CUPE Ontario

Submission to the

REVIEW OF STAFFING AND CARE STANDARDS FOR LONG-TERM CARE HOMES

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Introduction

> *Ontario needs minimum standards of care in nursing homes that give seniors the "dignity and respect" they deserve, Premier Dalton McGuinty says…*
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> *Legally binding minimum standards of care could be in place within three months of the next government taking office, thanks to legislation the Liberals passed earlier this year, Smitherman said.*
>
> - Nursing home changes coming, McGuinty says
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> *Toronto Star October 5, 2007.*

The Canadian Union of Public Employees is Canada's largest Union representing more than half a million workers across Canada including approximately 200,000 employees in Ontario.

CUPE Ontario members are employed in Health Care, Education, Municipalities, Libraries, Universities, Social Services, Public Utilities, Transportation and Emergency Services. Our members include service-providers, white-collar workers, technicians, and labourers, skilled trades people and professionals.

Across Ontario's long-term care sector, CUPE represents 24,000 workers in 217 long-term care homes. CUPE represents workers at 35 charitable homes, 69 Homes for the Aged, 71 nursing homes and 42 retirement homes. 47% of CUPE members work in the non-profit sector and 53% work in the for-profit sector.

In addition, CUPE members are residents and users of Ontario's health system. Many of us have family members, colleagues and friends living in Ontario's nursing homes.

The CUPE Ontario brief is submitted on behalf of our 200,000 members and in support of the 24,000 CUPE members working in the long-term care sector.

Overview

Health care reform and demographic trends over the last decade have made long-term care homes more and more central to care. The increasing age and acuity of residents in Ontario's long-term care facilities is now so well documented as to be beyond question. The continued movement of heavier care patients out of hospitals and mental health facilities into long-term care homes has created mounting care needs, which remain unmet. Demographic trends mean that the progressively more complex and heavier care needs of Ontario's long-term care residents will only increase in the next twenty years.

CUPE Ontario, together with the other unions representing long-term care workers, senior's groups and public health advocates, believes that the key focus of any long-term care reform must be the provision of a minimum staffing standard to ensure adequate care levels, a mechanism to measure and provide adequate funding to reach these staffing standards, and a compliance regime to ensure they are respected. Staffing levels are key to providing sound care, to preventing abuse and neglect, for ensuring the safety of residents and care workers, and for improving the quality of life of residents. The government must recognize that the homes are also workplaces, that current levels of care are inadequate and unsafe, and that the rates of illness, injury and violence in facilities must be recognized and prevented. The government must send a strong message to support non-profit and public delivery of long-term care, and to reverse the trend of for-profit privatization. Furthermore, the government must address the issues of respect, openness, transparency and support that are required to change the culture of secrecy and reprisal in the homes.

We have focused this submission on our research and international best practices regarding the following:

- our priority recommendation of a regulated staffing standard, with compliance and enforcement mechanisms
- the relationship between staffing levels and quality of care, quality of life and outcomes for residents in LTC homes
- work environment, violence, injury, quality, shortages and work load
- human resources recruitment, retention and turnover
- appropriate accountability and funding
- non-profit versus for-profit ownership and the evidence supporting regulation

It is essential that in your proposed comprehensive framework for human resources and quality of care you recommend the regulation of hands-on staffing levels. CUPE Ontario wishes to use the opportunity

afforded in this *Review of Staffing and Care Standards for Long-Term Care Homes* to put forward, again, our priority position that there is a need for a minimum average staffing standard of 3.5 hours of nursing and personal care per resident per day. This standard should include hours worked of Registered Nurses (RN); Registered Practical Nurses (RPN) and Personal Support Workers (PSW). As detailed in this submission, this standard should reflect actual hours - not paid hours – and should exclude administrative classifications. We have recommended such a staffing standard, to be put into a regulation under Bill 140, be designed to adjust with the measured acuity of the residents and contoured to the nursing and personal care funding envelope.

Though such a regulated and enforced staffing level standard will improve care, it is not the only requirement for a comprehensive framework. Staffing shortages are a critical issue for our members and residents. These must be addressed through a long-term human resources recruitment and retention strategy, based on evidence of the relationship between improvements in quality, workload, workplace safety on one hand and recruitment, retention and turnover on the other. Other quality of work and care issues must be addressed, including access to supplies, scheduling flexibility, training and support. Finally, the trend of increasing for-profit ownership must be reversed. The evidence is that ownership matters: for-profit facilities are subsidizing profit margins by moving costs into the hand-on staff funding envelope to make room for increased profit-taking from the accommodation envelope. Finally, any comprehensive framework must recognize that the levels of care and funding must be aligned, enforceable and publicly accountable.

Adequate Standards and Compliance

The first goal of any long-term care facility legislation should be to ensure that the assessed care needs of people residing in the facility are met. As it stands, the legislation fails to do this.

To effectively ensure that the care needs of residents are met and to fulfill the government's obligation to provide sound oversight and accountability for the use of public funds, we recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff (RN, RPN and PSW) to provide a minimum average of 3.5 hours per day of nursing and personal care per day per resident. This average should be weighted to the average case mix measure, and therefore reflect the actual acuity within LTC homes. It should be attached to the Nursing and Personal support envelope, excluding incontinence supplies and administrative classifications.

This standard must be subject to compliance and enforcement regimes.

In addition, the government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers.

I. The relationship between staffing and quality of care, quality of life and outcomes, and the evidence regarding regulated staffing levels

From the 1995 study on overstretched long-term care staff by O'Brien, Pallas et al to the 2001 PriceWaterhouse Coopers Report and our own study by Drs. Pat Armstrong and Tamara Daly, the chronic inadequacy of the current system in Ontario is indisputably revealed. While we are generally supportive of the improvement in assessment that will likely result from the pilot projects using the RAI MDS 2.0 classification system, the union should be consulted for input and changes before it is fully adopted. Moreover, the change in assessment is insufficient to deal with the problem of assessing adequate staffing and funding. What is needed is the necessary framework of legislation, regulation and policy that would ensure that care and funding are aligned and provided at levels necessary to reduce harm and provide safe and sufficient care conditions. This relies on the reinstitution of a staffing standard.

Not Enough Hands: Our Members' Experiences in Ontario's Homes

In 2004, CUPE Ontario commissioned a report by Dr. Pat Armstrong and Dr. Tamara Daly to assess the key issues in long-term care homes, as identified by the nurses, personal support workers, maintenance staff, homemaking staff, dietary workers, therapists and recreational workers who are involved in caring for residents on a daily basis. The purpose was to assess long-term care workplace issues, including staff training, workload, perceptions of resident care, worker health and safety and the relationship between work and family life. Based on over 900 detailed surveys from workers in a random representative sample of non-profit and for-profit facilities in March and April 2004, professors Armstrong and Daly compiled an illustrative and disturbing catalogue of issues and challenges. The report is appropriately titled "There Are Not Enough Hands: Conditions in Ontario's Long Term Care Facilities".

Like Monique Smith's investigation, our survey reveals a deeply disturbing lack of care. Heavy workloads mean that there is not enough time to complete tasks in a way that complies with standards. Nearly one in five reported that they are able to complete their tasks to established standards less than half the time.

An additional 14.3% report they are *never* able to do so. The survey authors tallied the types of care that are going undone:

> "We asked workers to indicate whether specified tasks were completed or left undone in the seven-day period prior to responding to the survey. What we found is disturbing and goes far beyond a lack of baths, appropriate food and recreation.... Nearly 60 percent of the time workers don't have the time to provide emotional support (59.8%), while walking and exercising of residents is not done more than half the time (52.3%). More than 40 percent of the time, recording, foot care, and providing support to co-workers is left undone.... More than 20 percent of the time, turning of residents, bed changing, room and bathroom cleaning, learning necessary skills and other unspecified tasks remain to be done. Bathing and building maintenance are left undone nearly 20 percent of the time. Nearly 15 percent of the time (14.7%), workers are unable to attend to clothing changing. Finally, referral to outside medical support is left undone more than 10 percent of the time. Nearly ten percent of the time (8.5%), feeding is left undone!"

Our study is in keeping with the wealth of research from the last decade linking staffing standards to improved care outcomes and safety. In the most rigorous and reputable studies on the question, both a major study commissioned by the U.S. Congress and a report by the Institute of Medicine conclude that there is a demonstrable relationship between staffing levels and quality of care and outcomes. Both recommend regulated minimum staffing levels:

- In perhaps the most rigorous research available on the subject, after a decade of scandals and erosion of public confidence in the nursing home industry – similar to those experienced in Ontario -- the US Health Care Financing Administration (HFCA) was federally mandated to deliver a report on whether there was an "analytical justification for establishing minimum nurse staffing ratios in nursing homes". The term "nurse" is used here to encompass RN, RPN and PSW/HCAs. The HCFA delivered two phases of its "Report to Congress: Appropriateness of Minimum Nursing Staff Ratios in Nursing Homes". Multivariate analysis and time motion studies yielded strong findings on the relationship between staffing and quality. **They found that preferred minimum levels existed above which quality was improved across the board. The total preferred minimum level was 3.45 hours of care, with a staffing mix of aides, RPNs (or equivalent) and RNs.**[1] Phase II of the report details the connection between staffing and care outcomes finding:
    - "The role of nursing home staff in treating CHF [Congestive Heart Failure] involves preventive measures to avoid declining health and early identification of signs and symptoms of CHF that should be brought to the attention of a physician to avoid hospitalization. The prevention side consists largely of proper administration of medications, which would be the responsibility of an RPN or RN. Nurse's aides might help to avoid hospitalization for CHF by making certain that any fluid and dietary restrictions (e.g. low salt) are followed, and by early recognition of increased shortness of breath or increased edema. Nurse's aides and RPNs who see residents frequently could observe breathing difficulties and increased fluid accumulation. The most influential role of RNs

might entail supervision of the nurse's aides and the follow-up on their concerns about particular resident's conditions….

- "Nurse's aides play a major role in preventing hospitalization for electrolyte imbalance by proper hydration and assistance with eating, while RPNs may play a role in proper medication administration and early recognition that an individual's physical and mental status is declining. RNs are essential for oversight and training of nurse's aides, as well as following up on any potential problems….
- "…nurse's aides play a major role in helping to prevent aspiration pneumonia through proper positioning and feeding and reducing spread of contagious respiratory infections through proper infection precautions. RPNs and RNs play a valuable role, not only in supervising aides, but in assuring that all individuals receive both the pneumovax and influenza vaccination, and in enforcing appropriate precautions so that infections do not spread throughout the facility. In addition, early recognition of respiratory infection symptoms, contacting the physician, and initiation of antibiotics are critical to successful treatment of pneumonia….
- "Sterile procedures for urinary catheter care are essential responsibilities of RPNs and RNs. Early recognition of the signs and symptoms of UTI [Urinary Tract Infection] can avoid hospitalization by prompt physician contact and initiation of treatment. This requires attention from all staff and sufficient RPN and RN staff to supervise aides and promptly follow up on any atypical resident behavior (e.g. confusion) which might indicate an unrecognized UTI….
- "RNs and RPNs must respond promptly when any symptoms of an infection are identified. This requires supervision of the nurse's aides and attentiveness to the condition of the residents in the nursing home. Once sepsis occurs, the nursing home must hospitalize the patient for treatment, but the mortality rate even after hospitalization is extremely high….
- "Thus all of these quality measures meet the first and most important criterion of a potential association of staffing. They all represent events in the nursing home of reasonably high prevalence…."

The study further found that for longer-stay residents:

- "Nursing homes where nurse's aides and nurses feel rushed to provide personal care and assistance are likely to have higher incidences of these occurrences [of skin trauma including abrasions, bruises, burns, cuts, and skin tears]….
- "In the Phase I study, significant weight loss was found to be associated with nurse's aide staffing and RN plus RPN staffing…. Thus, a decline in weight to a level below a BMI [body mass index] of 21 is an important quality measure influenced by staffing ratios….
- "Resisting assistance with ADLs [assistance with daily living] is a marker of the personal relationship between residents and staff….over time residents who initially resist assistance with ADLs out of fear or confusion should gradually become more accepting of care if well-trained and supervised staff are available to permit development of personal rapport…."[2]

In light of these findings, our study results showing inadequate staffing levels and time for feeding, bathing, turning, activation, building relationships, have serious implications for quality of care and outcomes.

- The Institute of Medicine (IOM) report Improving the Quality of Long Term Care (2001)

recommended the development of minimum care levels integrated with case mix adjusted standards concluding: "**The committee concludes that in view of the increased acuity of nursing home residents, federal staffing levels must be made more specific and that the minimum level of staffing has to be raised and adjusted in accord with the case-mix of residents.** The objective should be to bring those facilities with low staffing levels up to an acceptable level and to have all facilities adjust staffing levels appropriately to meet the needs of their residents, by taking case-mix into account."[3]

- The Coroner's Jury in the Casa Verde inquest recommended **increased staffing and regulation, including a minimum-staffing standard**.[4]

In fact, Ontario lags behind trends to achieve more accountable staffing levels in recognition of the association between staffing and quality of care, across Canada and the U.S:

- The New Brunswick Liberal Party recently won an election with a key campaign promise to phase in a 3.5 hour minimum staffing standard.
- Alberta has set a policy direction of 3.6 hours of care per day, an increase from 3.1 hours in 2004-05. There are criticisms from the province's major seniors' and consumers' groups that this policy is inadequate as it lacks clear enforcement mechanisms and should be targeted to hands-on care providers only.
- Nova Scotia has adopted an increase in staffing hour guidelines from 2.25 to 3.25 hours per day.
- Manitoba recently announced a 3.6 hour-per-day standard.
- 37 U.S. States have established minimum staffing standards either in statute or in regulation.
- While Ontario removed its former care standard, 13 U.S. states increased their staffing standards (between 1999 and 2001).[5]

II. Work environment, violence, injury, quality, shortages and workload

Violence, Illness and Injury

A recent study by researchers from the University of Toronto and University of Maryland found that for each hour of care, injury rates for nurses and nurses' aides fall by nearly 16%. For every unit increase in staffing, worker injury rates decrease by two injuries per 100 full time workers. Study authors concluded that more hours of care provided per patient, the fewer the workplace caregiver injuries, which leads to better care.[6]

The consequences of more residents with complex and heavy care needs were evident in the alarming statistics of violence and injury in the study of our members conducted by Dr. Pat Armstrong et al. The authors of the study found,

> "... Alarming rates of violence among residents and against workers and of both illness and injury. Within the most recent three-month period, almost three-quarters of workers

> have experienced some form of violence directed at them from one or more individual residents (73.3%). The combination of rising acuity, inadequate staffing and facilities creates conditions that are dangerous for workers' health. A stunning number (96.7%) in our survey reported having been ill or injured as a result of work in the past five years (1999 - 2003). More than 50% report that work caused illness or injury more than 11 times during this time period."

The recently enacted legislation has failed to tackle the serious issues of understaffing and illness and injury revealed in our research, and echoed in many other studies. The government must recognize that the levels of care are inadequate and unsafe, and that the rates of illness, injury and violence in facilities must be recognized and prevented. We believe it is unconscionable to leave vulnerable and dependent adults without enough care to provide adequate feeding, bathing, repositioning and activation. It is also unconscionable for the government to knowingly allow the continuation of inadequate regulation that has created understaffed workplaces in which caregivers are punched, kicked, strangled, injured and made ill while attempting to provide care.

Shortages

Like Monique Smith's investigation and many other studies, our survey by Dr. Pat Armstrong et al., identifies staff shortages as one of the central problems. Unlike the ministry report, however, our survey indicates that shortages in every occupational category are critical to care. While shortages in nursing, therapy and personal care staff are vitally important, so too are shortages in laundry, dietary, clerical, recreational, housekeeping and maintenance staff. If the dietary and housekeeping staff are not there, nursing staff end up doing cleaning and feeding. Our survey finds that future shortages result not only from the pay inequities and poor conditions that Smith identifies, but also from the aging of the workforce. A majority of our members surveyed were 45 and older, and one in five have worked in long-term care homes for over 20 years. Further our study shows that shortages in formal staffing levels, recognized by Smith's report, are in actuality even lower due to a failure to replace absent staff members.

III. Human resources recruitment, retention and turnover

Our members report that crushing workloads, increasing acuity, shortages, safety issues and a work environment that allows little control over scheduling, inadequate access to supplies, and an atmosphere of fear and reprisals for complaints about poor management practices, have decreased quality of life and led to an exodus of staff from the sector to hospitals. In a recent meeting of our Health Care Workers Coordinating Committee, members reported that their priority was to achieve an enforceable, accountable staffing standard to allow them to provide care to acceptable standards. They also identified

as priorities staffing shortages that are epidemic across all the facilities in all regions of the province. All members reported that their facilities are working “short” and that absences are not covered. They reported concerns about staff turnover and staff leaving for higher wages and better schedules in other health sectors. Further, they reported that inadequate incontinence supplies and requirements to limit the use of these supplies are among their top quality of care concerns.

IV. Appropriate accountability and funding

We are not alone in our deep concern that care levels are inadequate. The provincial auditor in 1995 and 2002 noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PriceWaterhouse Coopers Report, and inadequate tracking of contagious disease outbreaks.

As of the 2004 auditor’s report, some improvements to the inspection regime and reporting requirements had been made. However, no staffing standards have been created, despite the auditors’ repeated recommendations. Further, the Ministry has never updated nor has it addressed the findings of the 2001 PriceWaterhouse Coopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs including depression, cognitive impairment and behavioural problems. While every year funding has increased to the sector, there is still no assessment of whether funding levels are adequate to provide care to meet the assessed needs of residents. It is not clear what proportion of the new funding has gone to the expansion of the sector, and how much is going to increasing care levels. The best information available information puts Ontario’s actual care levels still well-below the 2001 minimum standards of other jurisdictions, while the complexity and heaviness of care requirements continues to increase with further downloading of mental health facilities and aging.

V. The impact of increasing for-profit ownership and the requirement for regulation

In Ontario's envelope funding system for LTC homes, only in the accommodation envelope do the facilities keep funding if they do not spend it all. In the nursing & personal care and programs & services envelopes the homes must return funding received from the government if it exceeds what they spend. In

the for-profit facilities this means that the accommodation envelope is the one from which they can take profits. This is the envelope also into which premiums charged for private and semi-private beds go.

Over the years, the operators have been allowed to do a number of things to shift costs from the accommodation envelope into the nursing and personal support envelope, including moving incontinence supplies, moving costs for building cameras and surveillance equipment, and shifting the work of accommodation staff to personal support staff. The fewer the costs in the accommodation envelope, the more room for profit-taking. In recent years, it has been reported that the government is directing the operators move incontinence supplies and surveillance and security costs back into the accommodation envelope so that nursing and personal care funds are not siphoned off into these other items. This has not been done. Essentially, staffing budgets and therefore staffing levels have been compromised to offset profit-taking.

The operators have also conducted public campaigns and lobbying to increase the amount of funding in the accommodation envelope. The fee increases for residents adopted by the Harris-Eves Conservative government go into the accommodation envelope.

The for-profit homes have an interest in increasing fees for seniors and in shifting costs out of the accommodation envelope, even if it lowers care staff levels, because it fits their requirement to maximize rates of return for their investors. Thus the profit and growth requirements of the for-profit nursing home industry are in direct conflict with the public interest in accessible and affordable care.

Research from more than a decade of experience in the United States shows that care in non-profit and public long term care homes is superior to that of for-profit homes.

- When releasing his recent study revealing better performance in non-profit versus for-profit nursing homes, University of Toronto PhD candidate Michael Hillmer noted that the difference, “could be as simple as them being required to put any profits back into the homes.” His study found non-profits performed better, especially in measures of patient care, than for-profits. Findings in the for-profits included higher rates of pressure ulcers (bed sores) and use of psychoactive medications to subdue patients and more use of restraints.[7]

- His conclusions were echoed in the June 2005 release of the University of Toronto, University of Maryland study on caregiver injuries and staffing levels in nursing homes.

> Lead researcher Dr. Carles Muntaner state, “Reductions in staffing ratios and numbers of staff hours lead to lower quality of care. At the end of the day, it’s a policy option, but the consequences are clear. If you try to squeeze the budget to maximize profits, it creates the dangerous situation we see in the United States.” [8]

Ontario has the highest proportion of for-profit LTC ownership in Canada. Given the evidence of poorer quality and staffing in for-profit homes and the current attempts by providers to move costs into the Nursing and Personal Care envelope displacing staffing funding in order to maximize profits, the evidence is that we have a greater need for an enforceable regulation of staffing levels in our facilities to protect residents and staff from harm.

Conclusion

We are well aware that umbrella lobby groups representing the for-profit providers in the sector have been lobbying hard against standards. In fact, it was these same groups that were listened to by the Conservative government almost a decade ago when standards of care were removed from the legislation all together. This decision flies in the face of the evidence, and best practices and trends across Canada and the United States. The current government needs to understand that when the voices that are listened to in relation to standards are those of the for-profit lobby, and when those speaking against standards of care win; that the residents, their families, and workers in the sector lose.

CUPE Ontario recommends that:

The REVIEW OF STAFFING AND CARE STANDARDS FOR LONG-TERM CARE HOMES recommend that cabinet *must* make a regulation under Bill 140 setting a minimum staffing standard. CUPE recommends that this regulation provide a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum average of 3.5 hours per day of hands-on nursing and personal care per day per resident. The average should be weighted to acuity so that an average CMM home receives funding and is required to provide an average of 3.5 HPRD care, with higher acuity homes providing more and lower acuity homes providing less based on the assessed actual care needs of the residents. The standard should apply to hands-on staff: RNs, RPNs and PSW/HCA/HA positions and attached to the Nursing and Personal Care funding envelope. This standard must be subject to a compliance and enforcement regime.

The REVIEW OF STAFFING AND CARE STANDARDS FOR LONG-TERM CARE HOMES recommend that cabinet ensure that there is consultation on the assessment system adopted in the regulations. The pilot of the new classification system should be assessed with input from CUPE and it must be ensured that the special care needs of

residents with cognitive impairment and those with aggressive tendencies are properly assessed and adequate care levels are provided to minimize risk.

The REVIEW OF STAFFING AND CARE STANDARDS FOR LONG-TERM CARE HOMES recommend that cabinet is required to create and maintain a *provincial* funding model that is based on a uniform assessment tool across the province to ensure that there are uniform provincial standards and funding assessment tools across all LHINs. The funding model must provide adequate funding directed to the nursing and personal care envelope to meet the required staffing standard, adjusted to case-mix, as set out in the regulation and clear accountability as to how that money is spent.

Footnotes

1. Health Care Financing Administration "Report to Congress: Appropriateness of Minimum Nursing Staff Ratios in Nursing Homes" Phase One and Phase Two Reports.
[2] Kramer, Andrew M., MD and Ron Fish MBA, Centre on Aging, University of Colorado Health Sciences Centre under subcontract to Abt Associates, "The Relationship between Nurse Staffing Levels and Quality of Nursing Home Care" Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report, December 2001.
3. Institute of Medicine, Improving Quality of Long Term Care, 2001.
4. Coroner's Jury Recommendations. Casa Verde Inquest. 2005.
5. See Harrington, 2001.
6. Medical News Today (medicalnewstoday.com). June 29, 2005. Study published in the American Journal of Public Health, July 1, 2005.
[7] Hillmer, Michael et al. Study is published in Medical Care Research and Review, April 2005.
[8] medicalnewstoday.com