
- 4) Delirium/depression best practices – 3 homes/organizations
- 5) Balanced score card for LTC - 2 homes/organizations
- 6) Pain management best practices – 2 homes/organizations

Pain, Palliative Care and Symptom Management consultants*

- Each consultant has 15-25 homes to provide support – upon request, proactively, etc – goal is to develop capacity in the sector through education, consultation, just in time learning, etc.

Building better systems report- care of residents with aggressive behaviours*

- Components of a LHIN based system of care is recommended for demonstration projects. Some of the components exist currently and need enhancement and others need to be established.
- Psychogeriatric resource consultants – assess allocations, synergy with outreach teams
- High intensity needs fund or equivalent – expand use for other needs
- Behavioural support nurse function (new)
- Specialized geriatric mental health outreach teams
- Behavioural Support Units
- Direct care services transition teams – support residents from one setting to next
- Other – need training/mentoring of physicians in LTC; electronic records; consent issues; development of behavioural assessment tool for MDS/RAI; review of current resident classification; staff training.

Quality Management

Innovative Models
➤Quality of Life

Resident quality of life tied with their and their families involvement in care decisions; meal times; choices/ autonomy; flexibility; consistency; respect; sense of belonging and sense of comfort that they are cared by competent people.

Lack of gold standardized measurement instruments.

Sloane (2005)

- No gold standard for measuring quality of life in residents with dementia. There are reliable tools (list in article) – need to use combination of methods and sources – validity – challenging due to different perspectives on quality of life – need to study use of multiple tools and tools from the perspective of residents/family

Voutilainen (2006) – family involvement and quality of care

- Respondents who visited less frequently rate quality highest; those who visited often were more critical in their ratings
- Quality ratings were associated with family involvement because of:
  - Available information
  - – support from staff encouraging family participation
- These factors explained 31.% of the variation of quality ratings
- Family members who participate in care and had opportunities for participating in decisions gave highest ratings for quality - calls for better communication between staff and family members
- Need to formulate ward policy with appropriate goals that is accepted by staff and family members; regular meetings between family members and staff; modes of family centered long term nursing care should be implemented to prevent the deterioration of family ties and promote/maintain a sense of belonging thus improving quality of care

Gibbs- Ward (2005)*

- Quality of life tied in with meal times
- When meals are rushed, treated as tasks, pressured to complete within given time, then residents do not have quality of life, get agitated, don't eat
- Need individualized approach, emphasis on choice/autonomy where possible, consistency but also flexibility as each meal time needs to be seen as a unique process
- Dieticians can play a leadership role if they are supported to develop relationship, mentoring, educating, collaborating as a team with other care providers, can lead to better support of residents – hence need adequate staffing of RD, PSWs, etc

Quality Management

Innovative Models
➤Quality of Life

Quality of life measurement have had lower priority in the LTC sector compared to attention to quality of care

Definition of Q of L must include the resident's voice/ perspectives

Resident safety agenda needs to be promoted.

Reed et al (2005) – study with 2000 residents

- 50% of residents had low food and fluid intake. Factors associated with low food intake included the level of encouragement provided by staff, eating in the dining room and the features of the dinning area – non-institutional features meant better food intake.

Tauton et al (2005) – qualitative study, incontinence

- Staff had different conceptualization about definition of continence – there needs to be a common understanding and approaches to continence management – little evidence of formal programs
- Medical staff saw incontinence as a nursing problem
- Motivation to manage incontinence was largely to prevent pressure ulcers.

Kane (2003) – measurement of quality of life

- Addressing quality of life has had a lower priority than quality of care in LTC
- Various challenges in defining and measuring quality of life including ensuring the voice of the residents is part and parcel of defining quality of life for them. This is complicated by the fact that 40% or more residents are not able to be interviewed.

Borgling et al (2005) – qualitative research identifying meaning of quality of life

- Four themes emerged that frame the definition of QofL as preservation of self and meaning in existence. The four themes are:
- Anchorage to life (living in the present, living at the end of life, acceptance and adjustment, recollection of previous life – reminiscence)
- Conditions of governing one's life (material wealth – having freedom as opposed to limitations; home – as integral part of oneself)
- Satisfied body and mind (activities – participating in life, enjoying life, giving meaning to the day; health – independence, being aware of the inevitable, keeping control as opposed to losing control of one's body/ mind)
- Access to significant relations (staying together as opposed to losing a part of oneself, being involved as opposed to being left out)

Wagner et al (2008) – Canadian Patient Safety Institute

- Review of literature and key informant interviews reveal that measurement of indicators of adverse events continues to be challenging from a QI perspective,
- Priorities identified include: examining aggressive resident behaviour and related adverse events; strategies to balance safety and quality of life, maintaining safe environments.
- Communication and staffi ng/human resource challenges were identified as barriers to safety.

Quality Management

Innovative Models
➤Quality of Life

Support for resident, family and staff satisfaction surveys using third party.

Suggestions on operational strategies include the need to have separate surveys for residents and families as the perspectives are different; residents should have in person interviews whereas family could have mailed survey.

Stodel and Chambers (2006) – recommendations from report

- The following recommendations are put forward to the MOHLTC in this report:
- Collect satisfaction data from all LTC homes in Ontario in the interests of quality improvement and public reporting.
- Identify Ontario's needs and goals regarding measuring satisfaction before choosing or developing a tool as well as get input from wide range of stakeholders
- Examine the NRC+Picker, Rutgers, and Vital Research tools to determine whether they meet Ontario's needs and goals.
- If the province of Ontario decides to implement satisfaction surveys for the explicit purpose of public reporting to help the public make choices among long-term care homes, as per the recommendation of Monique Smith (2004), the tool used has to be valid and reliable the data have to be collected under tightly controlled circumstances (e.g., be interview-administered), and the survey must be implemented in every home in Ontario.
- The province is cautioned that this type of public reporting may foster competition and ranking between the homes and shift the focus from the process of quality improvement within a home to marketing of their superior quality services. Measures should be taken to prevent this.
- Determine whether home-specific questions can be added to the NRC +Picker, Rutgers, and Vital Research tools without affecting the psychometric properties of the instrument in order to facilitate quality improvement initiatives.
- Use one satisfaction tool for residents and a separate tool for family members as these two groups have different perceptions as to what is important in long-term care. The data from the two tools should be analysed and presented separately to reflect these different views.
- Use a third-party to administer the surveys to ensure confidentiality and minimise bias.
- The resident satisfaction tool should be administered face-to-face by trained interviewers who are not members of the long-term care home staff. A multiple contact approach should be used; that is, if the resident is fatigued, unavailable, or not functional on a particular day at a particular time, the interviewer should come back on another day at another time to administer the tool.
- The family satisfaction tool should be administered by mail.
- In order to ensure that the sample of residents and family members surveyed is representative of the home population and that it provides sufficient data for analysis, survey all residents in long-term care homes with less than 50 beds, and a family member of each. In the larger homes the sample of residents and family members to be surveyed should be big enough to obtain results that reflect the target population with a 95% confidence level. The residents and family members to be surveyed should be randomly selected from the total population by someone who is not a member of the long-term care home's staff in order to avoid biased sampling.
- Data should be analysed by a third-party to ensure consistency in analysis across homes, which is necessary for public reporting.
- The skills of the administrative staff in the home should be considered if they are going to be required to work with the data and findings; this should inform what is requested of the third-party vendor in their analysis.
- Guide homes in the satisfaction survey process and help them see how they can use the data to drive quality improvement initiatives. Consider providing incentives for such initiatives.
- Consider assessing long-term care staff satisfaction, as well as resident and family member satisfaction, as it plays an important role in determining residents' and family members' satisfaction in long-term care homes.

Quality Management

Innovative Models
➤Quality of Life

Research based findings are now available to better define quality of life measures. This must be a dynamic process.

Edwards et al (2000) – extensive literature review on survey tools in US

- No one tool is superior and there are a number of different approaches to addressing quality of care and quality of life
- Consensus that it is important to ensure resident voice is central to assessing quality of life; family perspective is different than resident and both should be included. Proxy measures for residents may be necessary but all efforts should be made to obtain resident perspective using well designed tools.
- Residents should be interviewed in person.

Robichaund et al (2006)* – interviews with residents to identify important indicators for quality of life

- feeling that one's identity is respected by caregivers;
- a sense of belonging — being accepted and aligned with caregivers and other residents; and
- feeling that caregivers, through their gestures, attitudes and methods of work, are competent.
- Other factors included:
  - access to a private room with additional facility space;
  - feeling a sense of compassion and effective support from staff;
  - maintaining a role within the community;
  - sharing good times, laughing, playing and joking with peers;
  - preserving a sense of control;
  - reduced perception of the impact of government funding restrictions on life in the long term care home;
  - staff stability; and
  - having access to hobbies, leisure and spiritual resources

Sector characteristics

➤Ownership Status Regulation

For profit facilities associated with lower quality care (US), lower staffing levels, smaller homes in Ontario, benefits of economies of scale.

Current Ontario regulatory climate favours for profit homes

- **Devereaux (2002)** – systematic review of 15 observational studies
  - Private for profit hospitals were associated with a statistically significant increase in risk of death

- **Berta (2005)***
  - Ontario LTC sector dominated by proprietary for profit facilities
  - 62% of facilities are for profit, 17.4% of facilities are gov owned, 14.1% are non profit lay, 6.5% are non profit religious
  - proportion of for profit beds grown from 56% in 1996/97 to 59.6% in 2001/02
  - Stringent regulatory conditions in Ontario have favoured for profit operators for their abilities to realize economies of scale over independent non profit organizations
  - Research to date does not conclusively support any relationships between profit status of facility owners and quality of residents care
    - Research outside Canada shows lower staff ratios and fewer types of services are offered in for profit facilities which may account for higher rates of adverse outcomes (pressure sores, restraint use) (Harrington, 2001)
    - Other research shows for profit status related to lower adverse outcomes such as mortality rates(Zinn, 1993)
  - Significant differences are found in staffing levels across ownership types: nurse staffing intensity and direct care staff levels are higher in gov owned facilities and significantly lower in for profit operators
  - researchers suggest low subsidy levels, coupled with increasing stringency regulations result in operating environment that may discriminate against small facility which are unable to exploit economies of scale and may be disadvantaged when it comes to meeting costly standards or stipulations of staffing
    - small facilities generally have a lone administrator or few management staff
    - evidence from other jurisdictions suggest size can negatively affect quality of care (Banaszak-Holl, 2004)
  - gov owned facilities are significantly larger than other ownership types
  - increase in homogeneity of type of care required by residents of LTC facilities
  - 2001/02, 61% required type II care from 52.7% in 1997/98
  - suggest organizations offering a single or restricted range of products or services ore restrict market to particular type of consumer can benefit from developing expertise and from economies of scale
  - gov owned facilities provided care for significantly more residents with higher care needs – chronic type III care and hyper type care – than other types of facilities
  - facilities caring for residents with higher care needs (gov) and older residents (religious and non profit) have a higher nursing intensity and direct care staffing levels
  - critical question is whether or not current staffing levels are adequate
  - avg direct care staffing levels in Ontario LTC in 2001/02 are lower than US national avg

Sector characteristics

- ➢Ownership Status
- Regulation

Greater direct staffing and support time in not-for profits.

Higher staffing levels associated with better outcomes.

McGrail (2007)* -review

- Beta and McGregor –separate studies found higher direct care staffing in for profit homes, in Ont and BC respectively
- Manitoba study found higher hospitalization of residents with several diagnosis from for profit homes
- BC study (McGregor, 2006) found same results but also that difference greater for not for profit homes that were multi site, attached to hospital, amalgamated with health authority (pneumonia, anaemia, dehydration) – explanation – economies of scale, availability of specialists, sharing of other resources and higher staffing

McGregor (2005)

- number of hours per resident day provided by direct care staff and support staff was significantly higher in not for profit facilities than in for profit
- difference of 20 min per resident day for direct care staff and 14 mins per resident day for support staff
- research in US links higher direct care staffing levels to better outcomes
- US congress study, 5000 LTC facilities in 10 states, determined higher staffing predict improved outcomes (skin integrity, good nutritional status) up to thresholds of 1.3 RN and LPN hours and 2.8 RCA hours per resident day which are considerably higher than mean staffing levels in this study
- Reid and colleagues found higher ratios of activity aides lead to beneficial effects on cognitive function and social and language skills

Sector characteristics

Ownership Status
➤Regulation

LTC sector improvements have been a result of both advocacy groups and government regulatory practices. It is unclear which of the regulatory practices have made significant impact on overall quality in the sector. Wide range of regulator practice include staffing & care standards, funding mechanisms, public reporting and engagement, data support, support for specific innovations, etc.

Wiener, 2003

- numerous strategies have been used to increase the strength of the LTC sector:
  - – Strengthening the regulatory mechanisms such as establishment of standards, monitoring, inspection and licensing apparatus.
  - – Improving information systems for monitoring the quality of care that residents receive in homes. This area is more advanced in the US than in Canada.
  - – Strengthening health human workforce. In the US, this has translated to some states mandating the amount of direct care provision time as well as skill set requirement.
  - – Providing consumers with more information through public reporting.
  - – Supporting the capacity for consumer advocacy through establishment of structures such as resident and family health councils.
  - – Various changes to funding and reimbursement mechanisms.
  - – Developing and implementing clinical practice guidelines.
  - – Changing the culture of long term care homes – cursory efforts in Canada.

Lenhott (2005)

- Trends in regulation – to prevent resident abuses, neglect and address quality
  - – Several US sources cite widespread extent of abuses, neglect – as high as one third of nursing homes
  - – Debate on whether regulatory system is failing versus others who are advocating for a non-adversarial system of technical assistance and support to home operators
  - – Need for better trained staff; better care practices – US has federal mandatory training requirements for certified nurse aides
  - – Female dominated workers who have low wages/benefits, mandatory overtime, and difficult working conditions leading to high turnover rates in US studies.
  - – Requirement of RN for 8 hours (US), 24 hrs (Ontario)
  - – Ratios (National State Legislature, 2000)
  - – Minimum staffing levels – California + other states (2.8 for NAs and 1.3 for licensed staff) – where there are no mandated minimum staffing levels, hprd is still used as an indicator for quality care
  - – Standards in care processes
  - – Public reporting of compliance/public education/complaints process
  - – Protection of resident rights (bill of rights)
  - – Supporting consumer involvement and advocacy (family and resident councils)
  - – Need for reporting systems and available of accurate and consistent data
  - – Funding to support culture shifts – e.g. Transform nursing homes to communities (e.g. Eden Alternative); use of different models of care delivery (e.g. Wellness Spring – use of nurse practitioners, inter-disciplinary collaborative).

APPENDIX 2
Summary of Stakeholder Submissions

Stakeholders were asked to address five key questions in their submissions:

1. **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?**
   Factors that affect human resources/staffing requirements and standards can be grouped in four areas: factors related to residents, staff, the work setting and the LTC industry.

   a) Factors related to residents:
   There was consensus that those entering LTC homes today are older seniors with many physical, mental and emotional care requirements that were not seen in the past. In other words, residents are sicker and more frail. Their health status requires complex assessments, treatments and preventative interventions. Stakeholders noted that residents are not a homogenous group. Increasingly residents form small, but distinct, 'specialized care' cohorts. Because they do not have a critical mass of residents with the same set of needs, homes are not often equipped to provide highly specialized custom care. The trend toward higher acuity among residents will continue in the foreseeable future. Also highlighted was the trend toward higher turnover in the resident population.

   Stakeholders identified several factors that increases the workload of staff; these include: unpredictability or fluctuations in resident status; increasing mental health care needs of residents along with high numbers of residents with cognitive impairments; and the necessity to prepare residents for (and coordinate) referrals to various specialists (and others) outside of the LTC home.

   b) Factors related to staff:
   Most stakeholders spoke of the dedication and care that all staff demonstrated on a day-to-day basis toward residents. However, they pointed out that LTC homes struggle to provide high quality care and services in face of: inadequate numbers of staff or, often, the right skill mix; insufficient supports for continuing education and mentoring; and unsatisfactory logistical and administrative supports. Skills shortages (or the 'mismatch' of talent) in the local workforce also challenge LTC home operators.

   Typically, the mix of skills among staff in LTC homes varies and is influenced by the philosophy, leadership and goals of the organization. Personal support worker training is not consistent and results in variation in the knowledge and skills of staff providing personal care to residents. Often, there are very few therapists, social workers and activation/program staff. This leaves the larger

burden of personal care, treatments and quality of life programs to nurses and personal support workers. Shortages of talent in the broader community have often left LTC homes working without the appropriate skill sets for long periods of time. For many, this has meant resorting to agency or temporary solutions which do not provide the same level of effectiveness or productivity.

c) Factors related to the work place:
The philosophy of care, leadership and collaborative approaches were routinely identified as key factors contributing to the standards and staffing of the home.

Another variable consistently identified by stakeholders related to the physical layout of facilities. Although smaller and newer facilities were more homelike and had better esthetics, these homes required greater overall staffing to provide safe care and monitoring of residents.

d) Factors related to the industry:
Most stakeholders suggested that the industry was highly regulated and did not allow for flexibility/creativity on the part of LTC homes and/or staff. Heavy accountability requirements (in terms of meeting established care standards) require home operators to allocate resources to fulfill extensive documentation requirements and other procedures that provide evidence of compliance with MOHLTC standards. Additionally, a persistent wage imbalance between the hospital, community and LTC sectors has meant that home operators (who are unable to offer higher wages) have had great difficulty competing for appropriately skilled staff. Other disincentives from the worker's perspective are the low staff to resident ratio and the perception that working in this sector would not provide career opportunities to young people.

2. What are the implications of these factors on human resources/staffing requirements and standards?

Most stakeholders share the opinion that the result of lack of human resources/staffing and/or staff shortages has meant that residents are not receiving the best quality of care they require and deserve. It has also meant that home operators have had to increase their productivity with little slack in the system to: address unexpected contingencies; provide time to staff to attend conferences or other professional networking events; or establish processes that allow staff to meet and discuss care requirements of residents on a frequent and regular basis. The major fallout of the factors discussed earlier is that care has had to be established in a routine and inflexible manner with little room for addressing customized services for residents.

3. What are the components that would go into establishing a staffing standard and what is the evidence to support this?

All stakeholders spoke of the need to increase staffing in most job categories including decreasing the span of control for managers/DOC. Stakeholders spoke of the value that managerial oversight has in providing support, coaching/mentoring to staff and ensuring alignment with organizational

objectives. Many stakeholders suggested increasing the number of hours of nursing and personal care hours to 3.5 per resident day. Some made reference to staffing benchmarking and US-based studies. Also, some noted that 3.5 hours per resident day would bring Ontario in par with other Canadian jurisdictions as a minimum staffing standard . Other stakeholders requested sustainable funding mechanisms that ensure stability in human resources in the sector.

Many suggestions included: creating a role for Nurse Practitioners among others; addressing team cohesion; standardizing ratios of RN, RPN, PSW and Dietary Assistant per resident; more and better education and training; limiting use of agency and temporary help; and developing strategies for creating greater efficiencies in the system.

Stakeholders were clear that the proposed staffing standard could not be met within the current allocated funding and that this, plus the above suggestion, would require a significant influx of new sustainable funding. Various amounts were suggested as well as funding formulas to allow greater flexibility in managing human resources.

4. **What are the key priority areas that directly impact on resident outcomes related to human resources/staffing requirements and standards?**
   There was unanimous agreement that the top priority needed to be the enhancement of staffing capacity in LTC homes. Other priorities that followed (not in any specific order of priority) included: strong leadership in the LTC homes; training and development needs of all staff; implementation of MDS/RAI to address common assessment and workload measurement; use of HOBIC outcome measures to evaluate quality of care; inter-professional collaboration; and optimizing the scope of all members of the LTC provider team including food service staff and other support staff.

   There was little feedback on how priorities should be determined. Some feedback pointed to meeting the needs of residents with mental health/cognitive impairment issues due to the large volume of residents with these conditions.

5. **What are innovative approaches, research, performance indicators and best practices that we should consider?**
   A range of innovative approaches were mentioned including: the use of best practice guidelines; public accountability/transparency; and mandatory accreditation. Additionally, programs that provide support to the care of residents with dementia were noted as well as systems that provide better methods of conducting patient assessment, defining workload and measuring quality of care. Also provided were references to documents and research that support the need for more staffing.

APPENDIX 3
Staffing Standards in Other Provinces

Information was gathered form other provinces on their approach to staffing standards for their LTC facilities.

Direct comparisons among Canadian jurisdictions can be challenging. There are differences in the way each province's LTC system is organized to provide health care services to individuals that require the availability of 24 hour nursing care and supervision within a secure setting. The most significant areas where the provinces differ include:

- Organization of provincial long-term care services;
- Service delivery models;
- Approach to assessment of resident care needs; and
- Funding frameworks.

Provincial approaches vary from standards that set the expected average hours of care to be provided by licensed nurses and personal support workers to no specific standards or guidelines.

The following is a summary of current provincial practices:

Province	Description of Current Practices
British Columbia	• BC has not set minimum staffing levels for residential care facilities, but rather expects that health authorities will work with their residential care facility providers to adjust staffing patterns as necessary to address residents' unique needs. • BC established a Provincial Performance Management Framework for Residential Care Facilities as of April 1, 2008, that includes an indicator to measure direct care nursing and personal care hours worked. • The Ministry of Health and health authorities are working together to develop a draft provincial staffing framework for residential care facilities in BC.

Province	Description of Current Practices
Alberta	• Alberta has a minimum staffing standard, embedded in regulations under the Nursing Homes Act, of 1.9 paid hours of combined nursing and personal care per resident per day. At least 22% of these hours should be provided by nurses. There is also a requirement for 24 hour coverage by a nurse at each nursing home. • Staffing measures for personal and nursing care in LTC facilities (nursing homes and auxiliary hospitals) are established in annual grant agreements between the province and RHAs. The 2007/10 Accountability Guide for RHAs provides a measure of an average of 3.8 paid hours for personal and personal care per resident per day for LTC facilities (nursing homes and auxiliary hospitals) in 2007/08.
Saskatchewan	• Nursing care requirements are set in Regulations under The Housing and Special-care Homes Act that require special care homes to: - employee sufficient staff (excluding dietary, laundry and maintenance staff) to provide at least 2 hours of personal or nursing care per guest per day; - ensure a nursing staff ratio of one registered nurse (or registered psychiatric nurse) to seven ancillary nursing staff such as nursing aides, orderlies, etc. - ensure that nursing care by a registered nurse or registered psychiatric nurse is provided on a 24-hour basis.
Manitoba	• Staffing standards for nursing and personal care are set in provincial policy. The most recent policy sets 3.6 hours of personal and nursing care per resident per day as the provincial target by April 2011. • In personal care homes with more than 80 beds 30% of the time should be provided by licensed nurses and 70% by resident assistants. In homes that have fewer than 80 beds, the ratio changes to 35% for licenses nurses and 65% for resident assistants. • A provincial group is studying staffing standards for allied health professionals in personal care homes.
Quebec	• At the time that this report was prepared information was not available on staffing standards in Quebec.

Province	Description of Current Practices
New Brunswick	• Nursing homes are funded a total of 3.1 hours per resident per day. The funding formula has two components: - Funding for Core Care Staff (registered nurses (RNs), licensed practical nurses (LPNs) and resident assistants (RAs) based on 2.5 hour of care per resident per day at a standard of (20% for RNs, 40% for LPNs, and 40% for RAs). RN and RA ratios are adjusted to ensure one RN is in the building 24 hours each day in nursing homes with 49 beds or less. - The additional 0.6 hours of care funding per resident per day is comprised of Peak Workload Staffing by RAs; Care Support staffing by RAs, rehabilitation support by LPNs; and clerical support by clerk typists.
Nova Scotia	• The province is shifting towards smaller long-term care facilities, with staffing standards and physical designs intended to decentralize care into separate self-contained, more home-like 'households' that offer a more personal and flexible living experience for the resident. • Although much of the staffing requirements are still determined by the number of residents (e.g. RN and LPN), staffing standards have changed to promote a focus towards a Continuing Care Assistant (CCA) Full Scope of Practice Staffing Model in which a qualified employee applies all of the required components of the CCA program curriculum skills within the household setting, including household management, personal care, mobility assistance, meal preparation, respite and emotional support. With this model, CCA FTEs are allocated to the household rather than hours of care per resident to provide for appropriate 24 hour coverage.
Prince Edward Island	• The current average staffing ratio is 3.4 paid hours of nursing and personal care per resident per day provided by RNs (18%), LPNs (30%) and resident care workers (52%)
Newfoundland and Labrador	• Staffing standards for nursing and personal care are set in policy. They are based on a level of care assessment from 1 to 4, where 4 represents residents that have the highest care needs. For this group the staffing standard is 3.0 worked hours of care per resident per day. 20% of the time should be for RNs, 40% for LPNs and 20% for personal assistants.

APPENDIX 4
Stakeholder Engagement

1. Meetings with Key Stakeholder Organizations

Activity Professionals of Ontario
Advocacy Centre for the Elderly
Association of Municipalities of Ontario
Canadian Automobile Workers
Canadian Union of Public Employees
City of Toronto
College of Nurses of Ontario
Community Care Access Centres and the Ontario Association of Community Care Access Centre
Concerned Friends of Ontario Citizens in Care Facilities
Dietitians of Canada
Family Council Group
Ontario Association of Non-Profit Homes and Services for Seniors
Ontario Association of Residents' Councils
Ontario Association of Social Workers
Ontario Health Coalition
Ontario Home Care Association
Ontario Long-Term Care Association
Ontario Long-Term Care Physicians Association
Ontario Ministry of Health and Long-Term Care
Ontario Nurses Association
Ontario Pharmacists' Association
Ontario Physiotherapy Association
Ontario PsychoGeriatric Association
Ontario Public Service Employees Union
Ontario Society of Occupational Therapists
Registered Nurses Association of Ontario
Registered Practical Nurses Association of Ontario
Seniors Advisory Committee of the Seniors Secretariat
Service Employees International Union
The Gerontological Nursing Association of Ontario

2. Stakeholder that Provided Submissions

More than 100 submissions were received stakeholder including residents, family members, staff, associations and LTC home.

Some organizations submitted more than one brief at various stages of the review.

The following is a list of stakeholder organizations that submitted briefs:

Activity Professionals of Ontario
Advocacy Centre for the Elderly
Canadian Auto Workers Union (CAW)
Canadian Coalition for Seniors' Mental Health
Canadian Society of Nutrition Management
Canadian Union of Public Employees
College of Nurses of Ontario
Concerned Friends of Ontario Citizens in Care Facilities
Dieticians of Canada – Ontario Region
Dietitians of Canada
Family Council Group
Ontario Association of Non-Profit Homes and Services for Seniors
Ontario Dental Association
Ontario Federation of Labour
Ontario Health Coalition
Ontario Home Care Association
Ontario Hospital Association
Ontario Long-Term Care Association
Ontario Nurses Association
Ontario Public Service Employees Union
Ontario Society of Nutrition Managers
Registered Nurses Association of Ontario (including briefs from chapters of RNAO)
Registered Practical Nurses Association of Ontario
Service Employees International Union
The Gerontological Nursing Association of Ontario
Peterborough Regional Health Centre, Fairhaven, St. Joseph's Fleming, Omni-way

3. Meetings with Researchers and other Experts

Geoff Anderson
Catherine Bennett
Ann Brignell
Marcy Cohen
Lois Cormack
Mary Depuis
Debbie Devitt
Lena Dutton
Hadas Ficher
Andrea Gruneir
Laureen Hayes
John Hirdes
Nadine Janes
Deb Jenkins
Cathy Joy
Stacey Karp
Elaine Klym
Wendy MacDougal
Linda McGillis-Hall
Margaret McGregor
Debra Morgan
Janice Murphy
Linda O'Brien-Pallas
Vivian Papaiz
Marg Poling
Dona Ree
Paula Rochon
Joy Richards
Marilyn Rook
Donna Scott
Chris Sherwood
Betty Smallwood
Gary Teare
Ida Tigchelaar
Ann Tourangeau
Mary-Lou van der Horst
Laura Wagner
Walter Wodchis
Marsha Wolowich
Heather Woodbeck
Judy White
Peggy White

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